The United Republic of Tanzania

Ministry of Health and Social Welfare

The Tanzania Quality Improvement Framework in Health Care 2011 - 2016

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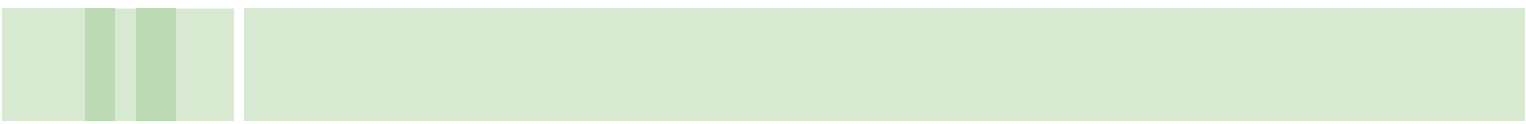
Quality Improvement Series

1. Tanzania quality improvement Framework: September 2004

2. National Infection Prevention and Control Guidelines for Healthcare Services in Tanzania: November 2004

3. National Infection Prevention and Control Pocket Guide for Healthcare Services in Tanzania: February 2007

4. Mwongozo wa Taifa wa kukinga Maambukizo katika Utoaji wa Huduma za Afya: Kiongozi cha Mfukoni wa Watoa Huduma za Afya Tanzania: Aprili 2007

5. Implementation guideline for 5s-CQI-TQM Approach in Tanzania: May 2009

6. Quality Improvement - Infection Prevention and Control Orientation: Guide for participants: July 2008

7. National Supportive Supervision Guidelines for Healthcare Services: September 2010

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Foreword

The second edition of the Tanzania Quality Improvement Framework (TQIF) in health care, is a response to many developments in the areas of: Policies, Quality Improvement (QI) initiatives and approaches, as well as an increased awareness on the demand side, for quality health care services. Various policies have been reviewed and others developed since the TQIF first edition of 2004. These include: The National Health Policy (2007); The Primary Health Services Development Program (2007); The Human Resources for Health Strategic Plan (2008-2013); The Health Sector HIV and AIDS Strategic Plan-II (20098-2012); The Health Sector Strategic Plan-III (2009-2015); and The National Development Plan (2011-2016). In all these policy documents, emphasis is placed on the provision of quality services at health care facilities.

As part of the support that is extended to the Tanzania health care system, a number of QI initiatives and approaches have been introduced, after the first edition of TQIF. These initiatives and approaches include: Infection Prevention and Control-Injection Safety (IPC-IS); Standard Based Management and Recognition (SBM-R); Health Improvement Collaborative (HIC); 5S-[Sort, Set, Shine, Standardize and Sustain]-KAIZEN (CQI)-TQM; Health Laboratories Accreditation, initially using a standard accreditation approach and later on switched to a Stepwise Certification towards Accreditation and the Association of Private Health Facilities in Tanzania (APHFTA) program on Stepwise Certification, towards Accreditation of health facilities. All these initiatives and approaches are addressed in this second edition.

Based on the review of the current QI situation and developments in the health sector; this second edition has incorporated a number of new things, and updates on the materials that were covered in the first edition. The new and updated areas include: principles and dimensions of quality; progress made in the implementation of the first edition; updates in the policy environment; current QI initiatives; updated "strength, weaknesses, opportunities, and threats - SWOT" analysis on QI; introducing stepwise certification towards accreditation; improvement of work environment and occupational safety; implementation of standards for medical equipment and their maintenance; improving health workers productivity; strengthening management at health facility level , through the introduction of: clinical governance; reporting of medical errors, accidents, and mistakes; and improving clients satisfaction, implementation of health facilities structure standards by updating and disseminating them, organizational structure for the QI in health care at all levels (with actors and their roles including the envisaged National Quality Improvement Team); institutionalizing the QI in health care by phases, activities readiness and indicators of phases, introducing the quality auditing; facilitating dissemination of technical information and exchange of experiences in developing an ICT strategic framework and creating a countrywide information network; TQIF Model, with four pillars; and salient features of client's charter indicators.

Enjoying the highest attainable standard of health – the "Right to Health", is enshrined in the Constitution of the World Health Organization (WHO). The Alma Ata Declaration; the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the General Comment-14 an interpretation of the "right to health" by the Committee on the ICESCR, have all recognized it. The WHO Eleventh General Program of Work (2006-2015) provides a global health agenda for member states. The agenda highlights seven priority areas, including "promoting universal coverage, gender equality, and health-related human rights". The awareness of the people of Tanzania on their rights, including the "right to health" has been increasing over the years.

The result of this increase in awareness, is reflected in the increased demand for quality health care at health facilities. This second edition of the TQIF has outlined various ways that can be used to collect the client's feedback on the quality of health care, and strategies to increase their satisfaction with the quality of health care services. It sets a pace for all stakeholders to work towards QI, in a coordinated and integrated manner. A sister document to this framework: "The Tanzania Quality Improvement Strategic Plan", will be developed. It will stipulate clearly, the objectives and activities that are to be implemented, so as to achieve QI at health care facilities.

The MoHSW urges all stakeholders, to use this framework consistently, so as to guide all QI efforts in health care, in Tanzania. Sharing of experiences and challenges that are encountered in the next five years of implementation, will guide all future review processes towards producing the third edition of the TQIF in health care.

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Acknowledgement

Revision of the Tanzania Quality Improvement Framework, intends to create more attention on quality improvement of health care, among health managers and workers, and thus meet the expectations of all quality improvement programs, that are currently implemented in Tanzania.

This revised framework, the Tanzania Quality Improvement Framework in health care (TQIF), puts to emphasis on high quality health care, and that is developed by the efforts and contributions of quality experts, institutions and individuals. The Ministry of Health and Social Welfare would like to express its appreciation, to all individuals who committed and participated in the revision process of this framework.

This framework is a symbol of partnership between the Ministry of Health and Social Welfare and development partners, and we therefore express our sincere thanks to the Japan International Cooperation Agency (JICA), through the HRH Development Project for the technical and financial support in initiating and to the completing all the activities pertaining to the revision of this framework. We appreciating the contribution of Dr. Melkiory Masatu the lead consultant and Dr. D. Simba for their initial assessment, literatures review in the development of the first draft of the framework. We would also like to express our gratitude to the URC and JHPIEGO, for the technical contribution of the framework.

The Ministry of Health and Social Welfare would like to thank Dr. H.A.M Ngonyani, Head of the Health Service Inspectorate Unit and all unit staff, who coordinated well their role during the process of revising the framework.

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List of Acronyms

ADDO	Accredited Drug Distribution Outlet
AMMP	Adult Morbidity and Mortality Project
ANC	Antenatal Care
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
BEmONC	Basic Emergency Obstetric and Newborn Care
CBO	Community Based Organization
CBRCH	Community Based Reproductive and Child Health
CBW	Community Based Workers
CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital
CE	Continuing Education
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CHW	Community Health Workers
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COMATAA	Community Action and Theatre against AIDS
COPE	Client Oriented Provider Efficient services
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
CQM	Comprehensive Quality Management
DCS	Directorate of Curative Services
DCH	Designated Council Hospital
DDH	District Designated Hospital
DHRD	Directorate of Human Resource for Health Development
DMO	District Medical Officer
DPP	Directorate of Policy and Planning
DPS	Directorate of Preventive Services
DSC	Directorate of Sector Coordination
EFQM	European Foundation for Quality Management
ETAT	Emergency Triage Assessment and Treatment
FANC	Focused Ante Natal Care
FBO	Faith-based Organization
FGD	Focused Group Discussions
FLHF	Front Line Health Facilities

GTZ/GIZ	German Technical Co-operation
HBF	Health Basket Fund
HCs	Health Centers
HMIS	Health Management Information System
HMT	Hospital Management Team
HRH	Human Resource for Health
HSIU	Health Services Inspectorate Unit
HSPS	Health Sector Program Support
HSR	Health Systems Research
HSSP	Health Sector Strategic Plan
IEC	Information, Education Communication
IHI	Ifakara Health Institute
IPC	Infection Prevention and Control
IQCCE	Improving Quality of Care through Continuing Education
ISQUA	International Society for Quality in Health Care
JICA	Japan International Cooperation Agency
LGA	Local Government Authority
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aides
MHCP	Managed Health Care Program
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MUHAS	Muhimbili University of Health and Allied Sciences
MuHEF	Muhimbili Heath Exchange Forum
NGOs	Non-Governmental Organizations
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
NQIC	National Quality Improvement Committee
NSGRP	National Strategy for Growth and Reduction of Poverty
NSSS	National Sentinel Surveillance System
OPD	Out Patient Department
OPRAS	Open Performance Appraisal System
PDSA	Plan, Do, Study and Act
PHSDP	Primary Health Services Development Program
PI	Performance Improvement
PLWA	People Living With HIV/AIDS

PMORALG	Prime Ministers' Office Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
POPSM	Presidents Office Public Service Management
PPE	Personal Protection Equipment
QAP	Quality Assurance Program
QAU	Quality Assurance Unit
QC	Quality Circles
QI	Quality Improvement
QIRI	Quality Improvement and Recognition Initiative
QIT	Quality Improvement Team
RHMT	Regional Health Management Team
RMA	Rural Medical Aid
RMO	Regional Medical Officer
SWAp	Sector-Wide Approach
SWOT	Strength, Weakness, Opportunity and Threats
TDHS	Tanzania Demographic and Health Survey
TEHIP	Tanzania Essential Health Interventions Project
TFDA	Tanzania Food and Drugs Authority
TQIF	Tanzania Quality Improvement Framework in Health Care
THSAC	Tanzania Health Services Accreditation Council
TOR	Terms of Reference
TQM	Total Quality Management
USAID	United States Agency for International Development
VHW	Village Health Workers
WHO	World Health Organization
WIT	Work Improvement Team
ZHRC	Zonal Health Resource Centre

Executive Summary

The improvement of health services quality is a central issue in all countries, including Tanzania. Given the expansion of health services that has occurred in Tanzania, quality of care remains a major concern of the Ministry of Health and Social Welfare, health workers and the public in general.

The Ministry of Health and Social Welfare developed a quality improvement framework in September 2004 and has been the guiding document for quality improvement initiatives since then. Over the past five years of TQIF existence, a number of changes in the national as well as the health sector policies and strategies have occurred. These changes have necessitated review of the existing health care quality improvement framework in order to respond to prevailing situation. Hence, the productions of this second version of Tanzania health care quality Improvement Framework, which serves as a guide for the next five years 2011 - 2015.

The TQIF has two main purposes. First, is to encourage all health workers at all levels and other stakeholders in the sector to develop innovative approaches for quality improvement and implement them. Second, to outline what needs to be done to institutionalize quality of health care at various levels based on national interests and vision.

This second version of TQIF retains some of the information, which was in the first version, but also adding new information or re-organizing some of the existing information to make the document user friendly. It begins with an introduction section, which describes the various concepts associated with health care quality improvement; the vision, mission and core values of the framework; and progress made in the implementation of the first version of TQIF. Then, the framework presents background information regarding contextual issues (population, policy, health care system), health care quality improvement initiatives that have been tried out and found to be effective in the country as well as health care quality SWOT analysis. Further, it presents information on health care quality improvement priority issues and strategies, organizational structure for health care quality improvement, how to institutionalize health care quality at various levels and monitoring and evaluation of health care quality initiatives. Twelve (12) priority issues and corresponding strategies on how to address the issues are described. The priority issues are: advocacy for QI; strengthening leadership structures and mechanisms that will develop, implement and sustain QI; improvement of work environment and occupational safety; strengthen the referral system, improvement of environmental health, hygiene and sanitation and capacity building for biomedical engineers for maintenance of medical equipment. Others are enhancing integration, sustainability and equity in health care; enhancing provider capacity and performance; strengthening supportive supervision, monitoring and surveillance; facilitate evaluation of quality in health care through operational research, dissemination of the findings for quality improvement, strengthening health care management through reporting of medical errors and clients satisfaction improvement and ensure quality of health care facility structures and designs. The target audience of the framework includes health service planners and managers, healthcare service providers, teachers and students in health training institutions, as well as health services development partners.

Tanzania Quality Improvement Framework in health care

1. Introduction

1.1. Health care Quality Improvement

No consensus exists across countries or cultures on the definition of "quality" or how it should be measured. Different cultures have different values and priorities; for some goodness means the provision of staff and facilities, for some means equity and compassion, for others it means optimum clinical outcomes.

However, in simple terms, quality means "performance according to standards" or doing right thing, the right way at the right time. In health care, quality is considered as a degree of performance in relation to a defined standard of interventions known to be safe and have the capacity to improve health within available resources.

Quality improvement (QI) in health care is the ability of health providers to provide care that will address the clients' needs in an effective, responsive and respectful manner on continuous basis. Quality improvement aims to identify, implement and maintain best clinical and organizational practices that ensure better care for clients in order to achieve positive health outcomes.

Approaches for improving quality of health care have evolved over the years with different terms, from "quality control" to "quality assurance" to "Total Quality Management" and more recently, to "Population health improvement". The changes reflect the evolution of health policies in different countries over time. For example, there have been two interrelated shifts in health policy: from focus on hospital care to health networks and to ' population focus' (individuals, families and communities) and from authoritarian approaches to more participatory management. Other reasons for the changes include preferences of specific terms by different institutions, sometimes leading to a dialogue of the deaf.

Quality Control (QC) relates to compliance with pre-defined, measurable standards. Quality Assurance (QA) is the process of verifying or determining whether products or services meet or exceed clients' expectations and put measures to ensure quality is maintained. In healthcare settings QA has been referring to a set of activities carried out following set standards of work, monitors implementation and improves performance so that the service provided is as effective as possible. The concept of Total Quality Management (TQM) is more recent. It refers to an approach by which management and employees can become involved in the continuous improvement of the services aimed at embedding awareness of quality in all organizational processes.

Despite the use of different terms, the initiatives address a core of similar issues. To avoid potentials for the many terms confusing operational staff, it has been decided to use the term "quality improvement" throughout the framework. It is thus expected, in the development of QI plans and strategies the districts, hospitals and other institutions will do the same. In improving quality of health care, there are fundamental principles and dimensions that need to be borne in mind.

1.1.1 Principles of health services quality improvement

The principles of health services quality improvement are:
- Client focus
- Provider focus
- Systems and processes focus
- Team work
- Effective communication
- Use of data

Client focus

Clients are the reasons for existence of healthcare providers. They provide the purpose for the structure. One of the main goals for quality improvement is to meet the expectations of the clients both internal and external. External clients are generally the population served, including patients, caretakers, families, and communities. Internal clients are health workers who may need a service from a colleague to perform a job function.

Knowing the needs of clients both felt and unfelt is important for health facility or institution to identify issues related to quality improvement. Felt needs are those, which a client is aware of, while unfelt needs are those that the client is unaware of. For a quality improvement Program to succeed it has to carefully identify its clients and learn their needs and expectations and then find ways to meet them.

Possible needs and expectations from external clients are;
- Quick recovery and back to their social life
- Clean Health care facilities (OPD, wards, toilet etc.)
- Friendly attitude of staff toward patients and visitors
- Reliable services
- Less pay

Provider Focus

The health workers play crucial role in provision of health services. For them to execute their responsibilities they need support from administrators. The support include getting   clear   job description, receiving clear and immediate feedback on performance, equipment and supplies, good work environment, recognition, motivation, etc.

Possible needs and expectations from internal clients are;
- Clean and well organized working place
- Better remuneration and benefits
- Good teamwork
- Clear job description with appropriate work load
- Proper equipment and medical supply for provision of appropriate services
- Staff recognition, appraisal and communication
- Family friendly measures
- Appropriate supportive supervision

Systems and processes focus

A system is a set of interacting and interdependent parts and processes working together to accomplish an activity. A process is a series of steps used to perform a task or accomplish a goal. A system is made up of inputs processes and outputs. Health care delivery involves a number of processes occurring simultaneously, each affects the quality of services offered. In order to do an activity, it is important to understand what need to be done, which steps have to be taken, and in which order.

