CONCEPT NOTE

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

A BACKGROUND INFORMATION:

During the 12 Annual Joint Health Sector Review that was held between 11 October to 3, November 2011. It was agreed to adopt improvement of the Council Health Plans in 2012-13 by implementing revised Comprehensive Council Health Plans Guidelines as one of the milestones. Two process actions were recommended in order to achieve the milestone these are; building capacity on planning and budgeting at district and Regional levels by involving Zonal Health Resource Centres and using Plan Rep. Create model districts for peer learning in each of the eight zones. The model health districts have been selected by MOHSW based on seven indicators that have looked on the current strength of leadership, functional structures, availability of functional CHF and NHIF, facility account, timely and quarterly CCHP Plans and reports, and quick response to Ministerial instructions, guidelines and circulars
The sixteen districts are; Bahi DC, Iramba DC, Kilolo DC ,Mbinga DC, Rungwe DC, Mbozi DC, Meru DC, wanga DC, Serengeti DC, Magu DC, Nzega, Kasulu, Kilosa, Kibaha Rular, Mtwara MC, Nachingwea MC. Some of these districts can be adjusted in the process by adding or removing others as the ministry is still reviewing them. These are a sample of the districts that scored best in all seven criteria. Therefore, it is envisaged making the better use of the existing resources will yield better results which other districts can learn on. Modest investment, will be done if need be.
It is recognised that different Stakeholders are participating in strengthening Regional and district health services to mention a few these includes; the Japanese International Cooperation Agency (JICA) who are supporting these efforts across the country, Germany Development Cooperation (GIZ), in Lindi, Mbeya, Tanga and Mtwara Regions, Swiss Development Agency for Cooperation in Dodoma and the planned support of the World Bank IDA Grant across the districts. A massive support is through the Health Basket Fund that has been in place since 1999.

The contribution of the Health Basket Fund and other resources from different stakeholders is commended for the improvement of health services that has taken place so far. However, as it has been noted by different reports the room for improvement is still there, since there is variance between policy guidelines and implementation. This concept note outlines and suggests on ways to implement the two process actions mentioned above. The focus of implementation will be on sixteen (16) Model Health Districts, two in each of the eight ZHRC.

However, this note moves far by proposing that among the sixteen districts whereby the strengthening of RHMT and CHMT in planning and management will be undertaken simultaneously a special attention can be directed towards two districts to maximize their impact and make them centres of excellence. These districts have been agreed by MOHSW they have been chosen because of their geographical closeness thus facilitating their monitoring and supervision, these are Iramba DC and Singida DC. The special attention would be directed on strengthening their health programmes so that they deliver effectively.

B OBJECTIVES OF THE MODEL DISTRICTS:

a) To strengthen Council Health Management Teams (CHMTs) and Regional Health Management Teams (RHMTs) by building their capacity in health services planning and management in order to contribute towards improvement of district health services.

b) To promote local Regional and district health leadership, in strengthening community access to priority PHC health services (district roll out of priority interventions-maternal and new borne services, EPI, Nutrition, TB, Malaria , essential commodities and medicines and HIV/AIDS services).

c) To demonstrate that with the existing resources if they are better coordinated and used efficiently and effectively is possible to improve both process and output indicators.

C KEY AREAS OF INTERVENTIONS:

1) Improve RHMTS and DHMTs capacity in planning & budgeting and health service delivery to revitalize PHC in the following areas;

   a. Strengthen HMIS for District Health data analysis and information generation for decision making. It will facilitate on the priority areas of investments in terms of the available funds and the skilled health workers.

   b. Strengthening management, of human resource ; through identification of HRH gaps, recruitment of new skilled staff, employment of new staff in the districts and providing them with space to live and their settlement allowances, deployment to facilities where they are needed most and retention strategy which include payment of their salaries on time, where necessary by provision of an expenditure code to provide for salary advancements while waiting for the new staff to be placed on the pay roll.

   c. Strengthening financial and assets management; the sources of financing the district health budget include the grants from the central government, the cost-sharing funds, the National Health Insurance Funds, the Community Health Funds, the health basket funds and support from vertical programmes and NGOs projects working in the districts. All these funds need to be brought on the plan of operations and applied to the priority activities and cost centres as explained in the CCHP-Guidelines. The funds need also to be reported upon on where and when they are spent, and financial statements availed for annual auditing. Through the health boards and the facility governing committees, the expenditures of the funds need to be posted on the boards for public scrutiny as per the financial requirements and guidelines.

   d. Strengthening medicines and health technologies management. To ensure that proper ILS system is introduced by the ministry for ordering and Inventory Management of Medicines and supplies through appropriate supervision and mentoring. Support will be provided to improve the quantification and forecasting capacity, the local procurement and tendering systems, storage and record keeping, distribution of medicines (availability of distribution schedules and transport), pharmaco-vigilance, post market surveillance, availability of management tools, rational use of medicines and functional hospital therapeutic committees at the health facilities.

