IMPLEMENTATION OF THE MODEL DISTRICTS FOR PEER LEARNING IN EACH OF THE EIGHT ZONES HEALTH RESOURCE CENTRE (ZHRC) OF THE MINSTRY OF HEALTH AND SOCIAL WELFARE

Comments

Introduction

Peer learning is one of the well-known modern instruments for quality improvement. It works best when it is combined with tools e.g. supervision, on the job training, inspection etc. TGPSH has partly used this approach to support improvement in planning and progress reporting in Tanga. A peer review of RHMT functions in the 4 regions where TGPSH is supporting was done in 2008. A lot of useful information was collected, but again a combination of approaches was seen as necessary for tangible results to be realised.

There is a need to explore further on the best method to apply the suggested approach. Inputs from the CHMTs themselves, LGAs, service users, Civil Society Organizations and in particular DPs operating at the de-central level are necessary in order to make the approach relevant, effective, efficient, impact oriented and sustainable.

Comments – background and steps in implementation

1. Need to define and remain in focus – Model district is used interchangeably with Model CHMT. Assumption is that the approach targets to improve performance of the CHMT as an entry point for improvement of the District Health System. Model district will refer to issues beyond health, including the district council, governance structures, all health delivery points, the community, vertical programmes, NGOs etc. For that reason, the comments below refer to model CHMT rather than model district

2. A vision, an imaginary model CHMT – what shall we expect to see in a model district? Could even be summarised into a document which outline the stages to a model CHMT.

3. A model CHMT should be recognised by transparent and specific set of indicators covering the key functions of a CHMT – planning, implementation of the plan at all levels, logistics management, emergency preparedness, supportive supervision, data management etc..

4. Selection of the 16 CHMTs – the criteria used must be further clarified and transparent

5. Target – 2 districts in the zone regardless of the region from which they are from (e.g. Rungwe and Mbozi are from one region - Mbeya)? Or could it not be better to have the second district from a different region? There are future benefits in terms of logistics etc.

6. Development of a standard comprehensive CHMT functionality assessment tool – to identify performance gaps (baseline and successive measurements)

7. Establish (CHMT) capacity building packages (this is where the Modular CHMT course could play a very important role)

8. Examine the capability of the ZHRC to deliver capacity building according to each package in number 6 above. The capability of the ZHRC should be assessed in the background of the right skills, management of the centre, financial and material/equipment resources. Strengthen the ZHRC accordingly – fill the identified gaps. Identify alternative sources of such capacities within the zone, or facilitate the ZHRC to deliver.

    a. RHMTs/CHMTs hardly know the potential in the ZHRC. At times they do not even know that they exist

    b. ZHRC to hold strategic marketing- what they offer, efficiency, backup support etc.

    c. MoHSW to set purposeful moves to support ZHRCs to function and survive. MoHSW should refrain from services down to facility level particularly those ZHRCs can do.

9. RHMT should have the right skills and experiences in all packages (supervision, coaching, …)

10. Develop an Implementation framework for the involved Council; some kind of Council SWAp with; Activities and Concrete Budgetary Commitment ;(Recurrent and development-to ensure sustainability-in issues like capacity building)

11. Definition of Roles for all key actors (MOHSW, PMORALG, Council, Development Partner, Community and other identified actors.

Comments – alignment with other programmes and strategies

1. How can the Basic Health Services Project (WB) be aligned to the Model District concept (to foster synergies and reduce overlaps)

2. The planned areas for intervention in HRH are many and have different aspects – consider focusing and prioritising

3. HRH gaps are similar but sometimes differ according to different regions advantageous /disadvantageous – this has to be distinguished in the sampling the districts

4. Many CHMTs already have initiated their own, existing local solutions that works in their settings – consider harmonising/integrating them into this learning

5. Consider enhancing the understanding and localising/strengthen the relationship between ZHRCs, Councils/Regions and their institutions like hospitals etc. on: how they can depend on each other in utilising each other's resources even without a formal structure that links them.

Comments – TGPSH perspective

1. 4 CHMTs already earmarked to be among the 16. This is already overwhelming in terms of resources and technical support, considering that the rest of the districts will continue to need support
2. A Combination of the already available TGPSH Instruments within the Components is a big advantage
    a. Planning and Management support (C4)
    b. Quality checks, teams and monitoring (C4)
    c. PPP issues (C4)
    d. Facility Planning (C4)
    e. Public finances management improvement (C2)
    f. HRH (C3)
    g. Use of Community Health Workers (C1)
3. This proposal sheds light on how we should mould the next phase of the TGPSH. The support could make use of the already established approaches and tools within TGPSH in addition to what will be developed as part of the WB/WHO/LGA project.