Teamwork

A team is a group of professionals working together towards achieving a common goal. In health care, service deliveries are too many and complex for one health care provider to work individually. Teamwork is a process involving health workers of various disciplines or professionals to accomplish a task. Collaboration and assisting each other is necessary for effective teamwork.

The team should also be able to lobby, sensitize, and share information with others on what they are doing. The purpose of doing so is to get support from leadership of the organization/ health facility so that leadership can incorporate the QI plan into overall plan for the health facility.

Effective communication

Effective communication is a process of sharing or exchanging information between two or more persons. It involves the transfer of information, ideas, emotions, knowledge and skills between people. Effective communication is essential for ensuring the quality of health care delivery and the satisfaction of users or clients.

In healthcare settings, communication would exist between:
*   QI team with leaders/ management of the hospital, health centre or dispensary
*   Health workers
*   Health workers with clients
*   Management with health workers
*   Management with community.

Use of data

Data is needed to determine the baseline performance status, decision-making, planning, monitoring and evaluation. Quality improvement efforts should be based on evidence based practice. This requires use of correct, complete and current data.

1.1.2. Dimensions of Quality in Health Care

These are aspects of care pertaining to clients (internal and external), which should be considered during provision of quality services. These dimensions are explained below

Acceptability/ Patient centeredness

Delivering healthcare which takes into account the preferences and aspirations of individual service users and cultures of their communities.

Technical competence

The tasks carried out by a qualified and skilled healthcare provider or facility in their usual situation in line with set guidelines and standards

Access to services

Delivering healthcare in a timely, geographically reasonable, and provided in a setting where skills & resources are appropriate to need.

Interpersonal relations

These should include; trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening and communication.

Effectiveness of care

Delivering health care services adherent to evidence based practices and results in improved health outcomes for individuals and communities.

Equity

Delivering healthcare services, which do not vary in quality because of personal characteristics such as; gender, age, race, religion, ethnicity, geographical location or socio-economic status.

Efficiency of care

Delivering health care services in a manner, which maximizes resource, use and avoids waste

Safety

Delivering healthcare services which minimizes risks and harm to service users and providers

Continuity of care

Implies delivery of care without interruption throughout the course of care, appropriate referral and communication between skilled health care providers.

Choice of services

Clients are allowed to make informed choice.

Physical infrastructure and amenities

Physical appearances on cleanliness, comfort, privacy and confidentiality of health facility

1.2. The Tanzania Quality Improvement Framework (TQIF) in Health care 2004-2010

The improvement of health services quality is a central issue in all countries, including Tanzania. Given the expansion of health services that has occurred in Tanzania, quality of care remains a major concern of the Ministry of Health and Social Welfare (MoHSW), health workers and the public in general. The Ministry of Health and Social Welfare developed a quality improvement framework in September 2004 and has been the guiding document for quality improvement initiatives since then. Over the past five years of existence of the TQIF, there have been changes in the national as well as the health sector policies and strategies. These changes have necessitated review of the existing health care quality improvement framework in order to respond to prevailing situation. Hence, the production of this second version of "Tanzania Quality Improvement Framework (TQIF) in health care", which serves as a guide for the next five years 2011 – 2015.

1.2.1. Vision, mission, Core values & Objectives

Vision
To have a level of performance of health care services that are effective, equitable, sustainable, and affordable, gender sensitive and user friendly.

Mission.
Quality improvement shall focus all health care services through instilling among health workers a philosophy of client and community centered care, ensuring strong and transparent leadership at all levels and making quality of health care part and parcel of the culture of daily activities of all health staff, partners and the public in general.

Core values for QI
The values for quality improvement are to ensure that health services are provided efficiently with the following in mind:
- Care for patients / clients,
- Personal integrity and respect for professional ethics and,
- Equitable access to health care by all with focus on community involvement and participation.

Objectives
The objectives of the Tanzania Quality Improvement Frame work in health care are to:
- Effectively give technical advice or guidance on quality improvement of health care services.
- Advocate and inform stakeholders for enhancement and sustainability of quality improvement in health care services.
- Advocate to the public and other stakeholders their roles and responsibilities to ensure and sustain quality improvement of health care services at institutional and facility levels.

1.2.2. Purpose of the Framework

The THQIF has two main purposes:
- To encourage all health workers at all levels and other stakeholders in the sector to develop evidence based innovative approaches or practices for quality improvement and implement them
- To outline what needs to be done to institutionalize quality of health care services at various levels based on national interests and vision.

1.2.3. Contents of the framework

This second version of TQIF retains some of the information, which is in the first version, but also adding new information or re-organizing some of the existing information to make the document user friendly. The framework contains background information regarding contextual issues (population, policy, health care system), health care quality improvement initiatives that have been tried out in the country and found to be effective as well as health care quality SWOT analysis. Also, it has information on health care quality improvement priority areas and strategies, organizational structure for health care quality improvement, how to institutionalize health care quality at various levels and monitoring and evaluation of health care quality initiatives. Tanzania contextual issues, organization structure for quality improvement, how to institutionalize quality at various levels and monitoring and evaluation of quality initiatives are the new sections contained in this second version.

1.2.4. Who is the framework for?

The target audience of the framework includes health service planners and managers, health care service providers, teachers and students in health training institutions, as well as health services development partners.

1.2.5. How to use the framework?

The framework does not intend to serve as an operational plan of activities, but rather provides guidance that can be used to develop quality improvement work plans at various levels of health care delivery.

1.2.6 Progress in implementation of first version of TQIF

The first version of TQIF identified 8 priority areas as follows:
* Strengthening leadership, structures and mechanisms that will develop, implement and sustain QI
* Enhancing interest and active participation of all partners in effort to improve quality of health care
* Strengthen advocacy for QI
* Enhancing integration, sustainability and equity in health care
* Enhancing provider capacity and performance
* Strengthening supportive supervision, monitoring and surveillance
* Mobilizing financial resources for quality
* To Facilitate evaluation of quality in health care through operational research for QI

During the past five years of TQIF operation, there have been a number of achievements for each of the priority areas as outlined below.

Priority area	Achievements
1. Strengthening leadership, structures and mechanisms that will develop, implement and sustain QI	• Preparation of Terms of Reference for establishment of National Quality Improvement Committee (NQIC) • Strengthening the Health Services Inspectorate Unit by training its staff and recruiting new staff • Training of all RHMTs on QI thus empowering them to be trainers and supervisors of QI • Training of RHMT's and some CHMT's on QI, thus empowering them to be trainers and supervisors of QI
2. Enhancing interest and active participation of all partners in effort to improve quality of health care	• Establishment of stakeholders coordination forum
3. Strengthen advocacy for QI	• QI advocacy done to ministerial officials, RMOs and DMOs

4. Enhancing integration, sustainability and equity in health care	• Development of two documents to guide integration of health services
5. Enhancing provider capacity and performance	• A number of health managers and health care providers have been trained on QI, Infection prevention and control, and supportive supervision at national, regional, district and hospital levels • Some professional bodies developed codes of conducts to enhance professional ethics. Examples are the medical council, nurses and midwives council, pharmacy council, health laboratories practitioners' council and medical radiology and imaging professionals' council
6. Strengthening supportive supervision, monitoring and surveillance	• Development of national supportive supervision guidelines for quality of health care • Central management supportive supervision done as scheduled • Development of integrated set of indicators for monitoring and evaluation, including QI indicators, is ongoing • Development of health information system for districts and health training institutions
7. Mobilizing financial resources for quality	• Increased coverage with prepayment scheme • HSIU secured funding from some development partners for QI initiatives
8. To Facilitate evaluation of quality in health care through operational research for QI	• Work to identify strategies for operational research, implementation and dissemination of research findings has started

Despite these achievements, some challenges that affect the quality of health services remain. These are:
• Inadequate QI leadership at all levels
• Insufficient workforce both in terms of quantity and quality
• Inefficient supportive supervision
• Inefficient referral system
• Having many approaches in QI design, monitoring and reporting structures
• Inadequate coordination of QI efforts
• Inadequate funding

2. Background Information

2.1. Tanzania context

Several contextual issues pertaining to the country have been considered in developing this quality improvement framework. These include Tanzania population and health situation, relevant government policies, and the health care system.

2.1.1. Population and health situation

The population of Tanzania has been growing over the years. Positive trends on some health indicators such as Infant and Under-five Mortality Rates have been seen (Table 1).

Table 1. Demographic and health status indicators

Population July 2008*	43,739,000
Population density*	38 per square km
Population composition*	Males 49%, Females 51%
Population growth rate per year*	2.9%
Total Fertility Rate**	5.4
Life expectancy	Male 53 years; females 56 years
Maternal mortality ratio**	454/100,000 live births
Infant mortality rate**	51/1000
Under five mortality ratio**	81/1000

*Projection from Population Census of 2002   ** From TDHS, 2010*

2.1.2. Policy environment

National policies and strategies

Tanzania has developed various policies and strategies to guide the country's development. The policies described hereunder have issues pertaining to quality health care.

Vision 2025

Tanzania Vision 2025 was formulated in 1998. It is a document providing direction and a philosophy for long-term development. Tanzania wants to achieve by 2025 a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learning society and a competitive economy capable of producing sustainable growth and shared benefits.

The document identifies health as one of the priority sectors contributing to a higher quality livelihood for all Tanzanians. This is expected to attain through strategies, which will ensure realization of the following health service goals:

- Access to quality primary health care for all
- Access to quality reproductive health service for all individuals of appropriate ages;

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- Reduction in infant and maternal mortality rates by three quarters of current levels in 1998
- Universal access to clean and safe water
- Life expectancy comparable to the level attained by typical middle-income countries
- Food self sufficiency and food security;
- Gender equality and empowerment of women in all health parameters.

National Strategy for Growth and Reduction of Poverty (NSGRP)

The National Strategy for Growth and Reduction of Poverty (NSGRP), known in Kiswahili as the MKUKUTA (Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania) was approved by Cabinet in February 2005 for implementation over five years and is the successor to the Poverty Reduction Strategy Paper. The NSGRP is informed by Vision 2025 and committed to the achievement of the Millennium Development Goals (MDGs).

The NSGRP aims to foster greater collaboration among all sectors and stakeholders. It has mainstreamed crosscutting issues (gender, environment, HIV/AIDS, disability, children, youth, elderly, employment and settlements). All sectors are involved in a collaborative effort rather than segmented activities.

The NSGRP identifies three clusters of broad outcomes: Growth and reduction of income poverty Improvement of quality of life and social well-being, and Good governance

National Five Year Development Plan (2011/12 - 2015/16)

The National Five Year Development Plan (FYDP) foresees implementation of the Tanzania Development Vision 2025. It emphasises interventions to address the challenges facing the health sector. This imply increasing accessibility to health services, based on equity and gender-balanced needs; improving the quality of health services; strengthening the management of the health system; and developing policies and regulations on human resources for health and social welfare coherent with government policies.

Health sector policies and strategies

Health Policy

The vision of the Health Policy is to have a healthy society, with improved social wellbeing that will contribute effectively to personal and national development. The mission is to provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable. The health services will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians.

Specifically the Government aims to:

- Reduce morbidity and mortality in order to increase the lifespan of all Tanzanians by providing quality health care
- Ensure that basic health services are available and accessible
- Prevent and control communicable and non- communicable diseases
- Sensitize the citizens about the preventable diseases
- Create awareness to individual citizen on his/her responsibility on his/her health and health of the family

- Improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services
- Plan, train, and increase the number of competent health staff
- Identify and maintain the infrastructures and medical equipment
- Review and evaluate health policy, guidelines, laws and standards for provision of health services

Health Sector Reform

Health Sector Reforms (HSR) started in 1994 and aims at improvement of access, quality and efficiency health service delivery. Primary health care was adopted as the most cost effective strategy to improve health of the people. The major focus of the HSR is therefore on strengthening the District Health Services, as well as strengthening and reorientation of secondary and tertiary service delivery in hospitals in support of primary health care.

The program also aims at strengthening the support services at the central level, in the MoHSW, its agencies and training institutions. The HSR introduced a programmatic approach, replacing the project approach, in order to create coherence between activities and continuity.

Primary Health Services Development Program

A Primary Health Services Development Program (PHSDP) was developed in 2007. This is a 10-year program spanning from 2007 to 2017. The overall objective is to accelerate provision of quality primary health care services to all Tanzanian by 2012, while the remaining five years of the Program will focus on consolidation of achievements. The main areas are strengthening the health system, rehabilitation, upgrading and establishing health facilities at primary level, human resource development, strengthen referral system, increase health sector financing, and improve provision of medicines, equipment and supplies.

Health Sector Strategic Plan III

The Health Sector Strategic Plan III (HSSP III) reflects the strategic intentions of the health sector for the period 2009 – 2015. The plan consists of 11 strategies that explain specific issues related to health services delivery and one strategy on crosscutting issues. The health services delivery specific strategies seek to:

- Improve accessibility to district health services
- Improve access to referral hospital services
- Streamline support by central levels' departments
- Increase the number and quality of human resources for health
- Increase the financing of the health sector
- Forge public private partnership in the delivery of health care services
- Implement one plan for maternal, newborn and child health
- Improve disease control programs
- Build capacity for emergency preparedness and responses to diseases outbreaks
- Build capacity for provision of social welfare and protection services
- Strengthen monitoring and evaluation systems

Improving quality of health services is outlined as one of key cross cutting issues in the Strategic Plan and establishment of accreditation has been identified as important activity that will contribute towards sustaining efforts to improve quality of health services countrywide.

Human resources for health strategic plan 2008-2013

The plan aims at increasing productivity of health and social welfare workers at all levels through establishment of effective performance management systems such as Open Performance Appraisal System (OPRAS). To enhance the effectiveness of the system, incentive mechanisms will be designed, developed and implemented.

2.2.   Health Care System

Tanzania has a pyramidal structure of health care services. The primary health care services comprised of dispensaries, health centers and hospitals at district level form the bottom of the pyramid. This is followed by referral health services comprised of regional and national referral hospitals. Both public and private providers provide the health care services. Currently, there are 4,679 dispensaries, 481 health centers, and 219 hospitals distributed throughout the country. About 90% of the population lives within 5 kilometers of a primary health facility

2.3.   Health care Quality improvement initiatives in Tanzania

Various QI programs have been in practice in Tanzania. However, most of them have been focusing on specific programs and also not covering all levels and dimensions of   health care. These are Quality Improvement and Infection Prevention and Control – Injection Safety, (QI & IPC-IS) 5-S-Continous Quality Improvement-Total Quality Management (5S-CQI-TQM), Improvement Collaborative Approach, and Standards Based Management and Recognition Process (SBM-R). HeathWISE Quality Initiative: an ILO methodology for improving working condition of health workers. These quality improvement initiatives are briefly described below.

2.3.1.   Quality Improvement and Infection Prevention and Control (QI & IPC)

This program started in 2004. The MoHSW in collaboration with JHPIEGO-ACCESS is implementing it. Phase 1- started in five-consultant hospitals; Phase 2 was implemented in three regional hospitals, three district hospitals and one designated district hospital (DDH). Now the program is being rolled out to other regional, district and other Faith Based Organization (FBO) hospitals in phases.

Purpose

*   To strengthen the capacity of healthcare workers in the area of IPC practices.
*   To ensure availability of Personal Protection Equipment (PPE), supplies, Injection safety devices and related commodities.
*   To develop and implement advocacy and behavior change strategies to improve IPC practices.
*   To establish sustainable health care waste management system.
*   To promote Public-Private Partnerships and implement a global communication and advocacy strategy to leverage and coordinate support for IPC.
*   To strengthen capacity of the National IPC program of the Ministry of Health and Social Welfare to manage, coordinate and supervise IPC activities in the country.

Activities
- Training of health workers on infection prevention and control practices, behavior change communication, health care waste management, concepts of QI and supportive supervision
- Behavior change communication by developing IEC materials
- Supply of injection devices and safety boxes

Achievements
- Countrywide coverage.

2.3.2 5S-Continuous Quality Improvement / KAIZEN -Total Quality Management (5S-CQI (KAIZEN) -TQM)

In 2008, the MoHSW officially adopted 5S-CQI (KAIZEN)-TQM concepts that use 5-S principles for improvement of the working environment. Then, consider clients' satisfaction to improve clinical and non-clinical (responsiveness) issues with CQI (KAIZEN) activities. Then, other related issues such as financial, human resource management are considered. Considering quality in all services, in all departments and sections is called Total Quality Management. 5S Principles intend to improve efficiency by eliminating waste, improving workflow and reducing processes hindering efficiency. 5-S is literally five abbreviations of Japanese terms with 5 initials of S. Convenient translation to English similarly provides five initials of S. 1, Sort 2, Set 3, Shine 4, Standardize and 5, Sustain. These are explained briefly below:

1. **Sort:** Remove unnecessary stuff for current workflow from your workplace; and reduce clutter (Removal/ organization)
2. **Set:** Organize everything needed in proper order for easy operation (orderliness)
3. **Shine:** Maintain high standard of cleanliness
4. **Standardize:** Set up the above three S's as norms in every section of your place
5. **Sustain:** Train and maintain discipline of the personnel engaged (Discipline)

5S-CQI (KAIZEN)-TQM approach is problem-solving process to ensure productivity and improve quality of services. 5S-CQI (KAIZEN)-TQM approach is taken to meet clients' satisfaction. After the achievement of creating well-organized workplace using 5S principles, problems that affect clients' satisfaction and management of routine work are looked at, and find root cause solution with minimum resource input and improvement from systems perspective.

In 2009, the MoHSW developed and distributed a guideline called "Implementation guideline for 5S-CQI (KAIZEN)-TQM Approach in Tanzania" to guide health institutions for actual, effective implementation of 5S- CQI (KAIZEN)-TQM approach. The initiative started in four referral hospitals and few regional referral hospitals, and then later was rolled out to all specialized hospitals, regional referral hospitals and several district hospitals. Currently few hospitals are stepping up to 5S-CQI (KAIZEN)-TQM processes and start showing improvement of client services.

Purpose
5S activity is to improve working environment for creating enabling working environment for health care providers. CQI (KAIZEN) is to capacitate health workers on problem solving procedures ures

Activities

- Training of Trainers (National, National referral, Specialized and Regional referral hospitals)
- Establishment of strong QI implementation structure at hospital level
- In-house training for health workers at hospital level
- Consultation visit to hospitals by MoHSW for sustainable implementation of 5S-CQI (KAIZEN) -TQM activities
- Organize progress report meetings by MoHSW for monitoring progress of 5S-CQI (KAIZEN) activities and peer education among participating hospitals

Achievements

Ministry of Health and Social Welfare has developed a guideline "Implementation Guideline for 5S-CQI(KAIZEN) -TQM Approaches in Tanzania" in May 2009. Advocacy posters of 5S activity were developed in both Kiswahili and English, and distributed to hospitals.

- 5S approach is well adopted and disseminated under strong initiative of MoHSW. It is now integrated into IPC-IS training and rolling out to all levels of hospitals under HSIU-CMO, MoHSW
- As of August 2010, all National, Referral, Regional referral and several district hospitals have been trained. A Total of 37 hospitals are practicing the 5S- CQI-TQM approach in Tanzania
- Moreover, Tanzania is recognized as a successful country for 5S-CQI-TQM implementations by neighboring countries, and receiving trainees on 5S-CQI-TQM from Malawi, Uganda and Kenya.
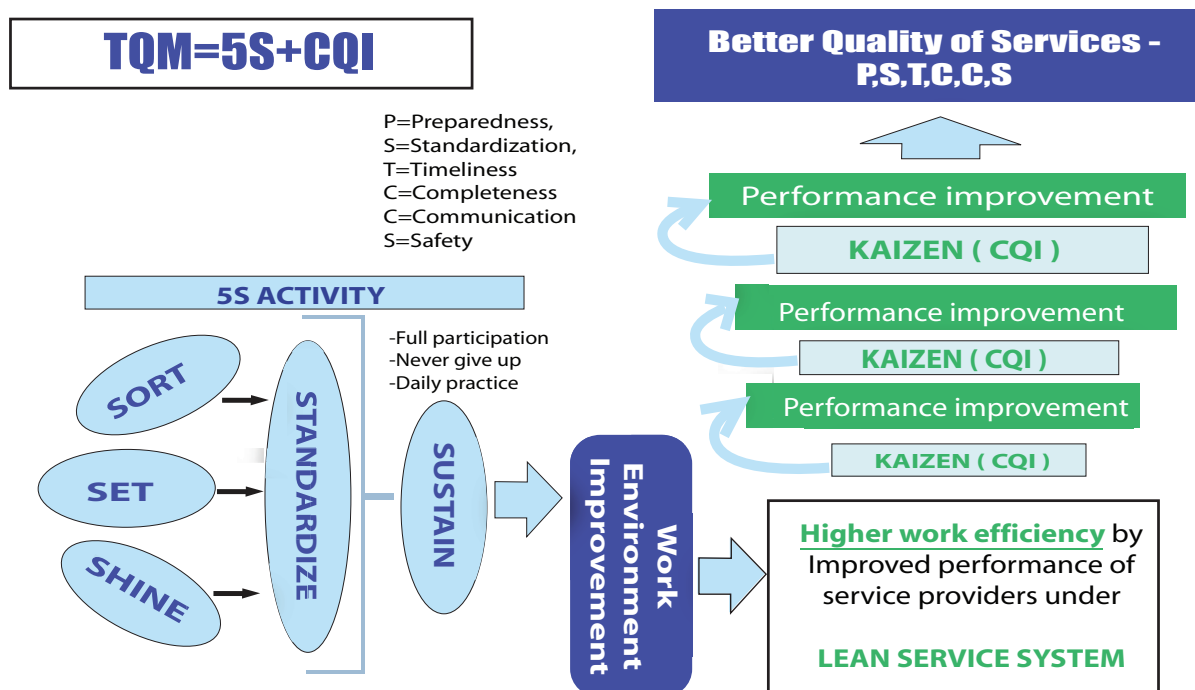

Figure 1. 5S-CQI (KAIZEN) -TQM Conceptual Framework

2.3.3. Improvement Collaborative Approach

An Improvement Collaborative is an organized effort of shared learning by a network of sites (or teams) to close the gap between desired and actual performance by testing and implementing changes within their local situations so as to develop a best practice model of care for a specific priority health problem. An Improvement Collaborative brings together groups of practitioners from different healthcare organizations to work in a structured way to improve one aspect of the quality of their service. It involves a series of meetings to learn about best practice in the chosen area, about quality improvement methods and change ideas, and to share their experiences of making changes in their own local settings.

In Tanzania, between 2004 – 2007 the Improvement Collaborative approach has been applied in improving Family Planning care in Dar es Salaam region, improving pediatric hospital care in Dar es Salaam, Coast region, Morogoro, Tanga and Arusha regions where all district hospitals were involved.

Through the Pediatric Hospital Improvement (PHI) program, the Improvement Collaborative approach managed to produce best practices in management of emergency pediatric conditions through Emergency Triage Assessment and Treatment (ETAT) initiative.

Since 2008, the National AIDS Control Programme (NACP) has used the Improvement Collaborative Approach in its efforts to improve quality of HIV/AIDS services countrywide. Starting with quality of care and treatment services, the approach has been adopted to improve quality of other HIV/AIDS interventions being implemented by NACP.

Purpose
"Collaborative" are organized to achieve results in a short period of time and then scale up the adapted best practice model throughout the organization using an intentional spread strategy.

Activities
Improvement Collaborative do vary in the subject chosen for improvement, the number of organizations involved, the resources available, the process by which teams work, however; the following activities are common:

*   Participation of a number of multi-professional teams with a commitment to improving services within a specific subject area and to sharing with other teams how they made their improvements.
*   A focused clinical or administrative subject (for example reducing postpartum hemorrhage, reducing patient waiting times, and improving asthma care, HIV/AIDS care etc) with evidence of large variations in care or of gaps between best and current practice
*   Participants meet in structured 2 – 3 days meetings (Learning Sessions) to learn from quality improvement experts about evidence for improvement, change concepts and practical changes that have worked at other sites, and about quality improvement methods. Each team presents data/results on key indicators share best practices, lessons learned, successes and failures and how to spread their innovations to other services.
*   Quality improvement teams set measurable targets, develop feasible 2 – 3 months work plans and collect data to track their performance.

- Quality improvement teams use a change testing method to plan, implement, and evaluate many small changes in quick successions also known as Plan, Do, Study and Act (PDSA) cycles.
- The period between learning sessions (usually 3 – 4 months) is called action period during which QI teams continue to exchange ideas and collaborative coaches and mentors provide extra support through site visits, email, and conference calls.

Achievements

- Between 2008 to date, quality improvement teams have been formed at regional, council and health facility level in four regions: Tanga, Morogoro, Mtwara and Lindi. These teams have been trained to improve their capacity to spearhead improvement of HIV/AIDS services in their respective areas.
- The improvement collaborative approach has been applied in improving ART/PMTCT services in the four regions mentioned above where a total of 39 health facilities are participating.
- Best practices and job aids from the ETAT initiative have been packaged and spread in all regions by the MoHSW. Furthermore, under the PHI program guidelines for management of severe childhood conditions were developed and published by the MoHSW in 2006.
- In the ongoing ART/PMTCT Improvement Collaborative, remarkable improvements on performance indicators for ART and PMTCT care have been achieved and best practices have been developed. For instance, all participating health facilities have managed to reduce loss to follow-up among patients on ART, more HIV positive pregnant women are enrolled in care and treatment so are the number of HIV-exposed infants receiving prophylactic ARVs and Cotrimoxazole.
- Quality Improvement Guidelines for HIV/AIDS and standardized training manuals have been developed to streamline quality improvement practices in HIV/AIDS care countrywide

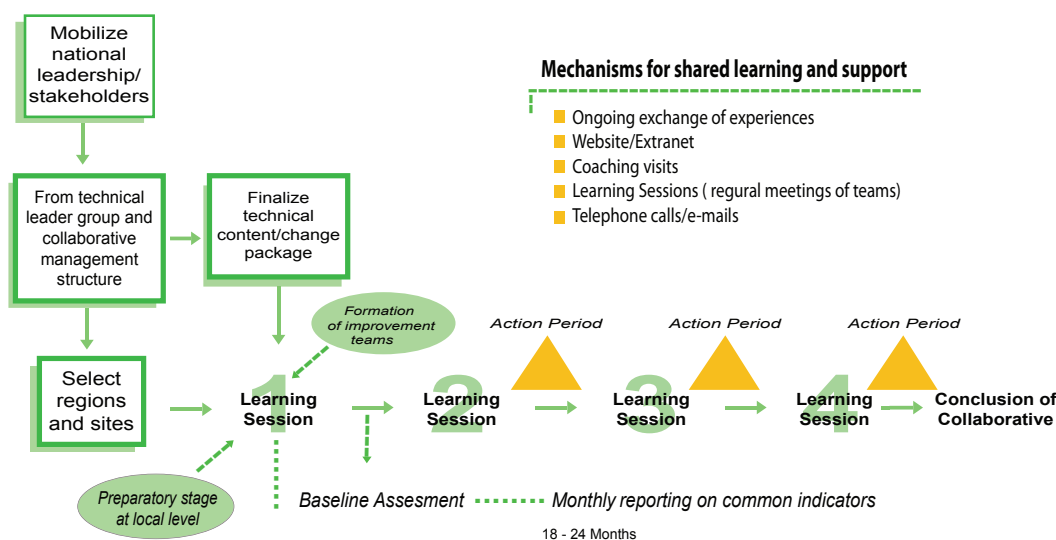## Improvement Collaborative Model as Adapted by QAP

Figure 2. Improvement collaborative model

2.3.4. Standard Based Management and Recognition Process (SBM-R)

SBM-R is a methodology designed to assist providers to improve their performance and thus, strengthen the overall quality of health services. It is a proactive approach, focusing not on problems but rather on the standardized level of performance and quality to be attained. SBM-R capitalizes on observing trends in quality of services/education starting with baseline followed by periodic assessments internally to recognize and address performance gaps. It also develops change management skills with multi-sector collaboration from facility to national levels empowering providers, clients and communities. SBM-R promotes the systematic, consistent and effective utilization of operational, observable performance standards as the basis for the organization and functioning of health services. Furthermore, it rewards compliance to standards through recognition mechanisms.

The purpose of SBM-R is to provide a step-by-step process, with practical tools and ways to identify resources, for improving provider performance and the quality of health services while promoting compliance to evidence-based best practices through the nationally set health care service standards.

Purpose
The purpose of SBM-R is to provide a step-by-step process, with practical tools and ways to identify resources, for improving provider performance and the quality of health services while promoting compliance to evidence-based best practices.

Approach
The approach involves the following steps:
- Setting performance standards that are constructed around clearly defined service delivery processes or a specific content area
- Implementing the standards in a streamlined, systematic way
- Measuring progress to guide the improvement process toward these standards
- Rewarding achievement of standards through recognition mechanisms

Activities
- Expand SBM-R process to all regional and district level hospitals
- Develop guidelines for recognition of high achieving hospitals. Establish an external verification team to carry out recognition.
- Provide on-site support, mentoring and coaching to assist in the achievement of additional standards
- Adapt IPC standards for health care and dispensary level
- Create community awareness on the importance of good IPC at health care facilities

Achievements
As of June 2010, SBM-R had been applied in about 3,000 health facilities (62%) with trained focused antenatal care providers in all Tanzania districts. A number of facilities have been recognized for achieving high standards in antenatal care provision. In addition, 12 regional hospitals have also started the BEmONC SBM-R process, and 6 referral hospitals have begun implementing IPC standards.

3. Healthcare Quality Strengths, Weakness, Opportunities and Threats Analysis (SWOT analysis)

This section outlines the strengths, weaknesses, opportunities and threats for health care quality improvement in Tanzania based on a SWOT analysis (Table 2).

Table 2: Summary of SWOT findings: strengths, weaknesses opportunities and threats

Level	Strength	Weakness	Opportunity	Threat
National	• The development of QA scheme features strongly in the Health Sector Reform and Health Sector Strategic Plan III 2009-2015, • Existence of MTEF for planning QI activities • Several QI initiatives launched by different program in the MoHSW, • Systems for recognition and rewarding for good performance in place, • Several MoHSW Programs have initiated aspects of QI. • Public-Private Partnership forum started • Inspection tools in place and used • Document on integrated training on QI and IPS-IS exists • Existence of client service charter • Health service scheme available • Existence of QI training program in undergraduate and postgraduate courses in higher learning institutions	• Weak system to coordinate, nurture and consolidate QI; • Vertical non-generic QI program introduced using 'trade names' • Government under-funding of health services, • Shortage of skilled staff, inadequate motivation, • Inadequate skills for QI among health workers • Sustainability in QI projects often an afterthought, • Supportive supervision often inefficient and measured by number of visits instead of outputs • Client service charter not enforced • Similar problems recurring over years • Developed tools not fully utilized e.g. client service charter • Safety and productivity are not well focused • Inadequate infrastructure both in quality and quantity • Minimal private sector involvement in QI initiatives • TQIF not operational resulting into slow	• Existence of regulatory bodies NGOs, health training institutions and growing private sector for enhancing QI, • Reinforcement/ consolidation of various health Acts in favor of QI, • Insurance schemes enforcing quality of care through refund mechanisms • Funding through development assistance partners • Professional associations to conduct continued professional development and licensing are available	• Calls for more money and staff whenever QI is mentioned • Profusion of terminologies and approaches by different initiatives with potentials for causing confusion, • Decline in QI activities upon withdrawal of donor support. • Human resources for health crisis

	• Professional associations exists to foster ethics in place	progress in the implementation of the TQIF resulting into slow progress in the implementation of the TQIF • Poor feedback mechanisms from professional bodies to policy makers • Insufficient link between continued professional development and licensing • Lack of national standards and indicators for quality		
Zonal	• MoHSW through the HSSPIII recognize the role of ZHRC in training and supporting RHMTs and CHMTs and training institutions in quality improvement	• Capacity of some of the ZHRC does not tally with the accorded responsibilities. • Slow progress in implementing QI	• Ongoing discussions provide opportunity to define appropriate roles.	• Overstretching capacity of the ZHRC.
Regional	• Budget line available for RHMT through HBF. • Roles and responsibilities of RHMTs clearly defined	• Limited capacity for supportive supervision • Limited capacity and resources to conduct operational research • Systems for recognition and rewarding good performance does not exists • Block grant is not provided systematically to all RHMT	• Capacity for QI available	• Dependency on HBF
District	• Availability of funds through HBF for recurrent costs and drugs; including other sources such as user-fees, CHF and NHIF • Autonomy given at district level in planning,	• Systems for recognition and rewarding good performance exists, Councils not using it • No organized system for QI, Poor feedback and exchange of information, • Relative neglect	• Pilot test on viable logistics for ensuring constant drug supply through ADDOs. • Existence of tools for adoption and implementation i.e. client service charter • Provision, through HSSP III, for working	• Power 'gets stuck at district level', • QI taken for granted. • Dependency on HBF • Human resource for health crisis

	• implementation, monitoring and evaluation through CCHP, • Defined roles and responsibilities of CHMT.	of environmental health problems as highlighted by endemicity of cholera in some areas, • Inadequate attention to certain areas, such as mental health, overall clinical skills, and non-communicable diseases	with NGOs in planning and implementation of health activities	
Hospitals Health centers and Dispensaries	• Better supply of drugs, • Some hospitals have local mechanisms for staff skill development, • Benefit from additional resources including HBF.	• Shortage of skilled staff at service delivery sites • Weak community focus, targeting (mostly) those coming to health facilities, • Ethical lapses / deficiencies, • Exemption mechanisms not functioning adequately most often due to shortage of drugs • Inadequate infrastructure and poor work environment	• Successful initiatives in other sectors, • Existence of initiatives on which accreditation can build, • Infection prevention protocols in some health facilities (can build on). • Empowered, through HSSP III, to plan, budget and implement accordingly	• Hesitancy by CHMT to devolve power, • Inadequate capacity for planning, M/E at FLHFs,
Community	• Community mechanisms in place for health financing such as CHF, cost sharing etc • Existence of community representatives in health facility governing committee and council/district health boards.	• Poor living environment • Weak community focus, minimal community participation and involvement, partner support uncoordinated, • Existing gender, socio-cultural inequalities and inequities hinder access to health services especially reproductive services • Community unaware of their rights,	• Growing public concern on QI. • Formation of boards/ committees enhances community participation • Local Government Reform structures	• Persistence of piecemeal support to community level, • Inadequate capacity of providers to support community initiatives.

4. Healthcare QI priority issues and strategies

From the SWOT analysis, several priority issues were derived, each with one or more strategies as shown in Table 3.

Table 3: The Tanzania quality improvement priority areas and strategies

Concerns	Priority issue	Strategies
Existing key actors lack vision while potential key actors have inadequate capacity for QI.	Advocacy for QI	1. To organize advocacy campaigns for QI at various levels
Quality improvement is assumed to be everybody's responsibility. Inadequate system to coordinate, nurture and consolidate efforts on QI.	Strengthening leadership, structures and mechanisms that will develop, implement and sustain QI	1. To ensure that strong and transparent leadership in quality is at all levels. 2. To introduce and implement an accreditation system
Disorganized work environment thus hindering QI Occupational safety not integrated in health care delivery	Improvement of work environment and occupational safety	1. To improve work environment and occupational safety
Referral system not functioning well	Strengthen referral system	1. To Strengthen referral system
Poor infrastructures for waste management, unplanned settlement and inadequate safe water supply, sanitation, and hygiene.	Improvement of environmental health, hygiene and sanitation	1. To strengthen environmental health, hygiene and sanitation
Medical equipment not well maintained	Capacity building for biomedical personnel for Maintenance of medical equipment	1. Formation of maintenance technical teams 2. To train adequate biomedical personnel to conduct maintenance of technical equipment.
Strategies for integration not adequately implemented. Most QI initiatives have sustainability issue as an afterthought. Ineffective exemption mechanisms lead to inequity in accessing health services.	Enhancing integration, sustainability and equity in health care	1. To enhance integration of services 2. To enhance sustainability of QI at all levels. 3. To enhance equity in health care delivery
Health facilities staffed by inadequate personnel in numbers and skills; lacking	Enhancing provider capacity and performance	1. To intensify training and skill development for QI

motivation; and eroded ethical and moral values.		2. To enhance recognition and reward for performance. 3. To enhance professional ethics and morality. 4. To improve working environment and occupational safety 5. To improve health workers productivity and increase the proportion of skilled staff in working places
Supportive supervision done but emphasis is on quantity and not quality. Standards and indicators for QI are lacking in the existing monitoring and surveillance systems.	Strengthening supportive supervision, monitoring and surveillance	1. To strengthen supportive supervision. 2. To strengthen monitoring system. 3. To strengthen sentinel surveillance on quality of health care.
Agenda for research is weak and not based on needs. RHMTs and CHMTs lack capacity to conduct operational research. Access to QI information is poor.	Facilitate evaluation of quality in health care through operational research and dissemination of the findings for QI.	1. To intensify training and skill development for QI 2. To enhance capacity for operational research 3. Facilitate dissemination of technical Information and exchange of experiences
Weak concern of health care management including patients' safety caused by weak openness culture and reporting system of medical errors. No or little reflections of clients needs and expectation	Strengthening health care management through reporting of medical errors and clients' satisfaction improvement	1. To disseminate the concepts of Clinical governance to strengthen health care management 2. To systematize reporting of medical errors 3. To strengthen collection of needs and expectations of clients for improvement of clients' satisfaction
Health facilities not built according to required standards Flow pattern of patients not clear or conducive Range of services not pertaining to level of health facilities Health facility buildings are not well maintained	Ensure quality health care facility care structures	Implement health care facility structure specification standards and designs

4.1. Organizing advocacy campaigns for QI at various levels

Status
QI features very high in the priorities for implementation of HSSP III.

Issues
Successes recorded in democracy and information technology will increase demands for quality improvement. The MoHSW need to prepare for the challenge by setting the ground for QI through setting standards, structures and outline processes for improving performance and results.

In the design of the first edition of the TQIF assumption was made that everybody understands quality improvement in the same way, at least at the national level. Thus advocacy was planned for lower level health workers and the general population. This might have led to the slow pace of implementation observed after the launching of the TQIF.

Quality has been taken implicitly. As a result it has not been possible to ascertain the impact of the strategies on quality of care and no particular attention has been given to quality improvement.

Strategies
Successful implementation of QI depends on high-level commitment of leadership at all levels. Changing mindset of health workers and the leadership has been reported to be the major stumbling block in quality improvement than any other bottleneck. It is therefore important, as the first step, to sensitize officials at MoHSW on QI concepts. The Health Services Inspectorate Unit / National Quality Improvement Committee in collaboration with the Health Sector Reform Advocacy Unit and the Health Education Unit of MoHSW will develop an advocacy strategy for sensitizing officials at all levels in the health sector, other key Ministries, partners and the general population.

National level QI experts (facilitators) will conduct advocacy campaigns at the national, regional and district levels. One or two day's sensitization meetings will be organized for all levels of health care personnel, including the top management. In order to ensure all staff is involved in a cost-effective way, on-the-site meetings will be conducted to all staff by their immediate supervisors.

Facilitators will carry out monitoring and evaluation of the effectiveness of advocacy campaigns at the national as well as district level.

At the district level, advocacy will target frontline health workers and members of the community. Advocacy at community level will build up pressure groups necessary for hastening the pace of QI implementation.

Appropriate media that reach the target groups most efficiently will be outlined in the advocacy strategy to publicize, among other things, incentive for QI. The media may include radio, television, newspapers, music and traditional dances. In the development of the advocacy strategy, consideration will be given to starting a QI newsletter and website. The newspaper will carry information that is interesting and relevant to the target groups e.g. performance assessment results, ethical disputes and disciplinary measures and accreditation status of the health facilities.

Networking mass media to make quality in health care an issue of public concern will be enhanced by HSIU / NQIC. A consensus-building workshop to define the role of the mass media in advocacy for quality improvement will be organized.

4.2. Strengthening leadership, structures and mechanisms that will develop, implement and sustain QI

Strong leadership from national to community level and clear QI organization structure is crucial to the success of quality improvement implementation initiatives.

4.2.1. To ensure that strong and transparent leadership in quality is at all levels

Status:
Quality improvement is seen to refer primarily to structure, equipment, supplies, buildings and health care providers rather than the leaders.

Issues
Interviews with leadership at different levels showed that many of them were either not familiar with or were not playing an active role to enhance QI. Strong leadership at all levels is required to inspire and motivate all involved in the provision of health. The slow pace in implementing the first TQIF version underscores this point.

Strategies
MoHSW will provide overall leadership for quality in health care. MoHSW will define an organizational structure that ensures smooth implementation of QI initiatives. Various actors and their roles will be identified. The proposed structure is described in section 5.

With the collaboration of partners, MoHSW will support different institutions and levels to carry out their responsibilities in QI.

4.2.2. To introduce and implement an accreditation system

Status
Accreditation is a process by which an authorized national body assesses and recognizes that a health care institution meets applicable pre-determined and published standards. The MoHSW plans to introduce an accreditation system and a proposal to establish accreditation system has been drafted through a consultative meeting with stakeholders since 2005.

The Diagnostic Services Section of the Ministry started to implement the WHO-AFRO initiative for stepwise certification towards accreditation of laboratory services in twelve hospital laboratories in the country since 2008. After four years of continuous support, the initiative has been a success as all facilities have incrementally improved quality of laboratory services. Two of the laboratories have been shown to have the potential to qualify for international accreditation and have been asked to apply.

Issue

Available data shows that accreditation is a potentially useful and important approach for Tanzania. One immediate advantage of accreditation in Tanzania would be removal of the current two standards between the public and private sector. For example certification of health facilities is necessary for the private/NGO but not the public sector.

The classical accreditation approach envisaged by the MoHSW might be difficult to be achieved by the majority of our facilities. It will be necessary to broaden the scope of the WHO-AFRO laboratory initiative to encompass all health care service elements with a patient centered approach. In a stepwise certification towards accreditation approach, health facilities will be encouraged to climb the quality ladder in a stepwise manner by incremental compliance to basic health care service standards with eventual accreditation as the goal. A certification aimed at recognizing attainment of pre-determined level of effort in improving quality of service will serve as a stimulant for facility's continuous involvement in quality improvement in the journey towards accreditation

Strategies

Standards and indicators will be developed and disseminated by the authorized accreditation body with legal mandate. Through licensure and other mechanisms facilities will be assessed on the extent to which they meet standards laid down by the Tanzania Health Services Accreditation Council (THSAC). Regulatory bodies will promptly address deficiencies emerging from external assessments.

Accreditation Council will be established as a matter of urgency. It will comprise of representatives of existing regulatory mechanisms including medical, nursing and other councils as well as other individuals selected by the Minister of Health and Social Welfare. The Council will be responsible for the accreditation of hospitals and other health facilities for general care and for special care such as ARV treatment for people living with AIDS. Quality of facilities, staff and activities will be among the key requirements. The Council will be semi-autonomous with funding from the government and fees from respective facilities. The Council role will be to set standards, commission independent assessors, and coordinating professional bodies and disseminate information. Both public and private facilities will be involved.

Given the low level of understanding on accreditation among members of the community as well as health workers an advocacy campaign will be conducted by the MoHSW prior to introduction.

Policy guidelines to provide a framework for operationalization of a stepwise certification towards accreditation shall be developed.

The HSIU shall be strengthened to enhance its capacity to guide the process of establishing an Accreditation Council, and as an interim manner up to the time the proposed Accreditation Council becomes functional, it coordinate the implementation of key activities necessary for establishing the stepwise certification towards accreditation system.

4.3. Improvement of work environment and occupational safety

Status

Improvement of work environment and maintaining highest standards in occupational health in health facilities features in the Health Sector Strategic Plan III. The MoHSW is focusing on improvement of work environment at all levels. Occupational safety through infection prevention and control is of high priority. National guidelines for 5S-CQI (KAIZEN)-TQM and infection prevention and control have been developed and training done. Also, a national guideline has been developed and training done. HealthWISE methodology being piloted in Dodoma, will provide more lessons on issues of occupational health and safety.

Issues

Caring for the sick is the core business of any health facility; there can be no quality if patient care is deficient. Improving the working environment in the hospital is crucial in improving quality of care. Access to safe health care environment is the right of people seeking health care services. Infectious diseases, if not controlled may lead to high rates of hospital acquired infections and deaths. Infection prevention is therefore one of the prerequisites for ensuring safe and quality health care services delivery, as well as protecting the population from outbreaks of infectious diseases. Infection Prevention and Control is one of the indicators of quality health care in hospitals and other health care facilities

Strategies

The MoHSW has directed that work environment improvement be the entry point of QI initiatives. This will establish strong foundation for safety practice of health care delivery. Further, it will advocate for adequate budget to finance working environment improvement using 5S- CQI (KAIZEN)-TQM approach and Infection Prevention and Control (IPC) activities in health facilities.

4.4. Strengthening Referral System

Status

A recent review of the referral system in Dar es Salaam reported an overuse of the Muhimbili National Hospital attributed mostly to inadequate capacity of the district hospitals. The MoHSW has adopted referral hospital services as one of the strategies to increase access to referral services for those who need it.

Issues

The problem manifests in two main forms. There is misuse of experts at higher level as a result of self-referrals of uncomplicated cases and stagnation of problems that cannot be solved at the lower level.

Strategies

Overuse of referral facilities is not cost-effective, leads to wastage of resource, workload at referral centres and thereby reducing quality of care. Mechanisms for gate keeping will be designed and strengthened by ensuring constant availability of drugs and motivated health workers in peripheral health facilities. The MoHSW will provide necessary equipment and staff to attend medical and surgical emergencies at various levels so as to reduce workload at referral facilities. Consideration will also be given to mainstream community health workers into the health system to support primary health care facilities with promotional and preventive services.

In line with the HSSP III, referral hospitals will conduct specialist outreach programs and regional hospital will provide technical support to district hospitals through supportive supervision.

4.5. Strengthen Environmental Health, Sanitation and Hygiene

Status

Environmental health, hygiene and sanitation are important aspects in human health and survival and one of the indicators for social and economic development of any community. Presently the environmental health situation in the country calls for urgent and concerted efforts to address major environmental health issues including excreta disposal, human settlement, adequate safe water supplies, waste management, communicable diseases outbreaks, adequate safe food supply, recreational facilities, pollution control and hygiene practices.

Issues

Currently less than half (47%) of the population has access to sanitary latrine. Only 53% and 67% of the population have adequate safe water supply in rural areas and urban areas, respectively. Less than 50% of the total wastes generated are uncollected and hence improperly disposed of in urban areas. About 60% of diseases reported among outpatients are related to poor environmental health and sanitation. The increase in disease incidences lead to increased medical care expenses, loss of productivity, students' school absenteeism, malnutrition and loss of life.

The continued poor state of hygiene, sanitation and water would continue to jeopardize the good intention of the Government of eliminating poverty in the country since people will continue to be sick and non-productive.

Majority of urban settlement are unplanned settlements that prevent accessibility to various services essential for the public health. Majority of health care facilities lack adequate facilities for safe segregation, collection, storage and transportation, treatment and disposal methods of healthcare waste.

Empirical evidence indicates that hand washing practice after visiting toilets and before preparing food is low. For instance, it is indicated that only 33% of household members washed hands after visiting toilets, 6% washed hands after attending a child who had defecated and 17% washed hands before preparing food (MoH and UNICEF, 1999).

Strategies

The MoHSW will allocate adequate resources for implementation of environmental health activities at all levels. The Public Health Act of 2009 will be enforced. Environmental- friendly waste disposal options will be made available. Environmental health will be mainstreamed into sector plans.

Tanzania Quality Improvement Framework in health care

4.6. Implementation of standards for medical equipment and their maintenance

Status

The MoHSW in the HSSP III has taken up the issue of equipment maintenance. Standards for medical equipment exist in the MoHSW. The policy for maintenance of medical equipment exists but not widely known, distributed and implemented. Some zonal/regional workshops exist but have limited capacities.

Issue

Although standards for medical equipment exist, they are not specific enough. Consequently equipment of poor standards is purchased. Many hospitals have medical equipment that does not function due to lack of maintenance. This undermines provision of quality services. Medical equipment requires special trained technicians to service and perform minor repairs. Technical teams existing at national level are weak thus offering inadequate support to the lower level facilities; there are scattered efforts to form such teams in the zones and regions. There is a limited budget for equipment maintenance. Planned preventive maintenance not provided. There is no planned preventive maintenance is provided. There is no inventory of medical equipment at national level. There is no monitoring of equipment functioning. Equipment maintenance is not an agenda item in management meetings.

Strategies

The MoHSW shall review specifications for medical equipment and make sure they are specific enough. The MoHSW shall improve equipment procurement system. The MoHSW shall initiate training of biomedical engineers for equipment maintenance. RHMTs and CHMTs shall develop and implement equipment maintenance plans and orient users on use and maintenance of equipment.

4.7. Enhancing integration, sustainability and equity in healthcare

4.7.1. To enhance integration of services

Status

Integration of health services is one of the crosscutting issues to be addressed by the MoHSW through the HSSP III

Issues

Despite MoHSW having integration strategies, implementation remains weak.

The organization of tasks, which has been in operation for more than twenty years, has had a number of achievements. A big disadvantage has been 'vertical approach' leading to inefficient use of resources and some programs falling behind.
*   Initiatives by MoHSW to enhance integration of health services are generally weak.
*   A number of donors and external agencies advocate and support vertical programs.
*   Most national health programs have their own set of guidelines; there is no clear mechanism to coordinate development and standards of guidelines.

Strategies

MoHSW Strengthen the capacity of HSIU to review new quality improvement initiatives in the country

Special effort shall be made by MoHSW to enhance collaboration between different programs in the development of guidelines and other products, in order to ensure integration. The HSIU / NQIC will oversee quality issues in the guidelines.

MoHSW plan to integrate training programs through the ZHRC's with a view to provide training that will prepare health workers to address community problems. MoHSW will create conducive environment for implementing and monitoring activities in an integrated way. Programs will be obliged to implement and monitor their activities according to the regional and district/council health plans.

Research institutions such as NIMR, IHI, MUHAS and any other institution shall be engaged to pilot initiatives to improve integration of services in the health sector in a selected number of districts. The objective of the study will include finding more efficient ways of organizing tasks to individual members of the CHMTs.

4.7.2. To enhance sustainability of QI at all levels.

Status

Government to prioritize activities as more off-budget funds gets transferred into government budget

Issues

Sustainability is often an afterthought leading to a number of QI initiatives not being sustained. Fear of collapse of program activities and loosing donor support may lead to development of unsustainable initiatives.

Strategies

In the advocacy strategy and the training modules, the MoHSW will emphasize that, in the development of interventions, sustainability should be one of the major priorities. QI will be integrated into the existing roles and responsibilities of all staff, but with clear definition of who will do what and where. The MoHSW will specifically discuss with stakeholders on ways of ensuring that initiatives, which they support, and others are sustainable.

4.7.3. To enhance equity in health care delivery

Status

Through the HSSP III, MoHSW plans to provide subsidy and sponsorship for the poor to join health insurance and to increase coverage of health insurance aiming at universal coverage,

Using the resource allocation formula applied in disbursement of basket funds poorer districts are allocated adequate funds. The MoHSW, through PHSDP, plans to have a dispensary in each village and a health centre in each ward.

Issues

The critical issue in equity is about eliminating unnecessary and unfair inequities in health and health care. Data on utilization of health care by social class (poor, poorest of the poor, the rich) and between risk and non-risk geographical areas is not available. The little data that is available shows that the situation is not satisfactory. (Mackintosh and Tibendebage, 2002)

Decisions on how health services are financed are essentially political. The role of TQIF is to assess the impact of policies on health care objectives. MoHSW policy requires exemptions to be part of the cost-sharing strategy.

Available data shows that exemptions have not been successful in preventing exclusion of the poor from services. A study in another country claims that health sector reforms are causing 'sustainable inequities (Nyonator and Kutzin, 1999).

The findings on equity in the literature are contradictory: One study concludes that in Tanzania "the current liberalized health care market displays a pattern of exclusion, impoverishment, abuse and poor quality care alongside substantial patches of accessibility and probity, while the government has few resources for inspection and control (Mackintosh and Tibendebage, 2002). Another study concludes that "With 23% of the total population exempted and getting free access to health care it can confidently be concluded that CHF program has taken care of the equity issue (Kapinga and Kiwara, 1999)

The issue here is that one cannot be sure that those exempted are the poor. Studies in many countries show that it is the rich who are often exempted! Yet, in another study district officials cited poverty as a major reason for people's failure to enroll into CHF (Ministry of Health, 2003). In this study, exemption guidelines were reported neither understood nor followed by service providers.

A growing problem with cost sharing is that some health facilities also have another unsanctioned, "under the table" fee that goes to the pockets of health workers. This is part of the growing problem of corruption. The end result is that the patient pays two cost sharing arrangements. Equitable financing basically means that the bottom 20% of the population pay no more than 20% of the total health expenditure.

Strategies

The policy of Tanzania is to ensure that all Tanzanians have access to essential health care - those who can afford it will have access to additional services. The MoHSW will monitor the implementation of this policy and impact of health sector reforms on equity in health using data collected through the HMIS supplemented by sentinel surveillance.

MoHSW through the HSIU / NQIC will review carefully results of the above and other studies as input to decision making results. MoHSW will also advocate and support research and academic institutions to carry out studies in this area.

The MoHSW will continue reviewing the effectiveness of exemption mechanisms followed by appropriate action. Social welfare will be given the responsibility to identify the poor. The HSIU / NQIC will oversee the formation of a task-force to develop a strategy to address the rampant corruption in the health sector, which also can be a barrier to health, as part and parcel of TQIF. Recommendations from the assignment will be incorporated into the advocacy strategy and the strategic plan for QI implementation.

4.8.   Enhancing provider capacity, safety, productivity and performance

4.8.1.   To intensify training and skill development for quality in care

Status

Human resource for health is the first priority among HSSP III strategies. MoHSW has rolled out Human Resource for Health Information System (HRHIS) and Training Institution Information System (TIIS) to collect information and monitor the numbers and location of qualified health workers, who are competent to provide quality of health care.

Issues

The approach to quality improvement as outlined in the framework is new to most health workers. Training capacity regarding quality improvement is inadequate. There is also a rapid turnover of staff. Many basic training programs for health workers do not include QI concepts.

Guidelines are available for many areas but minimal for clinical care. Dissemination and communication on clinical care standards is inadequate. The HSIU in collaboration with the Human Resources for Health Department has developed training modules for quality improvement in the country.

Training is not a panacea to challenges in implementing QI. More often, solution to performance problems lies on local problems than lack of knowledge.

Strategies

Training will use a cascading approach. The national level training will concentrate on the development of a critical mass of health personnel (National level QI experts) who can provide leadership and technical support to the local level. Priority will be given to key staff at central level, academic and research institutions, RHMTs, and directors (and facilitators) of hospitals to participate in such training programs. Facilitators and RHMTs will in turn train CHMTs and later support training for the lower levels. RHMT will follow up CHMTs for further on-the-job training and coaching.

For the purpose of sustainability resource centers and in particular Zonal Health Resource Centers will conduct and coordinate all quality related training activities. While participants from council level will be financially supported through basket funding, those from regional and national level will be sponsored through funds mobilized by the HSIU / NQIC. CHMTs will train and follow up FLHF workers.

Attitude and ethical issues in health care will feature in all training and consensus building activities. A culture of learning, making continuing education to be seen, as the responsibility of the individual health worker, will be developed. HSIU / NQIC will work in collaboration with various Councils, Institutions and Health Professional Associations to design incentive modalities essential for the development of such a culture. Professional advancement must be seen as mandatory. The HSIU in collaboration with professional Councils will demand for continuing professional development, as a condition for re-registration, taking advantage of the experience accrued by the Pharmacy Council. In addition, CPD will be among the criteria for accreditation of health facilities. HSIU will also utilize HRHIS and TIIS to obtain and monitor HRH production, distribution and management. This will help HSIU to judge whether situation is ideal to provide quality health care services, and use information for appropriate planning for dissemination and training of quality improvement.

Emphasis will be on training teams (this is essential for sustainability) rather than individuals. In addition to building providers capacity on medical ethics, emphasis will be placed on the provider's roles and responsibility as a "duty bearer" and rights of the user/client as a "right holder". Besides the specific skills of QI, other areas including medical ethics and operational research, supportive supervision and customer care will also be included.

HSIU/ NQIC will liaise with academic institutions to incorporate theory and practice of QI in medical and paramedical training institutions' curricula.

4.8.2. To enhance recognition and reward for performance

Status

The MoHSW will initiate the formation of national and regional hospitals' Health Boards with legal backing. In addition to increasing community ownership this strategy will increase accountability, a necessary incentive for QI.

Issues

Although job satisfaction alone does not work in QI, it is the cornerstone for achieving QI. But job satisfaction alone does not work in QI. Studies have shown that through better payment health workers can reduce wastage of resources at working places, increase compliance to guidelines and achieve targets according to standards.

Improvement of human resource for health is a crosscutting issue that involves other ministries such as PMO-RALG, POPSM, MoFEA.

Strategies

Incentives are important in fostering competition necessary for QI. MoHSW plans to roll out a combination of supportive supervision and performance based incentive systems and introduces Pay for Performance (P4P) and Results Based Bonuses (RBB). The incentive scheme will be transparent and provide equal opportunity to contestants. While incentives targeted to individuals will stimulate creativity, those targeted to a team fosters team building. RHMT will play the role of independent assessors.

HSIU in collaboration with relevant stakeholders started to work out on tangible non-financial incentives such as certificate of recognition and promotion. It is important that health workers through the advocacy campaigns know incentives for QI.

HSIU collaborate with other MOHSW departments/units and stakeholders to work out and pilot reward mechanism/incentives for health facilities that achieves a higher level of certification. Such rewards might include but not limited to pay for performance, level of reimbursement from health insurance organizations.

4.8.3. To enhance professional ethics and morality Status

Professional councils and associations are still weak to perform their duties.

Issues
Ethics and morality are dropping drastically.

Strategies
The MoHSW through the CMO's office will challenge professional associations to declare their values explicitly, so that their members can be clear about what the organization stands for. Similarly, it will challenge Health Professional Councils to be more explicit about quality improvement strategy in their respective areas.

The MoHSW will support the development of a strategic plan for the regions and councils and intensify dialogue with regulatory bodies and associations pointing out the unsatisfactory ethical and other professional deficiencies and the need for rethinking and taking prompt and sustained action.

Hospitals will strengthen their grip on the supportive supervision of staff under them, for example by ensuring that clinical meetings are conducted daily and effectively.

Teaching institutions will play an active role in finding out some of the root causes of the lapse on ethics. For example, is adequate training in this area provided? What is the role of peer examples? And how can they be utilized to serve as models to foster ethics and morality among the professionals?

Hospital management to ensure availability of an information desk at the OPD and functioning suggestion boxes at FLHF. Communities should be mobilized through advocacy campaigns to use the existing structures for example the hospital/facility governing committee, village health committees / village assemblies, to register their complaints.

4.8.4. To improve health workers productivity and increase the proportion of skilled staff in working places

Status
Relation between quality and productivity is not well enhanced in the health sector, and there is no mechanism of measuring productivity.

Human resource crisis is still a major concern. The MoHSW has improvement of human resource as priority number one in the implementation of HSSP III strategy. The MoHSW is rolling out OPRAS and is committed to implement performance based management system for staff incentives.

Issues
Productivity of health workforce is one of the important indices for health facility performance together with quality improvement.

There is lack of transparency in staff career development and promotion partly due to lack of data to measure performance.

The MoHSW will advocate the importance of productivity measurement to all health facility management; CHMTs and RHMTs will develop a human resource database in collaboration with the PMO-RALG in order to inform planning process. At district level the database will, in addition to serve as a tool for planning of human resource requirement, will also be used in staff management that will ensure transparency in assessing and rewarding performance.

The MoHSW will strengthen the capacity of ZHRC, giving priority to those that are currently weak to undertake their responsibilities. In turn, ZHRC will develop continuing education modules for health workers at the various levels.

RHMTs in collaboration with ZHRC will support CHMTs and hospital staff through continuing supportive supervision and coaching. Councils will be encouraged to sponsor staff according to needs assessment and award scholarship based on staff career development plans and work performance.

The MoHSW will establish staffing levels based on workload to ensure productivity by increasing the number of proportion of skilled staff.

The MoHSW will review the implementation of OPRAS with a view to enhance transparency and in collaboration with other key actors will ensure that career development and staff promotion is based on performance assessment

4.9. Strengthen health care management at health facility level

4.9.1. To introduce Clinical Governance

Clinical governance is a system through which hospitals and other healthcare facilities are accountable to continuously improve the quality of healthcare services and safe guarding high standards of care by creating an environment in which excellence in clinical services will flourish.

The effective clinical governance aim to ensure:
*   Continuous Quality improvement of patients care/services
*   A patient centered approach, treating patients courteously, involving them in decision making about their care and keeping them informed.
*   Commitment to quality; health professionals must be up to date and performing according to current evidence based practices with proper supportive supervision
*   Prevention of clinical errors and commitment to learn from mistakes and share that learning with others.

Clinical governance cover:
*   Standardized policies and procedures: All health care workers must take the responsibility to understand and implement all the available hospital policies and procedures
*   Quality improvement through QIT and Work Improvement Teams
*   Patient care: policies and procedure must guide the clinicians / providers to deliver optimal patient care

- Access to medical care: patients must be supported in their wishes to have a choice in access to medical care, the refusal thereof or opportunity to seek a second opinion
- Informed consent: patients must be provided with appropriate information relating to their diagnosis and planned treatment to enable them to make informed decisions. The patient must know the benefits and risks associated with treatment or investigations. Consent shall be obtained in accordance with hospital policies.
- Privacy and confidentiality: Patient's privacy and confidentiality must be protected during all examinations, procedures and consultations
- Recording of medical care: Policies, guidelines, standards and procedures must be developed to promote continuity of care among healthcare providers to incorporate health summaries into active patient medical records
- Clinical risk management.
- HRH management including welfare and working conditions of health care workers, capacity building through training and Continuing Professional Development.
- Utilization of hospital / facility data and research findings to improve patient care and its effectiveness (eg. Sharing of experiences, lessons, and clinical and organizational evidence based practices).
- Monitoring and evaluation of the clinical care with instituting enforcement measures
- Clinical Audit

Status:
Clinical Governance Strategy is not currently systematized in most of our hospitals in Tanzania

Issues
Currently, there is no national leadership and clinical governance strategy. Also, there is inadequate capacity in leadership skills and competencies in clinical governance at all levels of health care service delivery.

Strategies
The MoHSW shall develop and disseminate the national leadership and clinical governance strategy. Each hospital shall develop and implement leadership and clinical governance strategy in line with the national strategy.

Clinical governance strategy for health care facilities needs to be systematized. Work Improvement Team (WIT) shall review all clinical information including all adverse events. These reviews shall be summarized and reported monthly to QIT.

A system to collate and analyze information from activities throughout the health care facilities that relate to clinical quality shall be put into place by QIT and WIT's. Standard clinical guidelines and/or patient care pathways or equivalents must be developed and implemented across all health facilities.

Risk management process to be put in place as an official means of addressing risks:
- All services must take part in risk management
- Training needs to be organized for all staff
- All risks must be listed and analyzed

- A named focal person shall take responsibility for risk assessment
- The finding of these assessments shall be analyzed, work practices reviewed and changes implemented to reduce the risks

4.9.2. To systematize Reporting of Medical errors, accidents and mistakes for quality improvement

Status

Reporting of medical errors is not currently systematized and only few health facilities are practicing in Tanzania.

Issues

Currently, majority of medical errors, accidents and mistakes in many of health facilities are not reported due to weak reporting system or individual blaming culture leading to hiding of medical errors and accidents this has become part of organization / health facilities culture".

Strategies

Reporting of medical errors is very important for quality improvement of services. It can be utilized as an opportunity for prevention of errors and improve health care services. MoHSW shall develop standardized format for medical errors report and tools for analyzing the incidents. This shall be disseminated to both public and private health facilities, thus reducing medical errors, accidents.

To change the bad habits and culture, health facility managers should sensitize hospital staff that "hospital" must be a High Reliable Organization (HRO), and reporting medical errors and accidents makes a health facility "safer and reliable". It is also important to clarify those individuals (health workers) will not be blamed ("no-blame" policy) and the system will be reviewed and possible cause of errors and mistakes will be addressed.

Reporting all kinds of mishaps that are associated with medical and administration procedures should be systematized in the health facilities.

There are several methods that make it systematic. One that should be taken on board is "Incident reporting system", which refer to the structured reporting, collation and analysis of such incidents regular reporting system and data base shall be maintained at all levels of health care delivery system.

The following are examples of medical errors and accidents that should be reported;
- Procedures that involving the wrong patient or body part
- Suicide, injuries of a patient in a ward
- Sepsis case associated with open surgery
- Hemolytic reaction associated with blood transfusion due to ABO incompatibility
- Maternal death or serious morbidity and complications associated with labor or delivery
- Incorrect administration of drugs leading to events that cause serious patient harm or death

4.9.3. To improve clients' satisfaction

Status

Some method, like suggestion box for external client is often used at health facilities. However, usage of suggestion box is low and reflection of those suggestions for planning and improvement is not clear.

Issues

Unlike other service industries, health care service often does not take into consideration of needs and expectations from their clients (internal and external).

Health care providers pay attention on not only "Health related expectations" of patients but also need to know "Non-Health expectations (basic human needs)"

Strategies

MoHSW shall develop and disseminate policy guidelines on client service charter. Client service charter shall be developed at all levels of health care delivery system.

MoHSW shall facilitate training of trainers for improvement of client satisfaction. The trainers shall train health personnel at respective health care facilities. Facility Managers, QIT and WITs shall monitor, enforce and evaluate clients' satisfaction measures. The RHMTs, CHMTs and HMTs shall conduct regular supportive supervision, monitoring and evaluation.

Each facility shall institutionalize the collection of information on clients' needs and expectations, and utilize that information for further improvement of quality of health care services.

There are several ways to collect the "voice" of clients; examples are: -

	Methods of collecting information on client's satisfaction	Targets of clients
1	Patients' Suggestion box	For external clients
2	Staff suggestion box	For internal clients
3	Interview of patients and workers	For both internal and external clients
4	Periodical QIT/WIT Meeting	For internal clients
5	Questionnaire	For both internal and external clients

After collecting information with the above-mentioned methods, health care facility managers must classify the client's opinions/demands, analyze and reflect them on quality improvement plan of the facility.

4.10. Implementation of health care facility structure specification standards and design

Status

Standards for health care facilities guidelines are exist. However, it is not revised since 1996 to accommodate the reforming government sectorial policies and guidelines thus out dated.

Issues

The existing guideline is outdated. Health care facilities do not meet specification standards and design of services required and is not well maintained. In some health facilities the flow pattern of patients is not clear or conducive. The range of services offered does not pertain to health facility level and the skill of personnel.

Strategies

The Ministry of Health and Social Welfare shall review guidelines for health facilities facility structure specifications standards and designs to ensure they address QI issues. It shall sensitize architects and building maintenance teams on QI issues. Further, the MoHSW shall develop standard operating procedures for planned preventive maintenance of buildings. The health facilities structure guidelines and standard operating procedures shall be disseminated to all levels of health care (public and private). The MoHSW shall enforce compliance to health facility standards. RHMTs and CHMTs shall strengthen supervision of health facilities structures.

5. Organizational Structure for Health Care Quality improvement

5.1 The Structure of QI

Quality improvement (QI) aims to identify, implement and maintain best clinical and organizational practices that ensure better care for clients in order to achieve positive health outcomes. Sustaining these better care practices and corresponding results requires continuous implementation of QI activities at the point of service delivery and QI support activities from higher levels of the health system. Experience shows that while QI is everybody's responsibility, it is essential to define clearly the roles and responsibilities of all those involved at various levels, from national to community level. The Tanzania Health care Quality Improvement Framework identifies levels, actors and roles as shown in Table 4.

Table 4. Levels involved in QI, actors and roles

Level	Actor	Role
National	Office of CMO-Health Service Inspectorate Unit[1]	- Develop strategies and guidelines for implementing at regional and district health authorities, and health institutions - Organize training of trainers on QI initiatives in collaboration with partners - Coordinating supportive supervision to all levels regarding QI. - Collection and dissemination of national and international experience, techniques, data and references in regard to quality. - Review of relevant MoHSW guidelines and publications to ensure adequacy of standards and compliance with policies. - Coordination of Medical Audit procedures. - Coordination of external recognition program - Coordination of the zonal health resource centers. - Developing IEC materials in regard to quality. - Manage QI experts, national facilitators/trainers information - Coordinate establishment of stepwise certification towards accreditation system and oversee its implementation
	Quality Improvement Committee	- Formulate and update periodically a national Quality Framework and enhance its implementation. - Conduct QI activities at MoHSW Headquarters - Formulate national standards of services and processes and enhance compliance. - Ensure that appropriate QI mechanisms are established at different levels. - Supportive supervision and monitoring of QI activities at National and consultant hospitals - Establishment of technical sub-committee - Coordinate sub-committee activities

[1] The new department will be established (Health Service Quality Assurance Division – Health Services Inspectorate & Quality Assurance Section)

Zonal	Zonal Health Resource Centre (ZHRC)	• Support training of RHMTs and CHMTs in QI • Provide technical support to RHMTs and CHMTs • Dissemination of QI guidelines and information • Support supportive supervision and monitoring of QI activities in collaboration with RHMTs • Evaluation of QI activities in collaboration with RHMTs
Regional	Regional Health Management Team (RHMT)	• Training of Regional referral hospital and CHMT in QI in collaboration with ZHRC • Provide technical support to Regional referral hospital management team and CHMTs • Dissemination of QI guidelines and information • Supportive supervision and monitoring of QI activities at regional referral hospitals and district levels • Evaluation of QI activities at regional referral hospitals and district level
District	Council Health Management Team (CHMT)	• Training of health care providers on QI within the district • Provide technical support to health facility management and Quality Improvement Team (QIT) of health facilities • Dissemination of QI guidelines and information • Supportive supervision and monitoring of QI activities at district hospitals, other hospitals within the district, Health Centers and Dispensaries • Evaluation of QI activities at hospitals, health centers, dispensaries within the district
Hospital (National, consultant, regional, district)	Hospital Management Team (HMT)	• Development of strategic and business plan • Development of organization's vision and mission statement on QI • Dissemination of heath facilities strategic and business plans, vision and mission statement on QI • Develop functional QI structure • Oversee QI process and QIT function • Ensure effective top-bottom, bottom-top communication • Ensure proper allocation of resources for QI
	Quality Improvement Team (QIT)	• Oversee QI activities on daily basis in the hospital • Conduct periodic QI performance assessments • Liaise with the management on improvement strategies and activities. • Closely working with HMT and regularly reporting to HMT
	Work Improvement Team (WIT)	• Oversee QI activities on daily basis in the hospital's departments and units • Conduct periodic QI performance assessments • Liaise with the management on improvement strategies and activities • Closely working with QIT and regularly reporting to QIT

Health centre and dispensary	Health facility management	• Incorporate QI activities in the heath facility plan • Development of organization's vision and mission statement on QI • Develop functional QI structure • Oversee QI process and QIT function • Ensure effective top-bottom, bottom-top communication • Ensure proper allocation of resources for QI
	Quality Improvement Team (QIT)	• Oversee QI activities on daily basis in the health center or dispensary • Conduct periodic QI performance assessments • Liaise with the management on improvement strategies and activities. • Closely working with facility management and regularly reporting to facility management
	Work Improvement Team (WIT)	• Oversee QI activities on daily basis in the health center's or dispensary's departments and units • Conduct periodic QI performance assessments • Liaise with the management on improvement strategies and activities. • Closely working with QIT and regularly reporting to QIT
Community	Frontline health workers	• Educating communities on their rights and responsibilities for quality health care • Empowering them to demand for quality health services • Involve community in assessing quality of health care and developing community health action
	Community members	• Managing resources of health facilities • Demand for quality health services • Respond to actions by health workers • Assess quality of health services

5.2. Roles and Responsibility of key teams at health facilities

Hospital Management Team (HMT) or Health facility leadership

1. Development of strategic and business plan
2. Development of organization's vision and mission statement on QI
3. Dissemination of heath facilities strategic and business plans, vision and mission statement on QI
4. Responsible for developing and fostering in the participatory manner the organization's vision and mission statements
5. Developing the functional QI structure into hospital organization
6. Oversee the quality improvement processes and QIT function
7. Ensure effective top-down and bottom-up communication at all levels within the facility
8. Recognize efforts made by staff for quality improvement.
9. Ensure proper allocation of resources for quality improvement through investment of time, funds and education

Quality Improvement Team (QIT) roles and responsibilities

QIT Team is formed with middle and top management of the hospital. The team is obliged to improve the speed of decision-making & increase commitment for quality improvement.

1. Responsible for training of hospital staff
2. Conducting situation analysis before implementation of QI approach
3. Implementing QI activities for common problems of the hospital
4. Conducting periodical monitoring and provide technical advice to WITs
5. Conducting internal verification for recognition against given standards with HMT
6. Responsible for recording of all QI activities conducted in the hospital
7. Reviewing situation and the action plan
8. Providing necessary input for QI activities
9. Producing Progress report bi-annually and share with WIT, HMT, and CHMT/RHMT/MoHSW-HSIU according to the level of hospital

Work Improvement Team (WIT) roles and responsibilities

They are essentially employee-based small group activities. Their aims: to provide staff with opportunities for meaningful involvement, contribution and challenge. Bottom line results to higher quality outputs and service, and improved productivity

WIT comprises a group of between 3-15 members belong to the same work unit (e.g. the admin section members) who meet regularly to identify, analyze and solve problems and improve outputs of their work unit. They also implement measures or recommend them to management

1. Attend meetings regularly
2. Share and contribute ideas, effort and time to help improve the team's effectiveness.
3. Cooperate with and help team leader and others
4. Participate in problem-solving activities of the group
5. Effect improvements arising from projects carried out by the team
6. Conducting monitoring & evaluation of day-to-day 5s practice.
7. Document & share the results within the section/department.
8. Communicating their result to hospital QIT.

Figure 3. Quality improvement organization structure in health care

Tanzania Quality Improvement Framework in health care
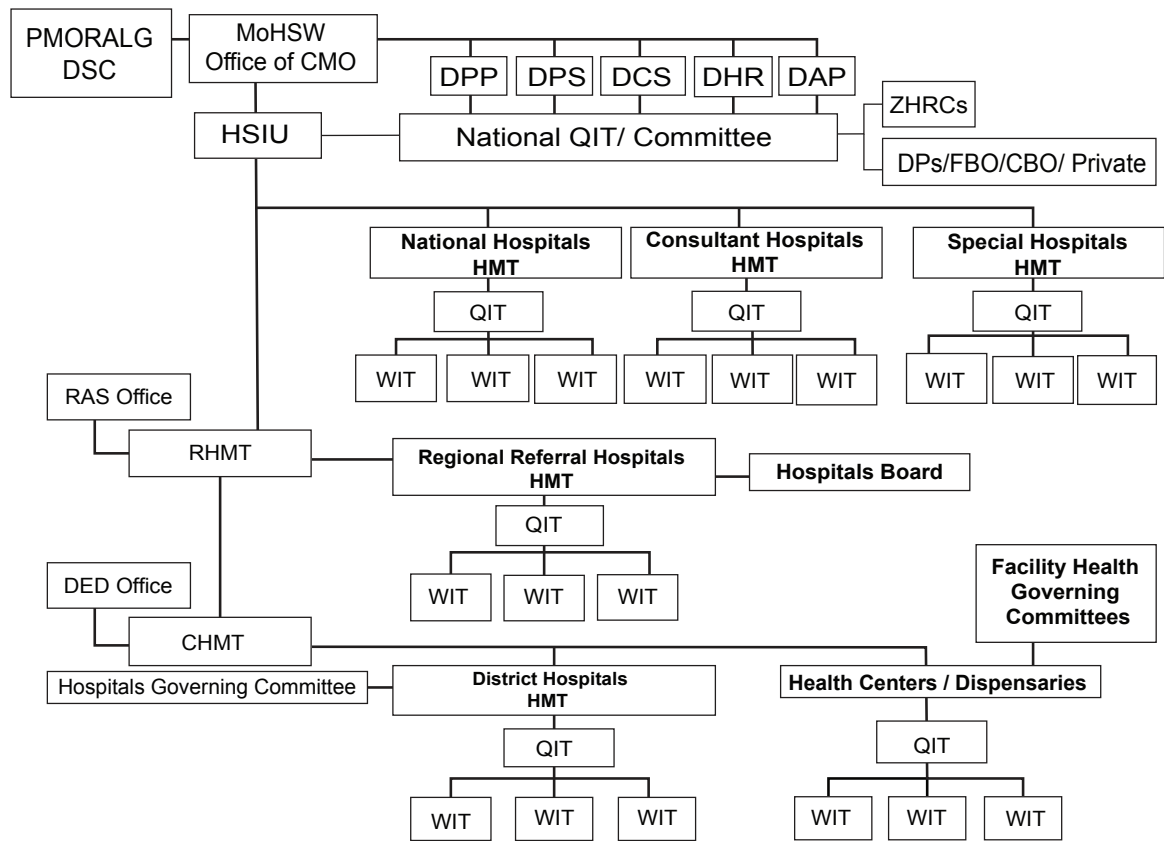
6.   Institutionalizing Health Care Quality Improvement

6.1.   Meaning of institutionalizing health care QI

Institutionalization can be defined as establishing and maintaining QI as an integral, sustainable part of health systems, woven into the daily activities and routine. Quality activities are incorporated into the structure of an institution, department, or unit, continuously implemented, and supported by a culture of quality improvement as reflected in the entity's values, vision, mission, and policies.

6.2.   Phases in institutionalizing health care QI

Implementation of QI is a process that involves a series of phases as follows: -
1)   Awareness
2)   Experiential
3)   Expansion
4)   Consolidation.

These phases are explained in Table 5 below.

Table 5. Phases for institutionalizing health care quality Improvement

Phase	Explanation	Potential Activities	Indicators for readiness to progress
Awareness	Leadership recognizes need for QI, because they are dissatisfied with situation and are willing to start in a small way to experiment and learn QI	• Sensitize staff on QI • Form QIT • Conduct situation analysis • Disseminate the findings from situation analysis • Develop QI action plan • Monitor and evaluate	Leadership formally decides to try out QI Approach
Experiential	In this phase staff undertakes QI activities and apply various QI approaches to learn from experience, document success and challenges.	• Select pilot areas to be a show case (model) • Train staff of pilot areas • Conduct pilot QI according to QI plan • QIT conduct Mentoring and coaching • Establish WIT's • Implement QI Plan of action • Monitor and evaluate	Facility top management supports for and /or formal decision to develop a facility strategy for QI. There is a desire to expand and often a formal or written decision to move forward with QI. • Availability of Strategic plan • Availability of progress reports

Phase	Explanation	Potential Activities	Indicators for readiness to progress
Expansion	Increase capacity of QIT and other staff at the workplace In this phase QI activities strategically expanded.	• Sharing of results and progress • Develop QI strategy for expansion • Disseminate success (Results, lessons, • Experiences and innovations) to staff of other areas • Train staff in expansion areas • QIT conduct Mentoring and coaching • Establish WIT in expansion areas • Monitor and evaluate	-Positive effects on quality of services can be demonstrated -Leadership/management and other staff agree on value of QI for the quality of services and that QI deserves continuation. • Availability of functional WITS • Number of trained staff
Consolidation	In this phase, there is attitude change among management and staff QI activities are strengthened and incorporated into routine operations. All staff and management feel accountable for quality and provide required leadership and stewardship	• Identify areas where QI needs strengthening • Establish a learning environment • Conduct refresher training for staff • QIT enhances coordination of QI activities • Set rules and regulations for sustainability of QI at each level • QIT conduct Mentoring and coaching • Monitor and evaluate	QI activities are fully integrated and implemented into the workplace. • Records of QI activities available at each level

7. Supportive Supervision, Monitoring and Evaluation

Supportive supervision, monitoring and evaluation are integral components of quality improvement in health services. These actions are performed in order to meet established quality goals, to identify problems (opportunities for improvement) and to ensure that improvements are initiated and maintained.

Table 6 outlines issues from the SWOT analysis and suggested strategies in relation to supportive supervision, monitoring and evaluation (Refer Table 2)

Table 6. Issues from the SWOT analysis and suggested strategies in relation to supportive supervision, monitoring and evaluation

Concern	Priority issue	Strategy
Supportive supervision done but emphasis is on quantity and not quality. Standards and indicators for QI are inadequate in the existing monitoring and surveillance systems.	Strengthening supportive supervision, monitoring and surveillance	1. To strengthen Supportive supervision 2. To facilitate introduction of quality auditing 3. To strengthen monitoring system 4. To monitor the use of resources 5. To strengthen sentinel surveillance on quality of health care
Agenda for research is weak and not based on needs. RHMTs, CHMTs and Hospital management teams have inadequate capacity to conduct operational research.	Facilitate evaluation of quality in health care through operational research for QI Facilitate dissemination of technical information and exchange of experiences	To enhance capacity for operational research
Access to QI information is poor.		To facilitate dissemination of technical information and exchange of experiences

7.1   Strengthening supportive supervision, monitoring and surveillance

7.1.1. To strengthen Supportive supervision

Status

Through HSSP plan III the RHMTs will be trained on skills to conduct supportive supervision to CHMTs and staff at regional hospitals to provide technical support to district hospitals.

Issues

Lessons from the field showed that supportive supervision is done at all levels. However, emphasis of supportive supervision was more on quantity (number of visits) and not the quality.

Supervisor with little understanding of its content uses the term of supportive supervision. Consequently, supportive supervision was found to have little impact on performance improvement. In other districts supportive supervision seemed to be overworked with paperwork in filling in lengthy checklists instead of focusing on supporting and imparting knowledge and skills through continuing education. In addition, the capacity of RHMTs and CHMTs to conduct adequate supportive supervision is inadequate.

National supportive supervision guidelines have been developed but their emphasis on performance (quality) improvement is inadequate. In addition, a number of supportive supervision guidelines for the same level exist.

Strategies

The NQIC at national level is to supervise national, referral and specialized hospitals. ZHRCs take a leading role in training members of Council Health Management Teams on a continuous basis. ZHRCs organize short courses. CHMTs plan and budget locally for members to participate in the short courses. Guidelines for supportive supervision will be revised to include supportive supervision. Districts can delegate supportive supervision of dispensaries to health centers that have adequate capacity. Supportive supervision will not be overworked with lengthy evaluation activities for awards. The guidelines will specify the roles of supervisors at different level.

The Ministry shall coordinate the development of tools to facilitate and improve the process of supportive supervision like self- assessment and peer-assessment.

To enhance efficiency and appropriate use, staff will routinely supervise only the level immediately below them. Staff members will empower those at the level below them to supervise activities at their own level.

National trainers will take part in the dissemination of the guidelines to the regions and districts. The MoHSW, RHMTs and CHMTs will monitor effectiveness of supportive supervision through 'spot checks' and evaluation (see Monitoring and evaluation). Best performers will be rewarded accordingly (see Rewarding and motivation strategies). Operational research in regard to such topics as different ways of enhancing the quality of supportive supervision will be encouraged.

7.1.2. To facilitate introduction of quality auditing

Status:

Clinical meeting are held in hospitals and some health centers, to discuss patient management with a view to improving performance. But the effectiveness of these meetings remains obscure. Maternal deaths audits are conducted in many hospitals and in-charges; DMOs and RMOs are expected to follow-up and report each death to the national level. However, in Tanzania, maternal mortality has for a considerable period remained quite high. This problem has been identified as one of the areas for increased efforts with concrete actions in the HSSP III. Laboratory quality auditing system was once an exemplary model. With time, the system has deteriorated leaving referral hospital with the responsibility but without the necessary support.

Issues

Apart from maternal death audit, quality, auditing in other areas are either not conducted and where they do, there is lack of coordinated efforts and follow-up from peer and higher levels authority to learn and improve based on the experiences. Much as maternal health is a good indicator of quality of health services offered, the major problem with audit is finding an effective solution to the gaps found. However, this is part of the mindset that needs to be changed for the success of QI.

Strategies

HSIU / NQIC to introduce quality auditing for the various services offered starting with areas that have shown some effort i.e. clinical and laboratory services. Quality auditing for maternal health and mortality will be intensified. Experience accrued should then be used to implement quality auditing in other areas. A team of experts from the relevant specialties and professional associations will be recruited by the HSIU at national level to work with members of the RHMTs on cases with national level interest. The RHMTs will audit, on a routine basis, a sampled number of deaths occurring in hospitals and FLHFs and follow up complaints raised by community members.

They will also conduct performance audit by inspecting records on human resource, equipment and finance. Audit on facility condition and the process of care will be through direct observation. CHMTs will put in place mechanisms for collecting clients concerns such as meetings with village / ward leaders; members of the community, suggestion boxes, and information desk and client exit interviews at hospitals. Furthermore the culture of medical audits after each case of death will be promoted. Hospital Management Teams will be tasked by the immediate level duty bearer (DMO for district hospital) to conduct medical audits for each death occurring in the respective hospital and in case of professional negligence appropriate actions will be taken.

Regional and Council meetings will be used as a forum to give feedback to the CHMTs and health facilities in-charges, respectively.

QITs and QAUs will be responsible for conducting internal audits for deaths and complaints rose by clients and present the report for discussion during hospital management meetings.

Leadership at the level of facility will be made responsible for taking corrective measures on weaknesses identified through audits. In addition, incentives and sanctions to be introduced be documented and implemented by the leadership to enhance good performance.

7.1.3. To strengthen monitoring system

Status

The MoHSW through the HIS section is developing a HIS policy to outline the role and responsibilities of the various stakeholders with a view to harmonizing the existing parallel system. Monitoring and evaluation is one of the main HSSP III strategies.

Issues

There are no explicit national standards and indicators for monitoring quality improvement. The HMIS is a routine data collection system aimed at measuring performance of health services at various levels. There also exist numerous systems for routine data collection for specific programs/ projects. Some vertical programs utilize data collected for monitoring performance at the national level. The use of data collected at district level in monitoring performance (quality improvement) is limited. Collecting a lot of data that they do not use de-motivates health care workers.

If progress is made in implementing this framework a contribution towards the Millennium Development and PRSP Goals is expected. However current monitoring systems to measure this progress remain weak. Existing indicators have quality improvement aspects though not explicitly. Some of the key data on QI cannot be obtained through the HMIS because it would be too costly to collect it countrywide.

Strategies

The MoHSW will improve monitoring through integrated HIS and integrate disease surveillance by supporting data collection and use at all levels. The HSIU will liaise with health information and research section to have QI featuring high in the HIS policy profile. HSIU / NQIC will establish integrated health care service standards and indicators for quality improvement in consultation with the HMIS Unit and experts from various specialties that will be used to monitor QI at national level. A minimum set of QI specific data will be agreed upon for incorporation into the routine data collection system. Caution will be taken not to overwhelm health workers at lower level with burden for data collection. As much as possible other appropriate data collection methods such as surveys will be used. The HSIU / NQIC will provide technical support to districts and hospitals that will plan to conduct such activity. HMIS / National Supportive supervision guidelines will be revised to include QI indicators and its use.

The RHMT will use national level indicators to monitor QI activities at the regional level. National level indicators will also be developed by HSIU / NQIC in areas needing special attention such as female genital mutilation, in collaboration with the respective RHMTs / CHMTs. CHMTs will be supported to fulfil their role in monitoring health services in the Councils. In addition to the national set standards and indicators, individual councils and hospitals will also establish their own standards within the national framework to monitor locally designed activities.

The HSIU / NQIC will work with the M&E section unit to harmonize information systems and support utilization of data. The use of electronic medical records in hospitals will be encouraged to allow real-time data for efficient patient management such as setting appointments, patient follow up, payments and control of drug use. Experience from the Muhimbili National Hospital will be used.

Indicators may include availability of drugs, maternal health, client and provider satisfaction (quality circles/FGDs), utilization of services by population groups (geographical and social stratification). Others include providers and community understanding and attitude to QI; availability and use of standards and guidelines; existence of functioning QI structures'; level of community involvement in QI issues; safety and risk to safety.

Relevant data from different sources particularly Population and Housing Census and Poverty Monitoring System (PMS) will be used. From time to time information that requires more expertise will be contracted out to National Bureau of Statistics and research institutions.
CHMTs and hospital management teams' skills will be developed to enable development of indicators and use them in monitoring performance. QAUs will use tools developed at national level (for monitoring and accreditation) for self-assessment. ZHRC's and other training institutions will offer short course in monitoring and evaluation that will include the use of data to improve quality of care. ZHRCs will facilitate development of indicators of local relevance at the Council level. With facilitation from the ZHRCs, CHMTs will support health centers, dispensaries and community to identify their own indicators.

For quality to work, people need information about their own practice, clinic or hospital, about best practices and about how to adopt them. Thus internal monitoring (self-assessment) will be carried out by institutions themselves to measure the degree of compliance to standards established locally or at higher levels. Among other things, monitoring at the village level will include areas of weakness needing targeted support. Monitoring at the district level will include identification of villages and areas lagging behind.

While national level indicators will be used at national level to compare performance between regions / Councils, local indicators will be used by the respective level to monitor QI issues of interest.

Incentive for collecting, reporting and use of data will include linking the data system with the accreditation system and financial accounting. In the private sector, reimbursement of services rendered will act as an incentive for collecting and report quality data.

Special effort will be made to generate adequate data for monitoring and evaluation of health components of the Millennium Development Goals and Targets. The HSIU will incorporate the data requirement in the regular and ad hoc national surveys.

Performance of the various mechanisms mentioned above will also be assessed to determine if they are effective in ensuring quality improvement.

Effective feedback is important as it exposes challenges to the respective level and creates a competitive environment. Feedback will be provided through quarterly / annual statistical abstracts reported by region and district. Reports / Feedback showing data by regions and district will stimulate competition. Existing forum at various levels will be used for peer review in which health workers will share results in performance (quality) monitoring and experience behind   successes.

At the national level, MoHSW mechanisms such as National Quality Improvement Committee (NQIC), SWAp; HSR Secretariat; Basket Financing Committee; Ministerial Management Meeting; Bilateral

and Multilateral Forum; NationalHealth Research Forum; RMO's Annual Conference; Professional Association's Annual Conferences; and Joint Annual Health Sector Review. These meetings will be used to monitor and discuss performance (quality) improvement regularly. CHMTs to organize meetings at Council level where health workers from FLHFs / Hospitals including FBOs and private-for-profit; NGO and representatives of development assistance partners will be invited to discuss performance in QI.

7.1.4. To monitor the use of resources

Status
MoHSW has developed a formula for resource allocation. The formulae relates to population size and burden of disease. Joint reviews are held annually at the national level to discuss the efficient use of funds.

Issues
There is no systematic assessment of how resources are used to highlight opportunities for more efficient allocation. Areas of possible waste include: inappropriate admissions, delays in carrying out investigations and clinical procedures, wastage of drugs and medical errors. Faced with many competing bids for internal resources, managers tend to stick to previous levels of allocation with minimal consideration of how efficiently resources have been used in the past.

Strategies
The MoHSW to intensify assessment of resource usage by encouraging stakeholders reviews at regional and council level. Discussion at the regional level shall focus on progress made in implementing Council planned activities in relation to disbursed funds. Evidence-based discussions will be guided by a set of indicators to be developed by the MoHSW.

7.1.5. To strengthen sentinel surveillance on quality of health care

Status
The National Sentinel Surveillance System (NSSS) has a number of sites scattered over the country. The HMIS also collects disease data that are reported on a quarterly basis from all facilities throughout the country.

Issue
HMIS data is inadequate for a detailed surveillance of some of the components of quality of health care. At the same time it will be too costly to collect all the required data countywide

Strategies
Sentinel sites will be used to collect data that will supplement that from HMIS. The National Sentinel Surveillance System has a number of sites scattered over the country. HSIU / NQIC will liaise with the respective research institutions to incorporate data that can be obtained through existing sentinel sites. HSIU / NQIC will also initiate the introduction of aspects of monitoring related to the Millennium Development Goals and targets in sentinel surveillance where appropriate.

7.2. Enhancing capacity for operational research

Status
Operational research is one of the agenda in the MoHSW strategy for monitoring and evaluation. Operational research has been incorporated in the new curriculum under development for some of the undergraduate courses at MUHAS.

Issues
Many difficult issues in QI have emerged and will continue to do so in the course of implementing health sector reforms. The culture of literature search and analysis of "difficult" papers/documents among staff is generally weak. Discussions on difficult issues often lack evidence and are based on generalizations

Capacity for conducting operation research (including simple surveys) exists at the national as well as zonal level. However, these important skills are weak at the Regional and district levels.

Research agenda among research institutions and training schools is influenced by interest of donating agencies and institutions and not necessarily issues of local priority.

It was extremely difficult for the assessment team to access information on operational research carried out. Such information was often piecemeal safely guarded in individual offices.

Strategies
Given scarcity of resources, large volume of health problems and their urgency, it is understandable that the preoccupation of leaders and providers of health care is on implementation. The danger with an exclusive focus on short-term activities is a Ping-Pong movement moving from one crisis to another. It is important for leaders to invest in operational research to find solutions to difficult issues. Even if some findings cannot be implemented immediately, they will indicate the direction of effort.

Staff (particularly at the central level) will make full use of literature data and information to improve quality of decision-making on difficult issues.

HSIU / NQIC in collaboration with the Health Systems Research Unit will organize / support operational research to facilitate development of informed decision-making at all levels. Complex issues and those of national interest will require research at the national level. Basic operational research skills will be included in the provider capacity building within TQIF.

Hospitals and primary health care facilities will be encouraged to evaluate locally designed interventions. Health workers in these facilities will be trained on how to document evidence on the existing situation prior to each intervention using objective methods such as data, minutes, clients' opinions, pictures and videos for comparison after intervention. Pictures, videos, maps, graphs and charts are user-friendly and can easily be comprehended even by people with little knowledge in statistics. The comparisons before and after interventions will, in addition inspire health workers to perform better, motivate providers from other facilities to emulate, especially, if the evidence for the success is objective.

Agenda for research will be drawn from various national forums in the course of discussing progress in QI. Since QI issues often interact, an appropriate mix of issues will be studied e.g. Staff moral and ethical issues; distribution equity; integrated community based care.

Examples of complex issues (emerging from strategies in this document) to be addressed at national level include:

- Impact of environmental pollutants from industries on health of local residents and employees;
- Role of accreditation in Tanzania;
- Impact of health sector reform on equity in health/care and remedial measures;
- More effective exemption mechanisms;
- Need/potentials of a Health Service Commission in Tanzania in resolving key issues including recognition and rewards in Tanzania
- Reasons behind the current low level of ethics and morality and remedial measures
- More efficient and integrated ways of organizing tasks of the CHMT
- Innovative but feasible ways of generating more resources for health sector (including a Social Health Insurance Fund).
- Quality of control activities for disease outbreaks including cholera.

ZHRCs and other training institutions will be encouraged to incorporate operational research in the curricula for various heath disciplines. Meanwhile, ZHRCs and other training institutions will be supported to offer short courses in operational research / research methodology.

CHMTs will plan and budget resources to enable members pursue the courses. The RHMT will assume regulatory role, which will entail conducting evaluation studies and/ surveys in the respective districts.

Together with the ZHRCs, members of RHMT will support CHMTs on-the-job, in the designing and conducting operational research on emerging issues of local interest to the district. By teaming up, members of the CHMT will get opportunity to learn the skills by doing.

Examples of issues that can be studied by district staff include:

- Time spent by patients, when they come for medical care in health facilities
- Coordination of the activities of different partners within the district
- Role of different institutions at the district and village levels
- Effectiveness of exemption mechanisms
- Collaboration with traditional healers.
- Enhancing the exchange of information and learning between communities, wards, divisions, districts and regions.
- Satisfaction of patients with care provided
- Enhancement of Community empowerment, ownership, planning, monitoring and setting standards for quality of health care with the service providers and making the services accountable.

7.3. Facilitate dissemination of technical information and exchange of experiences

Status

MoHSW plan to create a data warehouse to link disease and management and management of health services using new technology for information exchange. An ICT strategic framework will be developed and a countrywide information network created.

Issues

Access to QI information is poor. Many guidelines and technical documents have been prepared but accessibility to them is difficult. The situation is made worse by the minimal sharing of research findings and evidence based best practices.

Strategies

HSIU will make special effort to collect available data on quality in health care from different sources including HMIS, AMMP, TEHIP, global literature and other sources for data warehousing. Data will be analyzed and disseminated. Tanzania is not an "island" as such the country can benefit through dissemination of success stories from other countries.

The HSIU will disseminate research information from a central location and through the MoHSW library. In the facilitation of information dissemination the MoHSW will capitalize on the use of information technology to collect and disseminate information. A webpage will be created in the MoHSW website and other relevant websites such as the Tanzania website. Lessons learned from the Muhimbili Health Exchange Forum (MuHEF) established by the Muhimbili University College will be useful. Regular annual reports on quality of health care will be prepared and disseminated to relevant stakeholders.

The MoHSW will examine potentials for a newsletter. Study tours will be arranged for MoHSW officials to visit other low-income countries that have reported experiences on QI. Exchange visits between regions and districts will be encouraged and supported by the HSIU. Finally, there is need for HSIU / NQIC to advocate through the advocacy campaigns for districts to document and exchange experiences between villages.

8. Tanzania Quality Improvement Framework Model in health care

Experiences from implementing different QI initiatives in the country, have led the MoHSW to develop a framework model for quality improvement of health care services in Tanzania. TQIF Model is based on four pillars as illustrated in the figure. First pillar considers the logic approach: "Input, Process, Output, Outcome and Impact"; second pillar is the "Working environment Improvement-CQI-TQM"; third pillar considers the context in which QI approaches are implemented; the last pillar is Monitoring and Evaluation of QI activities.

(1) First pillar

The first pillar has several dimensions and those dimensions are separated into five categories; as discussed below:

"INPUT" is the requirement to deliver "OUTPUT" or "OUTCOME". These are different kinds of resources, strong leadership and commitment, and policy / strategies to support quality improvement programs.

"PROCESS" includes all activities, such as Infection Prevention and Control, Injection safety, Health Care Waste Management Guideline, implemented to improve quality and safety through transforming "INPUT" into "OUTPUT" or "OUTCOME".

"OUTPUT" is the immediate results produced through "PROCESS". All health facilities are expected to improve working environment, management leadership and commitment for QIP, team-working splits are strengthened, and proper QIP implementation structure is in place. Moreover, improvement no blame policy and Openness is also expected.

"OUTCOME" is defined as changes in the behavior, relationships, activities, or actions of the people, groups, and organizations through "PROCESS" and "OUTPUT". In THQIF, MoHSW are expecting all health managers and workers to have positive attitude towards to QIPs, improve productivity, safety and manage resources well.

"IMPACT" is defined as to measure the tangible and intangible effects (consequences) of one thing or entity's action or influence upon another. All health facilities in Tanzania are expected to have positive impact to improve quality of health care, client satisfaction, staff satisfaction and facility performance through all the process, policy, strategy alignment and intervention by Development Partners.
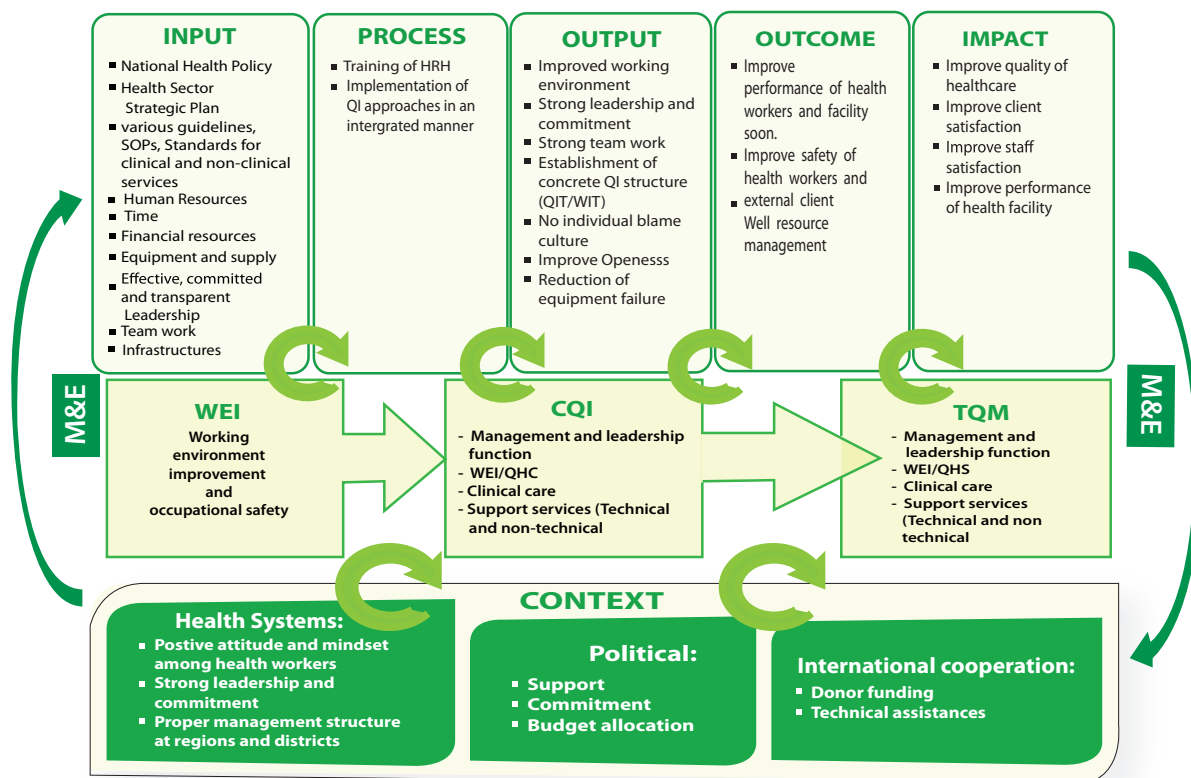
Figure 4: Tanzania Quality Improvement Framework Model in health care

(2) Second pillar

"Working environment Improvement-CQI-TQM" uses the environment in which health workers interact with patients/clients as entry point to improve quality and safety of health care services according to set standards. Approaches to improve the working environment include IPC practices, 5S (Sort, Set, Shine, Standardize, and Sustain), and other occupational health and safety measures in health facilities. In implementation of CQI activities to achieve TQM in a health facility, all health workers are involved. Activities covered fall into four major domains: Management and leadership functions, WEI and OHS, clinical care, support services both clinical (health laboratory, radiology and imagery services, pharmacy, physiotherapy) and non-clinical (laundry, CSSD, maintenance of medical equipments and other machines, health care waste management including incineration)

(3) Third pillar

Having an effective and responsive health system, political support and commitment and sustainable international cooperation are the key points of this pillar. International cooperation will assist availability of adequate funding for implementation of QI activities and health system strengthening which will effectively respond to client needs and sustain the system.

(4) Fourth pillar

This pillar dwells the Monitoring and evaluation of QI activities in all steps and levels of implementation. Strengthened HMIS activities at all levels will ensure quality (complete, correct and current) of health information used in planning and decision making.

Glossary

- **Blaming policy/culture** is the one often seen on the ground. It became "a part of organization culture" and is this "individual blaming policy" seems difficult to change at health facility. The reason why it became "a part of organization culture" is only health worker made mistake is blamed and need to take all responsibilities, which makes health workers scared and hesitate to report medical errors occurred during their duty.

  Another reason is errors and mistakes are not recognized as "errors and mistakes" due to weak knowledge of health workers and poor practices.

- **Clinical Governance** is a system through which National Health Service organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

- **Clinical Practice Guidelines** are standards and guidance to improve medical practice. The guidelines are developed (by consensus) by MOHSW or by specialist societies, council or associations and endorsed by MOHSW.

- **Community** consists of people, living in the same area (for example rural or urban communities), with similar occupations or interests (such as farmers, pastoralists, fishermen, employees and self-employed small and big business people) or the same origin (Europeans, Asians) or tribes.(Ministry of Community Development, Women affairs and Children, 1996)

- **The concept of Continuous Quality Improvement (CQI)** emphasizes continuity of effort and active identification of weaknesses as opportunity for improving quality.

- **Client Oriented Provider Efficient (COPE) Services** is a process and set of tools for health care staff to continuously assess and improve the quality of their services. COPE encourages and enables service providers and other staff at a facility to assess the services they provide jointly with their supervisors. Using various tools, they identify problems, find the root causes, and develop effective solutions. Equally important, the self-assessment approach creates involvement and ownership in the quality improvement process. COPE is cost-effective and does not involve large investments of time because some activities may be conducted while staff carries out their routine work. It is also results-oriented. COPE consists of four tools: self-assessment guides, a client interview guide, client-flow analysis and an action plan.

- **Client satisfaction (CS)** in health sector has two sides. One side is from external clients (patients, caretaker, visitors) and other side is from internal clients (health facility staff). First one is a measure of how health care services provided at health facility or health care providers surpasses client's need and expectation for both health and non-health. Seconded one is a measure of how staff working at the health facility satisfies working condition, welfare program, skill and knowledge up-date and so on.

- **European Foundation for Quality Management (EFQM) Model** is a non-prescriptive framework that recognizes that there are many approaches to achieving sustainable excellence. The model's framework is based on nine criteria: Leadership, Policy and Strategy, People, Partnership and Resource, Processes, Customer Results, People Results, Society Results and Key Performance Results. Using these nine criteria the quality performance of any institution, firm or authority can be evaluated.

- **Framework** in this context, refers to a document that sets the basic directions on health care quality improvement issues

- **Medical error** is often defined as human errors in health facility. It occurs when a health worker use inappropriate care/treatment method or the health workers chose the right care/treatment method but executed it incorrect way. Medical accident is often mix-up with medical errors. A medical accident occurs when a patient suffers unforeseen symptoms or injury, which cannot be attributed to negligence by either health workers or health product developers or manufacturers.

- **Indicator** is a measurable variable or characteristic that can be used to determine the degree of adherence to a standard or achievement of quality goals. Examples of indicators (for different aspects of health care) are: Bed occupancy rate (overall and by clinical disciplines); Average length of stay (overall and by clinical disciplines) Percentage of deliveries by Caesarian section; Percentage of outpatients undergoing x-ray examinations; Percentage of children below 1 year who had completed third dose of DPT immunization; Percentage of visual defect detected among Standard 1 school children and Passing rate of examinations.

- **Performance Improvement (PI)** is a process that helps organizations to create conditions for employment productivity. The process acknowledges that training of staff is important for improving quality of health care but this is not sufficient. Other interventions recommended include leadership, organizational design, performance support, supportive supervision, motivation, continued education and improvement in the working environment

- **Productivity** is a measurement of how much work comes from a given input during the given time. It can be measured as "labor productivity". It measures individual worker's performance, output and achievement. Note that technology, systems, processes, training adopted by the organization or institution might affects the productivities.

- **Quality Circles (QC)** are small group(s) of workers (about 6-10 persons) who meet regularly on a voluntary basis to identify, select and analyze work-related problems, focusing on those they can solve. The group(s) act on the problems they can solve and put forward suggestions on solutions (for difficult issues) to the management for consideration and decision. Subsequently they implement the decisions of the management

- **Quality Control and Quality Assessments** are increasingly being used as elements of other concepts rather than stand on their own. Quality control relates quality to compliance with pre-defined, measurable standards. Quality assessment compares performance with expectations, standards or goals and thus identifies opportunities for improvement. Introduction of solutions, changes and support in response to deficiencies identified by the process of assessment or control is usually not part of the two elements.

- **Quality Care Development** is seen as a dynamic process that encompasses the concepts of QA, CQI and TQM.

- **Quality of Health Care** is the degree of performance in relation to a defined standard of interventions known to be safe and that have the capacity to improve health within available resources. To measure quality of care, decisions have to be made on which area/s of health care is/are measured as well as indicators and standards to be used.

- **Quality Improvement (QI)** is a systematic effort to improve the quality of health system development and the delivery of health care services, including all methods of performance assessment and readjustment according to all available resources, thereby serving the health and welfare of the people. It involves a systematic process to collect information on performance of the health system and services; assessing performance trends; identifying shortfalls between performance and standards; determining the cause of shortfalls, introducing remedial measures to improve quality and involving communities and other partners in this process in order to establish ownership and its sustainability.

- **Quality Improvement Team (QIT)** is a group of selected, multilevel, multidisciplinary staff tasked to oversee improvement on the day-to-day performance in a health facility, conduct periodic performance assessments and liaise with the management on improvement strategies and activities.

- **A Standard** is a statement of the "desired achievable (rather than observed) performance or value with regard to a given parameter".
  Statutory inspection is a process carried out to check and enforce compliance with laid down policies, regulations and standards. It is usually a one-way process (in contrast to supportive supervision which is ideally a two way process).

- **Total Quality Management (TQM)** is an approach by which management and employees can become involved in the continuous improvement of the services aimed at embedding awareness of quality in all organizational processes.

- **Work Improvement Team (WIT)** is essential employees based small group, which aims to provide staff with opportunities for meaningful involvement and contribution in solving problems and challenges.

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