2) Support efforts and initiatives towards community involvement by strengthening health service boards & facility governing committee. These committees are in place in all the LGAs. However they are weak due to weak health management teams and weak governance and leadership in the LGAs. There is also lack of knowledge on the area of effective decentralization and decision making. There is a need to;

   i. Train the teams on how the health boards and committees can be strengthened and made functional as an important structure in the LGAs

   ii. Engage the Counsellors and the members of Parliament how to support the health sector development agenda and health services improvement.

iii. Advocate for change and focus on the most vulnerable groups in the community to foster equity of service access and use.

iv. Promote client satisfaction : Rapid client satisfaction survey

3) Explore the possibility of using Community Health Attendants (CHAs) as suggested by the ministry of health (CHW) (CHA s) how best to use the available CHAs to facilitate the inter-phase between the Health facility and the house holds.

4) Strengthening supportive supervision at all levels with specific focus to improve operational effectiveness of the Model districts, and address referral to higher levels. The supportive supervision is on of the strategic approaches to improve service quality and mentoring the health providers at lower levels. There will be a concerted effort to foster supervision by the district teams through a cascade. The central supervising the regions, the regions to the districts and the districts to HCs and HCs to dispensaries. The interphase between the dispensary and the House Hold is the CHAs. These will be supervised by the dispensary staff. The guidelines of supervision are already in place for use and adjustments will be made based on experience from these 16 districts.

5) Support work on governance, leadership & accountability in health care provision.

   a) Public Private Partnerships (PPP) – including fostering service agreements between– LGAs & private sectors providers. Through the PPP secretariat, they will propose how best to be involved in this undertaking to strengthen their presence in the service provision and visibility by LGAs. Currently they are members to the Health Boards and the Facility Governing committees. Some Private providers are chairs of some of the Health Boards and the Facility Governing committees. The issue is how best to improve the governance at this level and how to engage with the Village governments as well the primary level of governance of the sectors including health.

   b) Further decentralization of health services planning and management beyond the districts to lower levels health facilities, including the Health Centres and the Dispensaries irrespective of the ownership.

   c) Improve communication between management & communities on resources availability and usage. This will enforce transparency and accountability as well.

6) Address programmatic issues. This will include focusing on the regional level and district level planning and implementation and how to influence where the primary services are actually being delivered. Much has been done on policy and strategic level but much more need to be done on the service delivery points. These are the district level and beyond

   a) ATM implementation within the framework of the district plans, HCs, Dispensaries and Clinics

   b) Disease Control and surveillance including sanitation, environmental management and personal hygiene, infection control between communities and patients in hospital settings

   c) MNCH Services scaled up with appropriate indicators to measure change

7) Monitoring & Evaluation

   Before the implementation of the 16 Model districts and two special districts information will be collected to assess the current status of the performance of the health system and the levels of the health status. This information will be collected through the existing Health Information Management System (HMIS) and other existing reports. Monitoring of the progress during implementation will focus on how programme guidelines and policies are implemented as planned. Priority will be on

priority programmes contributing to MDG goals 4,5 and 6. The focus of monitoring will be on process and output indicators as presented in monitoring indicators of the Health Sector Strategic Plan III 2009-2015

D HOW THE SUPPORT WILL BE DELIVERED:

The support will be coordinated jointly by the Ministry of Health and Social Welfare and The Prime Minister's Office Regional Administration and Local Government. The existing structures for the implementation of Regional and District Health Services in these Ministries will be used. Stakeholders, who are interested to work within the 16 Model districts, will engage with appropriate units and offices in these two Ministries.

Upon agreement with these Ministries it will be necessary to pay visits to the districts to introduce the concept to the respective district authorities and then organise an inception or orientation meeting to all 16 districts. The implementation is not planning to introduce new tools but use the existing tools. Additional resources will mainly be to bridge identified gaps e.g. where there are no equipment. These will be procured.

E FINANCIAL IMPLICATION:

The plan is to maximise the effectiveness of the current level of funding and only making modest investments where deemed necessary.

F EXPECTED RESULTS:

The 16 districts will have a team with a better team work; and enhanced performance on the areas of management, supervision, reporting and health plans which are implementable and bringing change to the health of the district population: