First National Quality Improvement Forum on Health Care
Achieving Quality Health Services in Resource Constrained Settings:
Experiences from quality improvement initiatives and lessons learnt

Ubungo Plaza
Dar es Salaam, Tanzania
November 16 to 18, 2011

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FOREWORD

Tanzania mainland commemorates its 50th anniversary in December, 2011. Among the important milestones registered is that the Health sector has remained a key priority sector of the government since independence in 1961. Primary Health Care has been the main strategy to fight the three enemies identified by the first phase government i.e. Poverty, ignorance and disease.

Overtime, the Tanzanian population which has increased tremendously and advanced in education and change in lifestyle due to urbanisation, the demand for health services has also increased. Furthermore as a result of reforms in the health sector necessitated by a liberalized economy, the introduction of cost sharing mechanisms to widen financial base of the health sector resulted in the Tanzanian community demanding for better services. On the other hand, advances in Communication technology that have now transformed the world into a global village with regards to increase knowledge specifically in health that can now be easily accessed via the internet.

The government of Tanzania, through the Ministry of Health and social welfare (MoHSW) felt it's high time it meets the needs and desires of the entire social spectrum of the Tanzanian community by delivering health services that match with the investments made throughout the years on human capital and infrastructure. This first NQIF is an attempt to initiate a process whereby Quality Improvement is no longer a theoretical jargon but should now be practised at all levels of health service delivery. The MoHSW expects that this forum will stimulate Tanzanian health care professionals as individuals and as units to embrace a culture of self evaluation and improving performance that will ensure continuity of services and favourable outcomes. In addition, this forum is an avenue to demonstrate the public – private partnership that has been championed by the health sector for more than a decade. It is my hope that the rich experiences and new innovations that have been field tested in the country will facilitate the adoption of new strategies to implement Quality improvement initiatives at a broader scale and therefore reinforce the foundation for its implementation countrywide.

On behalf of the Ministry of health and social welfare, I would like to thank the sponsors who expressed their interest to join efforts with us in organizing this important event for the first time. I would also like to thank all those who submitted their work for sharing in this forum. This is a spirit of true partnership and professionalism in addressing the challenges of the Tanzanian health system. Lastly but not least, I would like to commend the organizing committee for taking the bull by the horns in making our dream a reality of holding this forum as planned.

Congratulations to you all and best wishes.

Dr. Deo Mtasiwa
Chief Medical Officer
Ministry of Health and Social welfare
United Republic of Tanzania

MESSAGE FROM CHAIR – ORGANIZING COMMITTEE

The first National Quality Improvement forum starts from Wednesday 16th November, 2011 to Friday 18th November, 2011 at the Ubungo Plaza in Dar es salaam, Tanzania. It is being hosted by the Ministry of Health and Social welfare. The forum has been kindly sponsored by the following development partners; Japan International Cooperation Agency (JICA), Pharmaccess International, JHPIEGO, Ifakara Health Institute, University Research Centre, Association of Private Health Facilities, German International Cooperation (GIZ), Pyramid Pharma, Family Health International and through the US government agencies: Centers for Disease Control and Prevention and United States Agency for International Development through PEPFAR.

On behalf of the Ministry of Health and Social welfare and development partners, the organizing committee warmly welcomes you to Dar es Salaam the "City of Peace" and to this forum whose theme is "**Achieving Quality Health services in Resource constrained settings; Experiences from Quality improvement initiatives and lessons learnt".** This topic was selected to be addressed by partners involved in quality improvement initiatives in the country. We are grateful that participants from the East Africa region have showed interest and are participating in this forum; namely Kenya, Uganda and Rwanda. Their presence will facilitate cross fertilisation in the area of Quality improvement.

The forum organizing committee has come up with a program that is divided into three subthemes namely;

1. Coordination, harmonisation and integration of quality improvement
2. Institutionalising quality improvement
3. Promoting health facilities as a highly reliable institutional for healthcare delivery

A total of 70 abstracts were accepted for both oral and poster presentation exhibition.
In order to give the forum a flavour, there will be panel discussions and special focus on innovations in QI.
All presentations will be in plenary and there is time allotted for poster presentations.
There will also be an exhibition area for different organizations to show case their products and services.
The social event at the forum will consist of a cocktail party.

We look forward to your active participation.

We wish you a pleasant stay in Dar - es - salaam. KARIBUNI SANA!

Dr. Henock A. M. Ngonyani
Chairman - Organizing Committee
First National Quality Improvement Forum
Dar es salaam, Tanzania
November, 2011

THREE DAY FORUM PROGRAM

Wednesday November 16, 2011	**Forum Facilitator**
8:00 to 9:00 am	**Registration**
9:00 to 10:30 am	**Opening**
	Guest of Honor **Key Note Speaker: Dr. Deo Mtasiwa, CMO, MOHSW** "*Achieving Quality Health Services in Resource Constrained Settings: Experiences from Quality Improvement Initiatives and Lessons Learnt*" **Launching of Tanzania Quality Improvement Framework (TQIF), MOHSW**
10:30 am to 11:00 am	**Tea Break**
11:00 to 1:00 pm	**Panel Discussion Forum Sub Theme One** *"Achieving better coordination, harmonization and effective integration of different quality improvement initiatives: challenges to countries like Tanzania"* **Key Note Address Sub Theme One: Dr. Henock Ngonyani**
Session Chair **Dr. A. Mwita, RMO Kagera**	**Dr. S. Hobokela**, URC, *Partnerships for Quality Improvement (QI)* **G. Kayita**, Uganda, *Institutionalizing QI* **Dr. H. Kiwelu**, Mbeya RH, *Promoting Health Facilities* **Dr. P. Risha**, PAI, *Can the lessons learnt from HIV and AIDS QI initiatives be broaden to cover the general health services?* **H. Ishijima**, MOHSW/ JICA, *National Roll Out of 5S-CQI-TQM Approach*
1:00 to 2:00 pm	**Lunch**
2:00 to 4:00 pm	**Oral Presentations Forum Sub Theme One**
Session Chair **Dr. B. Ngoli, GIZ**	**Dr. E. van Praag**, FHI360, *Integration and Quality* **C. Henjewele**, ICAP, *Data Sharing and Critical Data Review* **E. Mohamed Seid**, Rwanda, *QI Program for HIV/AIDS Services* **J. Emmanuel**, UNDP, *Tools and Strategies for QI in Waste Management* **S. Mujaya**, FHI, *Integration of Family Planning and HIV Services* **Dr. Mwanjelwa** MPAI, *Improving Quality Services in the Military Setting*
4:00 to 6:00 pm	**Guided Poster Tours** **Cocktail Party hosted by Pyramid Pharma**

Thursday November 17, 2011	
8:00 to 9:00 am	**Registration**
9:00 to 10:30 am	**Panel Discussion Forum Theme Sub Two** *"Institutionalizing Quality Improvement"* **Key note speaker: Dr. Rashaad Masoud**

Session Chair **Dr. E. Mpuya, RMO Iringa**	**M. Jacobson**, Arusha LMC, *Developing Measures of QI* **Dr. A. Komba**, Jhpiego, *Strengthening Infection Prevention and Control* **Mr. G. Moyo**, TNMC, *Professional Regulatory Improvements* **Z. Chaula**, Dodoma RHMT, *Strengthening the Health System for HIV with QI* **Dr. M. Mhando**, MOHSW, *Hospital Reform Program* **Dr. J. Lija**, MOHSW, *Towards QI of HIV/AIDS Services*
10:30 am to 11:00 am	**Tea Break**
11:00 to 1:00 pm	**Oral Presentations Forum Sub Theme Two**
Session Chair **Dr. R. Lipyoga, MOHSW**	**Dr. D. Bwogi**, ICAP, *District Mentorship Initiative* **Dr. Y. Abraham**, URC, *Improving Provider Productivity* **L. Ikamba**, Jhpiego, *Effective Mentoring and Supportive Supervision in MNCH* **T. Medeye**, FHI, *Laboratory Accreditation* **Dr. Mboya**, IHI, *Assessing and Improving Primary Health Care* **Dr. W. Schimana**, EGPAF, *Focused Pediatric Mentoring* **P. Komba**, AIDS Relief, *CQI Assessment Tool*
1:00 to 2:00 pm	**Lunch**
2:00 to 4:00 pm	**Panelist Discussion Forum Sub Theme Three** *"Promoting Health Facilities as Highly Reliable Institutions for Provision of Quality Health Care Services"* **Key Note Speaker: Dr. E. Samky**
Session Chair **Dr. G. Mtey, RMO Dodoma**	**Dr. L. Birigi**, Mbeya RH, *Promoting Health Facility as Highly Reliable Institutions* **R. Nyambo**, MNH, *Patient Satisfaction as an Indicator of Quality* **K. Masamaro**, KEMRI/CDC, *Waiting Times and Quality* **R. Boniface**, Liwale DC, *From Voluntary Community Health Fund to Compulsory Community Health Fund* **G. Bosse**, GIZ, *Introducing Quality Assurance Tool to Improve HIV/AIDS Care*
4:00 to 6:00 pm	**Guided Poster Tours**
Friday November 18, 2011	
8:00 to 9:00 am	**Registration**
9:00 to 10:30 am	**Oral Presentations Forum Sub Theme Three**
Session Chair **Dr. E. van Praag, FHI 360**	**S. Chombo**, Jhpiego, *Putting Quality in the Hands of Providers in MNH* **J. Kalimuda**, EGPAF*, Routing Data Quality Assessments* **R. Mdee**, Jhpiego, *Improving Interpersonal Communication Skills of HC Providers* **A. Kitira**, ICAP, *ART Ordering Cycles* **E. Mungure**, CCBRT/Jhpiego, *Experience Implementing IPC in Dar es Salaam* **J. Jaribu**, IHI, *Implementing QI in Southern Tanzania* **P. Rugimbanya**, ICAP, *Laboratory Services for HIV*

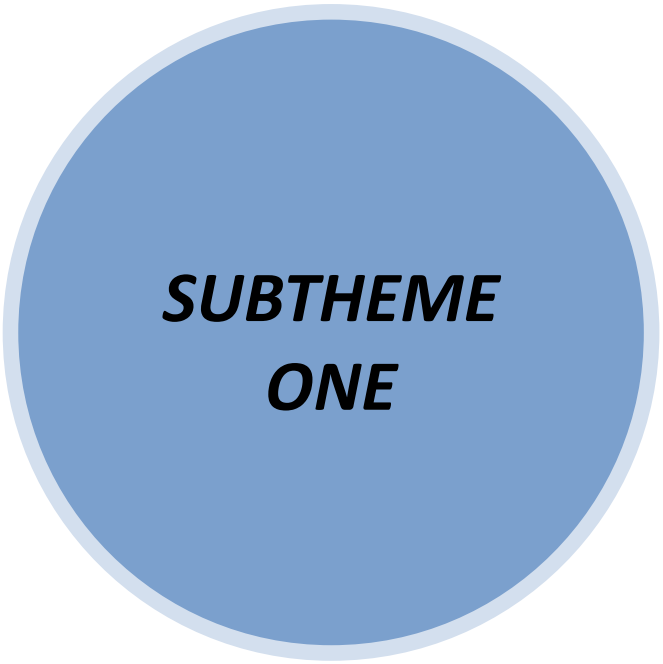
10:30 am to 11:00 am	**Tea Break**
11:00 to 12:30 pm	**Oral Presentations Innovations in Quality Improvement**
Session Chair **Dr. H. Kiwelu, Mbeya RH**	**A. Schulze,** IHI, *Making Supportive Supervision More Efficient and Sustainable* **D. Rumisha,** URC, *Health Provider Self-Assessment* **N. Hendler,** Jhpiego, *Getting Motivated* **N. Spieker,** PAI, *Safe Care Initiative* **J. Wanyungu** NASCOP Kenya, *Innovative Approaches to Sustaining QI* **M. Nyagawa**, URC, *Application of standards for MVC*
12:30 to 1:30 pm	**Forum Summary & Way Forward** **Closing**

Achieving better coordination, harmonization and effective integration of different quality improvement initiatives: challenges to developing countries like Tanzania

Coordination and integration of QI approaches at different levels

Lessons from functional coordination mechanisms

Influence of donor funding and organizations on integration of QI approaches



Abstract Title: **Data sharing and critical data review meetings: Measures towards improving data use and program quality**

Author List: **Henjewele C, Almeida A, Strachan M, Chintowa J, Sanga I, Zelothe J, Malanguka, D, Casalini C, Mbatia R**

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Project Objectives and Background
Given the rapid scale-up of HIV services and emphasis on transition and sustainability, there is a need for quality improvement systems integrated into district health management systems, and developing the culture of making use of program data among facility staff and management. Timely reporting of service delivery data from facility to national level is essential for compliance with national guidelines and program monitoring for quality of services. In response, ICAP-Columbia University introduced quarterly internal critical data review and annual external data sharing meetings in Kigoma, Kagera, and Pwani.

Methodology
Quarterly data review meetings, including ICAP staff across program areas, focus on selected indicators to monitor program achievements and identify challenges. Trends in program data are reviewed over the four previous quarters and follow-up actions items are reported on after investigation at site level, as well as new action items listed. Actions may relate to programmatic or strategic information corrections.

Annual data sharing meetings target all 127 care and treatment facilities, Regional and Council Health Management Teams (R/CHMT), and faith-based partners. Health care workers from selected sites, in collaboration with the CHMT and District AIDS Coordinator, are supported to prepare presentations on a program challenge theme which has been selected from the quarterly data review meetings. Participants are guided through a critical review of data slides, followed by discussion of the challenges and strategies for program improvement.

Results
Health care workers (219) and RHMT/CHMT members (56) participated in the last three regional data sharing meetings. Districts (19) shared experiences and came up with practical solutions for sub-optimal performance.

Policy Implications and Lessons Learned
Data review and data sharing meetings suggest that collective critical data review exercises can contribute to program quality improvement, ownership and engagement in identifying solutions to address weaknesses. CHMTs have applauded the approach and suggest conducting data sharing meetings more frequently.

Abstract Title: ***Health Care Service Integration and Strengthening Quality: what have we learned?***

Author List: **Eric van Praag[1], Patrick Mwidunda[2], Erenia Sambua[1]**

Affiliations: [1] **FHI360,** [2] **NACP-MOHSW**
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Project Background
While integration is being promoted as a national strategy, its meaning differs, ranging from adding tasks to providers, services into programs or unifying comprehensive health care programs into one budget. Whatever it adds the risk is the focus gets lost and quality compromised. However, adding tasks or services improves cost-effectiveness and saves money through using same resources.

Objectives
To compare quality improvement results among various services´ integration approaches at facility level in Tanzania.

Methodology
Quality indicators were extracted from monitoring and evaluation reports of various service delivery programs attempting integration such as medical supplies; one stop shops for comprehensive RCH, FP, MTCT and treatment; TB clinics with ART provision and CTC/FP integrated clinics and compared. Indicators covered provider and client satisfaction and efficiency of services.

Results
Availability of guidelines, tools, job aids, reagents and supplies scored low in programs where integration was implemented without specifying and formalizing additional tasks and services. Although cost savings were made, ultimate quality of services was put at risk. Provider and patient satisfaction, reduced waiting times and operational efficiencies scored high in programs that had clear training on new integrated roles, available tools, regular supervision and mentoring such as the One Stop Shops for RCH, TB/HIV and HIV/FP

Conclusion
Cost considerations cannot be the major justification for promoting integration. Various quality aspects such as ownership, efficiencies in service organization and clients´ views need to be planned for and assured when considering integration

Policy Implications and Lessons Learned
Future integration efforts at service delivery level needs to be well defined and understood by all players to ensure quality is maintained and strengthened

Abstract Title: **FHI360s experience on integrating family planning and HIV care and treatment services, a focus on improving health care quality**

Author List: **Mujaya, Stella MPH[1]; Lasway, Christine MPH[1]; Petruney, Tricia[1], Hiza, Maurice[2]; Mbuguni, Zuhura; Lema, Mary Ani[1] and Rwebembera, Anath[3]**

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Project Background
Family planning (FP) and HIV services in Tanzania have been both offered separately for years now. Several studies conducted at the HIV care and treatment clinics (CTC) reveal that clients attending CTC are in need of FP services. One of the national PMTCT targets calls for 80% of women attending PMTCT receive FP by 2015, on the other hand, one of the national FP target calls for an increase of CPR from 34% (TDHS 2010) to 60% by 2015. With this in mind, a need for integrated FP and CTC services was realized. In 2008, the MoHSW asked FHI360 to develop and test a model for integrating FP into CTC. FHI360 developed, introduced and evaluated a seven step service delivery model called *'Facilitated referral model"* in 12 sites of Iringa and Morogoro region with support from the Tides Foundation and USAID.

Objectives
This operational research focused on gradually strengthening the health system and ensuring quality of services. The main goal was to test the effectiveness and assess the feasibility of the model.

Methodology
A quasi-experimental pre-and post-test cross-sectional study design from a sample of 12 CTC sites. Intervention component involved orienting CHMT/RHMTs, conducting site visits, developing training curriculum and service delivery job aids, training service providers, monitoring and supervision.

Results
The model decreased unmet need from 12% to 8% and increased effective FP referrals and modern method use among CTC clients from 17% to 39%. Most importantly, this promising intervention was found feasible, acceptable and can be mainstreamed at all levels of health care where CTCs are available

Conclusions
Integration of services which takes into consideration strengthening the health system and improving quality of services requires good investment on valuable intervention inputs.

Policy Implications and Lessons Learned
This experience provided lessons on planning and implementing a scaled-up integration of FP services within HIV/AIDS programs.

Abstract Title: **A health facility-based quality improvement (QI) program for HIV/AIDS clinical services in Rwanda**

Author List: **Endris Mohammed Seid[1, 2], Umuhongerwa Alice[1,] Michelle Geis[2], Jean Pierre Nyemazi[1], Sabin Nsanzimana[1], Erin Wheeler[3]**

Affiliations: **RBC/IHDPC (Rwanda Biomedical Center/ Institute of HIV/AIDS & Disease prevention & control at Ministry of Health Rwanda, 2. HEALTHQUAL International 3. U.S. Centers for Disease Control and Prevention/Rwanda**

Background
The U.S. Centers for Disease Control and Prevention (CDC)-Rwanda began transitioning financial and technical responsibilities for HIV clinical services for 76 health facilities from international NGOs, AIDS-Relief and ICAP-Rwanda, to Ministry of Health (MOH)-Rwanda in March 2010. To maintain and improve the quality of HIV clinical services throughout the transition process, MOH-Rwanda, CDC and international partners undertook monitoring and evaluation of transitioned health facilities at baseline and every 6 months. To complement this, MOH-Rwanda, in collaboration with HEALTHQUAL-International, developed a site level quality improvement program in March 2011 and began implementation in May 2011.

Objective
To improve and sustain the quality of HIV/AIDS care & treatment & PMTCT services at health centers and district hospitals.

Methods
Nine transitioned sites (2 hospitals, 6 health centers & 1 ART clinic) were chosen to participate in the pilot phase of the QI program. Six HIV/AIDS clinical indicators were selected for inclusion based on the data collected during the transition M&E process and the priorities of MOH-Rwanda. Health facility staffs were supported to develop projects and work plans following QI principles including: data-use, team approaches, cause/effect analysis &PDSA (Plan-Do-Study-Act) model. QI tools, coaching visits, peer learning meetings and documentation of best practice are provided by MOH-Rwanda and HEALTHQUAL.

Results
Indicator results are pending the second round of data collection from transitioned sites planned for October 2011. Pilot facilities have implemented improvement interventions including: soliciting patient feedback on quality of services, revising the organization of services, and early tracking and identification of patients. Interim results using PDSA activities are starting to show improvement.

Conclusions
The QI program enhances the transition process by supporting health workers to incorporate performance data, patient feedback and a systems approach into service delivery to enhance quality. Based on lessons learned from the pilot, MOH-Rwanda can scale up QI to more health facilities.

Abstract Title: **Improving quality of care through sharing of best practices; experience from AIDSRelief CQI team**

Author List: **Komba Patience RN[1, 2], Regina Kimambo RN[1, 2], Kigombola Andrew MD[1, 2], Memiah Peter DrPH[1]**

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Project Background
Successful implementation of ongoing quality improvement (QI) methods requires investment in collaborative sessions. To improve the quality of decision-making process across health facilities and ultimately, patient outcomes, sharing best practices is advocated. However, current evidence suggests that best practices and shared decision-making for CQI is not yet widely adopted by health institutions in Tanzania. To address this gap, AIDS Relief consortium held a CQI symposium inviting health care providers for a three day meeting that discussed successes and challenges in CQI

Objective
To create a best practice sharing forum aimed at improving patient health outcomes

Methodology
From May 2009- May 2011, the AIDSRelief CQI team initiated comprehensive CQI technical assistance to Health Facilities .The first step was conducting an assessment to identify the gaps in implementing CQI at the health facility level; Intensive CQI trainings were then conducted for health care providers with the main focus being increasing CQI engagement. Specific action plans were developed for improvement projects to be implemented upon return to the health facilities. AIDSRelief and district focal persons provided continuous support and mentorship on data use to make informed decisions. By August 2011, 50 improvement projects had been completed and were ready to be shared as best practices across 23 facilities in 4 AIDSRelief supported regions.

Results
At the symposium it was observed that QI activities were implemented at the facility, district and regional levels. The improvement projects were categorized into 3 key categories. 1) Improving patient outcomes 2) Improving PMTCT activities and 3) Improving quality of care. All QI activities showed marked improvements over time between pre- and post-interventions. Post the symposium standard interventions were identified for institutionalization.

Conclusion
This pioneer initiative reveals that interventions to foster learning sessions is paramount to increasing patient outcomes. However, future studies on the impact of learning sessions are warranted.

Abstract Title: **Partnership for Quality Improvement (PQI): A Strategy for Harmonization of QI Efforts in Tanzania**

Author List: **[1]Stephen Hobokela, [2]Risha Peter, [3]Lija Gissenge, [4]Memiah Peter, [5]Masanja Benedicta, [6]Teri Ivan, [7]Mkiramweni Yohana, [3]Ngonyani Henock**

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Project Background
Although the Ministry of Health and Social Welfare (MoHSW) promulgated its Tanzania Quality Improvement Framework (TQIF) in 2004, the process for health care QI still had many gaps, including variations in QI indicators, practices and tools across partners; low involvement of R/CHMTs and poorly defined reporting framework. To achieve more effective harmonization of QI efforts, in 2007, the MOHSW, the USAID Health Care Improvement Project (HCI), PharmAccess and other implementing partners (IPs) developed the PQI.

Objectives
To unify efforts and harmonize practices towards improving the quality of HIV/AIDS services, build capacity of R/CHMTs to implement continuous QI, and spread improvements nationally.

Methodology
Improvement Collaborative approach was applied using common QI priorities across regional partners working through existing MoHSW structures. The first collaborative was initiated in Tanga; thereafter, similar collaboratives were started in Morogoro, Mtwara, and Lindi drawing lessons from Tanga.

Results
The PQI initiative has resulted in improved capacity to implement QI, led by R/CHMT in collaboration with IPs, manifesting in improved services. Since June 2008, enrolment of HIV-positive pregnant women into CTC increased from 50% to 95%; provision of co-trimoxazole prophylaxis to HIV-exposed infants increased from 5% to 70%; while lost-to-follow-up among patients on ART decreased from 20% to less than 5%. Furthermore, there has been increased agility and mobilization of human and material resources for QI.

Conclusions
PQI has shown it is possible to operationalize the TQIF and achieve promising results in HIV/AIDS care.

Policy Implications and Lessons Learned
The PQI experience was used to revise the TQIF, harmonize QI indicators and develop a National QI Training Package to harmonize QI practice for nationwide spread.

Abstract Title: **Spread of PMTCT and ART Better Care Practices through Collaborative Learning in Tanzania**

Author List: **[1]Stephen Hobokela, [1]Rumisha Davis, [1]Franco Lynne, [1]Moshi Edward, [1]Turuka Edgar, [1]Mohan Diwakar, [1]Mussanga Jared, [1]Mgunda Farida**

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Project Background
The MOHSW and implementing partners (IP) initiated the Partnership for Quality Improvement (PQI) in 2007 to develop a harmonized QI plan for HIV/AIDS services countrywide. The partnership included PEPFAR's HIV/AIDS care and treatment IP, with technical leadership from USAID Health Care Improvement Project, implemented by URC, and PharmAccess. PQI introduced "Improvement Collaborative" strategy to generate better care practices to improve care to PLHIV.

Objectives
To describe and analyze peer-to-peer learning among health workers and spread of better care practices within and across regions.

Methodology
Improvement Collaboratives were formed in 4 regions (25 sites) where multiple teams working on common goals, learned and shared what works to achieve results rapidly. Data to measure mechanisms for exposure, sharing of change ideas, changes implemented and factors facilitating or hindered sharing and uptake of change ideas was collected through interviews and focus group discussions with team members, R/CHMT, IP and NACP staff.

Results
Approximately 12.6 changes were tested per facility, four of which were tested by all facilities. Most ideas were "borrowed" from other teams, indicating that external ideas were main sources of adopted changes. Most commonly used methods of presenting information about changes were oral presentations, written descriptions and providing tools/materials. Simplicity of the change idea was most important factor for testing, while perceived lack of necessity was the top reason not to.

Conclusions
Shared learning and spread of better care practices/effective changes took place within and across studied regions. This experience demonstrates the theory of rapid spread of effective changes in the collaborative context.

Policy Implications and Lessons Learned
Better ways of providing detailed information about "how to do" the changes need to be developed to facilitate easy adoption.

Abstract Title: **The management of febrile patients after the introduction of Rapid Diagnostic Tests for malaria in health facilities of rural Tanzania**

Author List: **Tillya Robert [1]ADCM, MIH Candidate; Swai Ndeneria [3] ADCM; Dr Valerie D'Acremont[2] MD. MIH, PhD.; Prof Christian Lengeler[2]; [1]Ifakara Health Institute, Tanzania; [2]Swiss Tropical and Public Health Institute; [3]City Medical Office of Health, Dar es Salaam**

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Project background
Presumptive treatment with antimalarials is often considered the safest strategy for children presenting with fever in highly endemic areas, so that no malaria case is left untreated. Unfortunately, this results in a massive number of patients without malaria being treated, while other dangerous diseases can go undetected and hence untreated. Rapid Diagnostic Tests (RDT) that are highly sensitive and specific for malaria have a strong potential to improve the situation in endemic countries.

Objectives
To assess the impact of routine Rapid Diagnostic Test (RDT) introduction on the quality of management of fever patients in health facilities.

Methodology
After training of health workers, intervention was introduced in two health centers and four dispensaries. Baseline information was collected on routine statistics from health facility registers (longitudinal survey) and an observation of consultation process (repeated cross sectional survey). This was compared with similar survey done twelve months later to see changes on number of patients tested for malaria, number of patients treated for malaria, and number of ant malaria blisters prescribed.

Results
Before RDT-implementation, the proportion of febrile patients tested for malaria with microscopy was only 43%. About 23% were reported as having a negative microscopy result and, among them, 22% still treated with antimalarials. Among non-tested patients, 48% were not treated with an antimalarial drug. Results from the survey done one year after RDT initiation show that the proportion of febrile patients tested increased. Since RDT-performance was much better than that of the former routine microscopy, proportion of reported positive-results decreased from 63% to 35% after RDT initiation. This led to a drop of 1.8-fold in the overall antimalarials' consumption.

Conclusions
With RDTs, clinicians stopped leaving half of febrile patients untested and untreated for malaria. The strategy of using RDTs in routine management of febrile patients is clearly much safer than that of presumptive-treatment. Only true malaria cases are treated with an antimalarial-drug and negative patients are not treated. Ideally, investigations should then be pursued to determine the actual cause of the fever.

Abstract Title: **Performance and Quality Improvement Process in Maternal and Newborn health Care in Tanzania**

Author List: **Gaudiosa Tibaijuka, Rose Mnzava**

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Project Background
Maternal and Neonatal mortality in Tanzania has been persistently high for decades. In realization of this fact, the MoHSW (RCH Department) in collaboration with MAISHA with Jhpiego providing technical support and lead developed an intervention which focuses on improving the provision Basic Emergency Obstetrics and Neonatal Care (BEmONC) in regional hospitals and district health centers/ dispensaries of Tanzania. The project is being implemented in 21 regions of Tanzania.

Objectives
Describe the how the quality improvement process improves performance of health care providers and closes the gaps between actual and desired performance within Basic Emergency Obstetrics and Neonatal Care (BEmONC) in regional hospitals and district health centers/ dispensaries of Tanzania.

Methodology
The process included setting of standards in collaboration with key stakeholders in MAISHA programme. The first step of the process was to prioritize service delivery areas needed to be improved; develop quality improvement standards based on WHO and national guidelines and evidence-based practices, and national policies and strategies of MoHSW; select sites for intervention, trainings to health managers, supervisors and health care providers on the process. The second step includes implementing standards and conducting baseline assessment to identify performance gaps in health services. The third step is continual measuring progress to guide the process, assess success of interventions, identify persistent gaps and introduce necessary adjustment to the plans and reinforce the momentum for change.

Results
The key outcome of this process is improvement of quality of health service delivery to regional hospitals as measured using the developed performance standards. The results of the baseline assessments which were conducted in 12 pre-selected facilities in the year 2009 were as follows; the 1st group of 7 regional hospitals had an average score of 31%, while the 2nd group comprised of 5 regional hospitals was 22%. This was significantly low as compared to the MoHSW recommended desired level of performance, which requires a facility to at least meet 80% of the standards. However, the first internal assessments which were conducted within two to three years of implementation of the process, demonstrated remarkable improvements. The average score for the 1st group rose to 62%, while that for the 2nd group up to 54%.

Conclusions
Quality assurance process is a practical methodology which improves performance of individual health care providers and health services within health facility using evidence-based standards and involving community to measure the quality of services provided, thereby encouraging users to identify and address performance gaps.

Abstract Title: **Quality improvement collaborative Improves Infant Feeding Practices**

Author List: **Ngonyani Monica Msc CN; Hizza Elizabeth MD MMED; Shakir Fazila K. MHS; Gaudreault Suzanne**

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Background
Tanzania initiated efforts to Prevent Mother to Child Transmission (PMTCT) of HIV in 2000. Infant feeding practices are important determinants of the health and nutrition of children below the age of five years. Infant feeding, specifically optimal breastfeeding and adequate complementation, are questions that have remained unsolved in this era of HIV/AIDS. The PMTCT programme has trained trainers and counsellors on HIV and infant feeding at all levels however, this has demonstrated little effect on the rate and quality of counselling on infant feeding and infant feeding practices. The main challenge is how to improve, through optimal feeding the nutritional status, growth and development, health and thus survival of infants and young children amidst HIV/AIDS pandemic. In this aspect a QI collaborative was initiated in four districts at eleven sites of Iringa region in order to address these challenges.

Objective
Improve Infant feeding practices and support using the QI approach in Iringa region

Methodology
A baseline assessment on infant feeding practices was conducted to 79 mothers and 19 health workers in four sites of Iringa urban and rural districts to determine the practices and support mothers get on infant feeding. After that, QI activities were introduced which included process analysis of the problems on infant feeding practices and testing changes to obtain best practices. The QI comprised of learning sessions, action period, coaching and mentoring sessions.

Results
In the one year of implementation the percentage of mothers counselled on IF increased from <10 at baseline to 70%. EBF increased from 40 to over 70%. Initiation of BF within one hour of delivery rose from 10 to over 80%. Children who get CTX prophylaxis monthly increased from 10 percent at to over 30%.

Conclusion
This study shows that QI approach in the health settings improves counselling and infant feeding practices especially on BF initiation and EBF.

Abstract Title: **The Safe Care Initiative*:* Introducing standards and a structured stepwise improvement process for basic healthcare providers in Tanzania and other African countries**

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Project Background
The SafeCare Initiative is started by PharmAccess, COHSASA and JCI. SafeCare places the issue of quality and safe healthcare provision on the agenda in resource-restricted settings and creates a platform for like-minded who wish to provide safe health care despite resource constraints.

Objectives
- Securing quality of care through an external evaluation system that validates existing quality monitoring systems and allows for rating and benchmarking across clinics, networks and countries
- Working in a legal framework that can be adopted by local and national authorities and may be extended to national accreditation systems for both public and private healthcare providers

Methodology
SafeCare offers a step-wise improvement trajectory for basic healthcare providers in resource-restricted settings with respect to patient safety and quality using internationally accredited standards that are customized to the realities of resource-restricted settings. The 5 achieved improvement steps are rewarded through formal certification and accreditation.

Results
The SafeCare stepwise improvement process has been introduced in more than 100 healthcare providers in Tanzania (30), Kenya (40), and Nigeria (30) and the results of these interventions with respect to quality and patient safety will be presented. Two Tanzanian providers have received certificate levels 1 and two have received level 2. The program was found to strengthen patient safety, laboratory, pharmacy, and administrative aspects of the clinics. Additionally it encourages staff motivation of improvement. Moreover, all healthcare providers participating in SafeCare were able to attract performance-based loans.

Conclusions
The SafeCare methodology allows for stepwise improvement of healthcare facilities and international benchmarking.

Policy Implications and Lessons Learned
The initiative seeks alliance with national and international quality improvement initiatives to institutionalize quality improvement systems according to international standards, tailor made to reflect national requirements. SafeCare contributes to building trust with costumers, providers, donors, governments, investors and banks to actively participate in healthcare improvement in Africa.

Abstract Title: **The Level, Impact and Quality of Integration of PMTCT into RCH Services in Manyara Region**

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Project Background
The MOHSW, with support from USAID HCI Project worked with Manyara RHMT to initiate integrated Quality Improvement activities in the region for PMTCT/RCH services. Assessment of level, impact and quality of integration of PMTCT in RCH services highlighted the need to address client-based needs such as low male involvement, low disclosure of positive HIV status, high number of home deliveries, late-bookings to RCH services and losses to follow up among others. Health system findings necessitate use of integrated QI approach for efficient PMTCT/RCH integration.

Objectives
To better meet the needs of RCH and PMTCT clients in Manyara by improving the quality of services provided by integrating them at the service delivery level.

Methodology
Initial efforts to identify a package of care that will maximize RCH/PMTCT service integration in Manyara are planned. The QI collaborative model at regional, district, and facility level will work to introduce scalable changes to reduce gaps observed in the assessment and improve the level of integration of RCH/PMTCT services while increasing the ability of personnel to provide services and improving patient outcomes.

Results
A baseline assessment conducted in all districts of Manyara found that 71% of facilities provide integrated RCH and PMTCT services; however, it was found that there are challenges at the patient and health system level at RCH services to be addressed for efficient integrated services. Low number of personnel in RCH departments and inadequate information on efficient delivery of PMTCT services was observed.

Conclusions
Using QI approaches to address the multiple challenges in providing integrated and high quality services is a promising way to better meet client needs while drawing upon locally available resources and providing appropriate solutions.

Policy Implications and Lessons Learned
Lessons learned from this demonstration collaborative will be used to scale up this activity within the region and throughout Tanzania.

Abstract Title: **Getting motivated: Developing a recognition mechanism to strengthen and sustain quality improvement initiatives in healthcare services**

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Project Background
In order for health workers to provide quality healthcare services they need the capability, opportunity and motivation to perform to standard. In other words, they need to *know what to do*, *be enabled to do* it, and *want to do* the job. While capability and opportunity are often addressed with interventions such as training and provision of supplies, motivation can be more difficult to tackle. To this end, Jhpiego—an affiliate of the Johns Hopkins University supported the Ministry of Health and Social Welfare (MOHSW) with funding from USAID to draft Recognition Guidelines for Healthcare Quality Improvement Programs in October 2011. These guidelines will assist quality improvement initiatives to externally recognize and reward those facilities and health workers who are performing well.

Objectives
To present new guidelines on external verification and recognition of healthcare quality improvement programs.

Methodology
An initial draft of the guidelines was developed by Jhpiego and presented to stakeholders from within Tanzania. They were used as the basis for participatory discussion and making of key decisions. They address elements such as: criteria for recognition, rewards, organizational structures, the external verification process, community involvement and sustainability of the recognition program.

Results
National guidelines are currently in draft form pending review by a larger committee and final acceptance by the MOHSW.

Conclusions
Recognition and reward for a job well done is a critical component to motivating health workers to provide and sustain high quality services. Recognition programs can be implemented at a national, regional or district level externally, or internally at facility level. Furthermore, recognition programs can create an atmosphere of healthy competition that serves as an additional motivation for improvement of performance. Uniform guidelines will allow for objective assessment and an institutionalized recognition process, which will result in a cultural shift towards quality healthcare services.

Abstract Title: **Towards sustaining and institutionalizing Quality Improvement of HIV and AIDS Health Services**

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Project Background
Following global initiative to provide ARV at low cost, focus of HIV and AIDS interventions shifted from being predominantly preventive to include care and treatment. To respond to this paradigm shift, MOHSW developed first National Care and Treatment Plan, which was operational by 2004 with an objective of enrolling more than 400,000 PLHIV into care by 2008 yet maintaining quality of care. As different stakeholders took different approaches on implementing QI at facility level, MOHSW/NACP developed policy guidelines based aligned to the TQIF as well as tools to guide QI implementation

Objectives
To develop guidelines and associated tools that would contribute towards harmonizing, coordinating and institutionalizing QI of HIV and AIDS services

Methodology
MOHSW through NACP mapped the essential package of interventions for HIV and AIDS services and defined the delivery level for such services. This was followed by developing policy guidelines for QI including supportive supervision and mentoring as means for rrevitalising QI culture at health facility level, standardised and harmonising the approach as well as using the existing system to sustain QI

Results
Key policy documents, National Essential Health Sector HIV and AIDS Interventions Package, National Guidelines for Quality Improvement of HIV and AIDS Services and Manual and Tools for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services have been developed. Dissemination of this document was done for stakeholder buy in. Training packages associated with these documents were used for training R/CHMTs and HC workers to build capacity for training.

Conclusions
The key policy documents and associated tools will facilitate harmonization of QI approaches and contribute towards institutionalizing sustaining QI of HIV and AIDS services.

Policy Implications and Lessons Learned
MOHSW /NACP will support stakeholders use the policy documents as guidance during planning, implementation and monitoring of QI activities as to ensure sustainability of efforts and achievements

Abstract Title: **Institutionalizing Quality Improvement amidst many Quality Improvement Implementers: A case study of Uganda**

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Project Background
Uganda has been implementing quality improvement (QI) activities through various implementers using multiple methodologies since 2005 in HIV/AIDS, malaria and other chronic diseases. Most of these QI initiatives were donor driven without oversight from the Uganda Ministry of Health (MoH). A lack of a systematic government driven program created confusion at facility, district, regional and national levels. The multiple uncoordinated QI efforts resulted in (i) Lack of systematic method to assess monitor and improve care; (ii) Inefficiencies leading to suboptimal use of limited resources; and (iii) Duplicated efforts at the facility.

Objective
To develop a framework which provides a common platform for all public and private health institutions, partners and stakeholders to coordinate, plan, mobilize resources, implement, monitor and evaluate quality improvement initiatives in Uganda. in order to "ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being at all levels of health care".

Methodology
The MoH started by mainstreaming QI into the QAD through the National Health sector strategic and investment plan III;, regionalizing implementing partners (IPs) to cover specific geographic areas and reduce redundancy and held stakeholders meetings to harmonize QI tools, indicators and training materials. The Quality Assurance Department (QAD) with support from partners in 2010 contracted a consultant to carry out a situation analysis of QI initiatives to inform national planning.

Results: The national Quality improvement framework and strategy (QIF) was developed that will be launched in February 2012.

Conclusions: The National QIF has been developed. All public, private health institutions, partners and health consumers in the health sector shall subscribe to it to ensure responsiveness, transparency and accountability for service delivery.

Policy Implications and Lessons Learned: National led QI interventions are critical for the sustainability of the QI program at all levels of the health system.

Abstract Title: **FHI360s experience on integrating family planning and HIV care and treatment services, a focus on improving health care quality**

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Project Background
Family planning (FP) and HIV services in Tanzania have been both offered separately for years now. Several studies conducted at the HIV care and treatment clinics (CTC) reveal that clients attending CTC are in need of FP services. One of the national PMTCT targets calls for 80% of women attending PMTCT receive FP by 2015, on the other hand, one of the national FP target calls for an increase of CPR from 34% (TDHS 2010) to 60% by 2015. With this in mind, a need for integrated FP and CTC services was realized. In 2008, the MoHSW asked FHI360 to develop and test a model for integrating FP into CTC. FHI360 developed, introduced and evaluated a seven step service delivery model called *'Facilitated referral model"* in 12 sites of Iringa and Morogoro region with support from the Tides Foundation and USAID.

Objectives
This operational research focused on gradually strengthening the health system and ensuring quality of services. The main goal was to test the effectiveness and assess the feasibility of the model.

Methodology
A quasi-experimental pre-and post-test cross-sectional study design from a sample of 12 CTC sites. Intervention component involved orienting CHMT/RHMTs, conducting site visits, developing training curriculum and service delivery job aids, training service providers, monitoring and supervision.

Results
The model decreased unmet need from 12% to 8% and increased effective FP referrals and modern method use among CTC clients from 17% to 39%. Most importantly, this promising intervention was found feasible, acceptable and can be mainstreamed at all levels of health care where CTCs are available

Conclusions
Integration of services which takes into consideration strengthening the health system and improving quality of services requires good investment on valuable intervention inputs.

Policy Implications and Lessons Learned
This experience provided lessons on planning and implementing a scaled-up integration of FP services within HIV/AIDS programs.

Abstract Title: **National rollout of 5S-KAIZEN-TQM approaches in an integrated manner**

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Background
National rollout of 5S-KAIZEN-TQM approaches in Tanzania was started since 2007 for improvement of working environment in both public and private health facilities.

Objectives
To rollout 5S-KAIZEN-TQM approach, coordinated and complementing with other quality improvement approaches existing in Tanzania

Methodology
The National implementation guideline was developed, and series of Training of Trainers were conducted with the participation of hospitals, local health authorities, and private health organizations. After the TOT, series of Consultation visits and Progress report meetings were conducted to ensure sustainability for implementation of the 5S-KAIZEN-TQM approaches.

Results
National implementation guideline has been developed and distributed to all national hospitals, consultant hospitals, specialized hospitals and regional referral hospitals.
46 hospitals were trained on 5S approach, and 8 hospitals are trained on KAIZEN approach through Training of Trainers since 2007 to date. Infection Prevention and Control – Injection safety and 5S approach is integrated and operational. The integrated approach is included in Hospital Reform Program of the Ministry of Health and Social Welfare.

Conclusions
National rollout of quality improvement approaches need to use standardized guideline and training materials with a standardize way of teaching. Follow-up activities such as Consultation visit and Progress Report Meetings for monitoring the progress of 5S-KAIZEN-TQM approaches are very important for both implementers and MoHSW to sustain programs and harmonization with other national program and QI approaches

Policy Implications and Lessons Learned
Development of national implementation guideline on 5S-KAIZEN-TQM approach was helpful to accelerate harmonization and coordination of quality improvement approaches

Abstract Title: **Tools and Strategies for Quality Improvement in Healthcare Waste Management**

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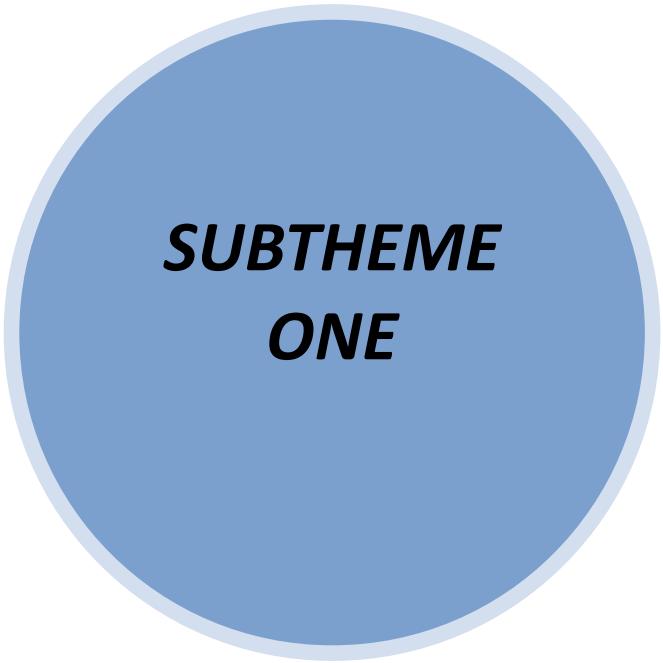
Project Background
Recent studies have suggested that half the world's population is at risk from healthcare waste, through impacts at work, in the environment and on public health.

Objectives
The objective of the United Nations Development Programme/Global Environment Facility project is to demonstrate best management practices and treatment technologies for healthcare waste management (HCWM) in eight countries.

Methodology
Among the tools developed by the project are: an Individualized Rapid Assessment Tool; a baseline assessment tool to gather data on waste generation and management practices; core competencies and training modules on all aspects of HCWM; and costing tools. The tools and guidances (www.gefmedwaste.org) are used with the WHO document "Safe management of wastes from health-care activities" which is currently being updated. Best practices cover waste classification, waste minimization, segregation, containment, colour coding, collection, transportation, storage, treatment, disposal and other aspects of HCWM. Strategies include the setting of facility policies and a HCWM committee; baseline assessments; identifying advocates; effective training techniques; participatory planning; setting of goals, timelines and indicators; monitoring, evaluation and continuous improvement; and financing.

Results
Examples of quality improvements in the eight countries include: significant reductions in waste generation; improved practices; expanded training coverage; lower mercury and dioxin releases; enhanced policies and regulatory enforcement; and environmentally sound waste treatment technologies. The project in Tanzania centers on technology development at the University of Dar es Salaam. A pilot project at the Bagamoyo District Hospital demonstrated the viability of an autoclave-shredder system. The new technologies, to be launched in 2012, include an ergonomically designed autoclave with different energy options (e.g., electricity, gas); reusable waste bins that eliminate plastic bags while maximizing processing capacity and steam penetration; pedal-operated stands to minimize cross-contamination; sharps destroyers; and a small waste compactor.



Institutionalizing quality improvement

Experience from health facilities: opportunities and challenges

Innovative approaches to improving sustainability of QI at health facility level

Role of health care managers at all levels of the health system

Role of QI implementation structure and operational research at health facility level

Role of professional associations and research institutions

Conducive Policy environment

Abstract Title: **Improving Quality of Care Using 5S Approach in Nachingwea District Hospital**

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Project background
Nachingwea district hospital is among the oldest hospitals in Lindi region (Since 1947). In improving the services (patient focused) the District hospital has now adopted the MOHSW –JICA guidelines for Quality Improvement and especially 5S Approach in order to achieve quality health services since 2008. Before the introduction of this approach the status of quality of health service delivery was poor; there were no proper arrangements of tools and equipment that could smooth work flow. There were no sign posts for directions, no labeling, zoning and there was high machinery turnover.

Objectives
To achieve clients' satisfaction, decrease delays and burnouts, reduce injuries to both workers and patients and increase productivity of the health workers.

Methodology
1. Staff commitment was measured by observing the responsiveness and positive attitude towards 5S activities.
2. Staff productivity was measured through exit interviews.
3. Workflow was measured by direct staff observation and interviews.

Results
Introduction of 5S activities have enabled the hospital to have in place more than 20 sign posts (none was in place before 5S),13 notice boards (4 notice boards were in place before 5S).There is improved labeling and zoning in theatre, dental unit ,OPD and dispensing room. Bed alignment is well done in our pediatric ward. There is improved filing system in our open registry-from paper folders to box files.

Policy implications or lessons learned
The hospital management has learnt that 5S is an approach which can be accommodated and be done by using less/no funds to make working environments conducive. Positive attitude is a stepping stone toward 5S activities success. Innovative ideas are much encouraged in 5S practice. Hospital management has instructed the 5S TOTs to continuously coach and mentor other hospital staff in strengthening 5S activities and the medical officer in charge's office is providing its full support to the 5S activities.

Abstract Title: **Improving Health Care Providers' productivity and engagement through collaborative Quality Improvement (QI) methods; Experience from Tandahimba District, Mtwara Region**

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Project Background
In Tandahimba district of the Mtwara region, there is an extreme shortage of health care workers, with 141 providers available, totaling only 34% of the estimated need. To address this shortage, staff productivity need to be addressed in order to create efficiency in HIV services. An improvement collaborative comprised of 12 health facilities was established with participation from the R/CHMTs, facility personnel, and partners EGPAF and CHAI, with support from the USAID (HCI).

Objectives
To improve Health Care Providers' productivity and engagement by addressing facility level human resource dynamics and clarify roles to increase efficiency and quality in HIV services.

Methodology
Health care workers developed process maps to better understand the patient experience on his/her journey through the facility and to identify their roles and create job models. From the job models providers developed; individual job description. Individual work plans derived from the process maps and the facility ART/PMTCT work plans were developed and shared among the team for collaborative implementation. They also designed feedback mechanisms at the facilities in order to receive regular feedback.

Results
Health facility personnel now have individual work plans, job descriptions, and competency models. They also receive regular feedback from supervisors. These efforts are having an impact on care outcomes, from July 2010 to August 2011, the percent of pregnant women testing positive for HIV and enrolled in CTC rose from 83% to 100%; infants exposed to HIV who receive co-trimoxazole has risen from 12% to 70%; and the percent of HIV-positive patients assessed for TB at every visit increased from 35% to 90%.

Conclusion/ Policy Implications/ Lessons Learned
This work has demonstrated that despite the critical shortage of human resources in rural areas of Tanzania, improved engagement of staff can significantly increase their efficiency and productivity, *thereby improving health* outcomes.

Abstract Title: **Innovative Approaches to Improve Sustainability of QI at Facility Level**

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Project Background
Health systems in low income countries are currently challenged to meet the long-term needs of patients with HIV and other chronic conditions. The RHMT in Morogoro, with assistance from the USAID Health Care Improvement Project, is piloting an innovative care delivery model for patients with chronic illness by supporting patient self-management.

Objectives
To train and introduce expert patients in health facilities to strengthen patient self-management for people living with chronic conditions in Morogoro region, Tanzania.

Methodology
Based on the WHO-endorsed Chronic Care Model (CCM), 14 facilities in Morogoro region are testing ways to support patient self-management. Rapid baseline assessments were undertaken to gather information from stakeholders on important principles of the Chronic Care Model, focusing on patient self-management and community support. Teams in the 14 facilities are using quality improvement approaches to identify and test solutions to resolve gaps in self management and other aspects of the Chronic Care Model.

Results
A total of 54 expert patients have been introduced in the 14 facilities. They have provided HIV education and shared personal experiences with 8101 out of 13,830, (59 %) of the PLHA who made clinic contacts during May – September, 2011). Expert patients have helped other patients face challenges of disclosure, partner testing, acceptability of HIV status, and ART services. They have assisted 220 out of 274(80%) new ART patients develop goals and action plans to address their personal challenges in self-management. Expert patients have also adopted other tasks, including triaging patients, taking patients' weight, and sorting files, thereby reducing provider workload and shortening waiting times.

Conclusion
The health system in Tanzania can be adapted to chronic conditions care by addressing human resource inputs and processes critical in caring for chronic illnesses.

Policy Implications and Lessons Learned
Expert patients are a feasible and sustainable intervention for improving clinic efficiency and providing a source of expertise and model for self-management to other patients**.** The stakeholders in Morogoro region are piloting the use of volunteers from Home based care program to offer support for self management at facility level as one way of sustaining the initiative.

Abstract Title: **Assessing Quality of PMTCT Services in Four Districts of Iringa: A Basis for QI**

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Project Background
Iringa region has high HIV prevalence in Tanzania. USAID-HCI project in collaboration with partners conducted a baseline assessment to determine: uptake, retention and quality of PMTCT services in the region. Having identified the service levels of attrition, HCI and partners are implementing an improvement collaborative to close the quality gaps through **A**ssuring **I**nfants and **M**others **G**et **A**ll **P**MTCT **S**ervices

Objectives
To identify magnitude and causes of attrition along the PMTCT cascade in two districts of Iringa region.

Methodology
ANC MTUHA and PMTCT registers were reviewed to determine PMTCT services rendered, magnitude and causes of attrition in a cohort of 139 HIV positive pregnant women and 132 HIV exposed children from six facilities of Iringa region. Patient records were reviewed for documentation on IFC, clinical staging, CD4 testing, provision and adherence to ARVs. Labour records were reviewed for ARV uptake by mothers and exposed children. Child follow up records were reviewed for CTX initiation, continuation and HIV monitoring.

Results
96% were counselled and tested, 61% of HIV positive enrolled to PMTCT care. 46% counselled for IFC and 16 % received CD4 test. During delivery 21% of mothers and 24% of HIV-exposed children received ARV prophylaxis. In the HIV exposed children cohort, 64 % of those enrolled received ARV within 72 hours of birth, 75% - and 59% received CTX and 1st PCR respectively. Documentation was poor for conclusion of services received. Other reasons of attrition not ascertained.

Conclusions
Inadequate documentation not only affects the quality of care but also affect explicit conclusion on service provision, client interview to ascertain causes of attrition is recommended.

Policy Implications and Lessons Learned
Service providers need supportive supervision for quality services.

Abstract Title: **Use of an Integrated Quality Team Model in Health System Strengthening**

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Background
Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Kenya –Pamoja Project is a five year project awarded in October 2010 being funded by PEPFAR through CDC and works in Partnership with PATH Kenya. It is implemented in twelve Districts Nyanza Province in Kenya.

A baseline assessment was conducted October-December 2010 to assess quality driven approaches to care. The objective was to assess health facility performance and data utilization.

Methodology
Primary data review was conducted in thirty six facilities from two of the twelve districts. Monthly data summary tool (MOH711) was reviewed. A joint supervision visit was conducted by the project staff and District Health Management Team. Key informant interviews were conducted in each district on service provision and data utilization.

Assessment Findings
District monthly meetings rarely focused on performance, quality and data use. The facilities lacked feedback meetings. 75% of the facilities were referring patients without follow up. 94% of the facilities whose summary data was reviewed showed discrepancy between the source documents (registers) and MOH711. Mechanism for patient retention and defaulter tracing wasn't clear.

Intervention
The Project and MOH formed an Integrated Quality Teams (IQT) at district and facility level providing leadership in addressing the gaps. Prior to monthly meeting the IQT reviews, analyses the summary data and compares with the source documents before forwarding to the District Health Records Information Officer. The teams identify areas of updates and provide mentorship to facilities.

Results
Quality of data being submitted has improved. Dispensaries now offer onsite integrated ART services leading to increased uptake and retention of clients. Facilities share their experience and innovations during monthly meetings thus promoting team bonding and peer learning.

Conclusion, Policy Implications and Lessons Learnt
IQT is a simple, acceptable MOH driven health systems strengthening approach. If scaled up to all district and health facilities, it can greatly improve coverage, retention, data quality and evidence informed planning.

Abstract Title: **The District Mentorship Initiative to improve HIV care and treatment services: Report from health facilities on successes and challenges**

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Project Objectives and Background
The District Mentorship Program (DMI) aims to build district-level capacity in ensuring continuous quality improvement, sustainability and ownership within the district health system. With support from ICAP Columbia University, and managed by the Regional/Council Health Management Teams (R/CHMT), the DMI is in 38 facilities across 19 districts in Kagera, Kigoma, and Pwani.

Four mentors/district regularly visit two high-volume sites, utilizing their skills in observation, chart review, case study, coaching. Mentors and mentees jointly address service gaps, provide feedback to site teams, and document visit outcomes. Mentors are clinicians/nurses currently working within the health care facilities; they supplement routine supportive supervision provided by HMTs.

Methodology
The quality of care provided at each site was measured at baseline and after 6-7 months of DMI implementation using six standards of care (SOC) indicators. Twenty randomly selected eligible medical charts were reviewed in order to score each indicator according to the following: <75% is *poor*; 75-89% is *fair*; and above 90% is *good*.

Results
Each of the SOCs showed improvement between baseline and follow-up. The SOC scores at baseline (% scoring poor/fair) and follow-up (% with improved scores) were:

	poor/fair at baseline	**improved at follow-up**
SOC1*: Pregnant HIV+ women enrolled in care/treatment ≤1 month of 1st ANC visit:*	97%	32%
SOC2: Pregnant HIV+ women enrolled in care/treatment ≤1 month of 1st ANC visit	82%	61%
SOC3: ART patients return for follow-up ≤1 month of starting ART	47%	83%
SOC4: All HIV+ patients have CD4 testing every six months	100%	21%
SOC5: All HIV+ patients assessed for TB disease every visit	87%	42%
SOC6: ART patients assessed for adherence every visit	79%	77%

Policy Implications and Lessons Learned
This quantitative approach to SOC review, provides a means for the mentors to work with facility staff to assess quality of care, identify problems/challenges, and work collaboratively to find solutions and improve services.

Abstract Title: **Strengthening capacity of RHMTs a prerequisite to sustaining quality improvement initiatives: A case study of Mtwara Regional Health Management Team**

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Project Background
Mtwara Region has 181 health facilities for a population of 1.3 million and HIV prevalence rate that is below the national average, being 3.6%. Provision of care and treatment services has been expanded to 85 facilities, including rural ones. The rapid expansion has met challenges requiring initiatives to improve quality of services. Rising to this challenge, the RHMT has collaborated with stakeholders to implement initiatives aimed at improving quality of such service HIV and AIDS services in general.

Objectives
Strengthen the capacity of RHMT to coordinate, provide technical and supervisory support to facilities undertaking quality improvement initiatives

Methodology
NACP and PharmAccess trained RHMT to carry on assessment of health facilities focusing on identifying structural and asset gaps and developing joint work plans to address them. Secondly, the RHMT in collaboration with NACP also worked with PharmAccess, URC, EGPAF and CHAI to implement a QI improvement collaborative approach in nine facilities. This was focused on improving quality of PMTCT and Care and treatment based on five quality of service performance indicators. Furthermore, the technical capacity of RHMT to support, oversee and sustain implementation of QI activities was strengthened.

Results
All 14 RHMT and co-opted members were trained on assessment process and then a regional assessment team that undertook re/assessment of more than 80 health facilities intending to provide care and treatment services was formed. Trained QI teams were formed at RHMT, CHMT and facility level to spearhead QI activities. RHMTs have also provided supportive supervision to QI teams in developing and monitoring implementation of improvement plans.

Conclusions
Capacity of RHMT to support implementation and sustaining of QI activities at facility level has been strengthened and contributed to improvement of services. For example the percentage of exposed infants under 18 months receiving co-trimoxazole has being raised and maintained above 90% in all of the participating facilities.

Abstract Title: **Establishing a decentralized assessment system to support improvement of quality of HIV and AIDS care and treatment services**

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Project Background
Since November 2004, Tanzania started providing care and treatment services to PLHIV through special clinics (CTC). Before being registered as a CTC, assessing if the facility had in place essential structures and processes to support provision of quality services was a prerequisite. Initially, assessments were carried out by national assessors. R/CHMTs were not involved and it took time to cover the whole country. In 2007, as MOHSW planned to include primary health facilities in the provision care and treatment services, the NACP saw the need to decentralize the assessment system. In collaboration with PharmAccess, NACP undertook capacity building efforts to enable RHMTs carry out assessments

Objectives
To strengthen capacity of RHMTs to carry out assessments, prioritize improvement areas to enhance capacity of CTCs to provide quality services to PLHIV

Methodology
RHMTs were trained on assessment process and afterwards Regional Assessment Teams (RATs) composed. Through a performance based agreements, NACP/PharmAccess provided support to enable RATs carry out assessments working in close collaboration with CHMTs and implementing partners. Assessments were done using the national checklist, observations discussed and improvement plans jointly drawn up. The assessment report was then shared with facility team, DMO, RMO and Implementing partners for follow up actions.

Results
Using the decentralized system, 550 facilities were assessed in 2007/08 and reassessed in 2008/09. 700 facilities were assessed in 2009/10 and 600 in 2010/11. Assessments and re-assessments took shorter time than it would have been using the national pool of assessors. The decentralization approach was further extended to CHMT level in select regions.

Conclusions
A well functioning decentralized system for assessment of district hospitals and primary health facilities has been established.

Policy Implications and Lessons Learned
Capacity that exists at regional level can be harnessed for speedier implementation of quality improvement of health services. Ownership has been built during the process, as R/CHMTs and Implementing Partners understands better facility's needs, plans and allocate resources to improve quality of services.

Abstract Title: **Can the lessons learnt from HIV and AIDS QI initiatives be broaden to cover the general health services?**

Author List: **Dr. Peter Risha[1], Dr. Jackson Lija[2], Dr. Edith Ngirwamungu[1], Dr. Jan van den Homberg[1], Dr. A. Ramadhan[2] and Dr. H. Ngonyani[3]**

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Project Background
As provision of ARVs became a reality in 2003, MOHSW developed the National Care and Treatment Plan (NCTP 2004 -2008) that embarked on a rapid scale up of care and treatment services countrywide. As the scale up was taking place within the realm of the weak health system, MOHSW through the NACP undertook initiatives to ensure quality of such services.

Objectives
To develop structures and build capacity for systematic improvement of quality of HIV and AIDS services

Methodology
Tools and structures for implementing quality improvement initiatives were established. Furthermore, NACP developed National Quality Improvement Guidelines for HIV and AIDS Services adopting assessment and improvement collaborative approach as basis for improvement of quality of services. The assessment was aimed at identifying structural and process quality gaps while improvement collaborative approach measures performance, analyze process of care to identify and address quality of service gaps as well as encourage sharing of best practices.

Results
Structures to support implementation of QI activities have been built, tools and database for facility assessment put in place and a functional decentralized assessment system established. Health workers including R/CHMTs have been trained on QI, supportive supervision and mentoring. As part of implementation, QI teams have been formed from facility up to region level. R/CHMT have carried out QI focused supportive supervision and mentoring to document achievements and share best practices between QI teams.

Conclusions
The success of implementation has brought into sharp focus several challenges to sustaining the observed achievements. Example of such challenges are: institutionalizing QI, better coordination of efforts between partners, building quality culture, harmonizing multiplicity of approaches and the need to broaden the scope of intervention specific QI to general health care.

Policy Implications and Lessons Learned
The infrastructure, capacity and momentum for QI already established can be harnessed to build a Quality improvement system that can leverage on resources to address the broad health services.

Abstract Title: **Quality Improvement of HIV services through early supportive supervision in IPT phased implementation in Tanzania**

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Background
WHO recommended countries to adopt public health strategy to reduce the burden of TB among PLHIV popularly known as "*Three I's*". These include intensified case finding (ICF) for active TB, Isoniazid preventive treatment (IPT) in PLHIV with latent TB, and TB Infection Control (IC). Tanzania has started to implement Three I's as a package in HIV Care and Treatment Clinic (CTC) services in 18 sites.
We describe the benefits of initial supportive supervision in improving phased IPT implementation.

Objectives
To demonstrate phased IPT program implementation improvement through early initial supportive supervision after program roll out .

Methods
Supportive Supervision was conducted in 2 sites (Mpwapwa District Hospital (MDH), Dodoma and Iringa Regional Hospital (IRH), Iringa) in July and August 2011. The supervision team was composed of 4 members from National AIDS Control Program, National TB and Leprosy Program, consultant radiologist and respective regional HIV implementing partner. Standard supportive supervision tool was used; strengths, areas of improvement and action plans agreed with respective site at the end of the visit.

Results
MDH started IPT 4 weeks before the visit whereas IRH started a week before the visit. PLHIV enrolled on IPT were 188 and 37 in MDH and IRH respectively. IPT registers in both sites included 2 PLHIVs under the age of 15 years (*however, further inquiry revealed that these were not given Isoniazid*). IPT register in IRH included all PLHIV screened for IPT eligibility. These inconsistencies were discussed and rectified on site.

Conclusion
Early **s**upportive supervision and coaching, which entailed identification and giving on the spot solutions to new interventions like phased IPT, is an effective tool for service delivery improvement.

Abstract Title: **Laboratories towards Quality Accreditation**

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Project Background
In Tanzania laboratory quality improvement as per WHO accreditation was not yet initiated at both public and private clinical laboratories although national strategies are in place (NHLSP 2009-2015). To support implementation, TUNAJALI piloted laboratory quality improvement project using WHO set standards.

Objectives
To support 8 laboratories to move from star 0(0 to 137 points) to at least one star (138 to 160).

Methodology
Laboratories were selected based on the availability of trainable staff, good laboratory premise, management readiness and accessibility. i) baseline assessment of the laboratories against WHO standard, ii) gap analysis, plan for improvement iii) development of feasible action plan to address gaps and agreed upon timeline, iv) training of laboratory staff in standards adherence, v) support with relevant quality guidance, SOPs and job aids, vi) periodic monitoring through mentoring and vii) regular quality audits. MOHSW with support of CDC provided final assessment and feedback.

Results
Baseline assessment in 2010 showed a score ranging from 17 to 34 WHO standard points. Since then efforts were directed to improve the quality of the selected laboratories by training and mentoring as per SOP and job aids. A follow in June 2011 showed a range between 76 to 168 points with three laboratories reaching two stars.

Conclusions
MOHSW should address the laboratory human resources crisis as a prerequisite to quality improvement. Implementation of WHO Standards is a practical approach for improving the quality of laboratory services. Substantial improvements within one year have been observed.

Policy Implications and Lessons Learned
WHO accreditation standard is practical can be adopted as a national standard for Clinical Laboratories.

Abstract Title: **Enhanced collaboration and coordination increases TB/HIV notification: experience from Iringa region, Tanzania**

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Project Background
NACP and NTLP support HIV Care and Treatment Clinics and TB diagnosis/DOT Clinics respectively at 49 health facilities in high HIV prevalence Iringa region. With PEPFAR support through FHI360/Deloitte TUNAJALI Program to CTCs and NTLP/GFATM support to DOT clinics, all 49 facilities have been assisted with renovations, staffing, supplies, trainings and supervision/mentoring since 2005 independently. Since 2007 however NTLP and NACP have improved collaboration and coordination of the programs. The strategies include employment of District TB/HIV Officers, 3I's implementation such as introduction of TB screening tools at CTCs, effective referrals, HIV testing at DOT clinics and joint TB/HIV trainings.

Objectives
To inform policy makers and implementing partners on the importance of effective coordination and collaboration between NTLP and NACP at site level.

Methodology
Review of TB Register and CTC2 data base 2007 to 2009 at all 49 sites. Interview of TB/HIV Officers from Kilolo and Iringa districts on progress and constraints of implementing TB/HIV services.

Results
TB notification as for 2007, 2008 and 2009 at 3,697, 3,546, 3,636 cases remained stable. However notification for combined TB/HIV disease for 2007, 2008, 2009 increased (1,322; 1,821 and 1,990 respectively). HIV/AIDS clients at the CTCs from 2007,2008 and 2009 increased substantially (15,310, 28,100 and 38,932 respectively). Coordinators expressed satisfaction having regular coaching but fear deterioration if patient loads increase without more staff

Conclusions
Coordination and collaboration between staff of CTCs and TB clinics, mentoring, joined trainings on 3Is and monitoring tools are crucial for improving TB and HIV services and resulting in better notification. With patient loads still increasing and no apparent staffing solutions, further integration innovations are needed .

Policy Implications and Lessons Learned
The employment of TB/HIV officers and closer collaboration between NTLP and NACP has contributed to increased TB diagnosis among HIV patients. The ongoing staff crisis limits efforts for sustained improvements

Abstract Title: **Effective monitoring of performance through mentoring and supportive supervision: A strategy for improving the quality of care provided to pregnant women and their babies at Majengo and Pasua health centers in Moshi Municipal Council Kilimanjaro region**

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Project Background
Effective monitoring of performance through mentoring and supportive supervision is an important aspect of improving the quality of care. Jhpiego MAISHA program, in collaboration with the Ministry of Health and Social Welfare, is implementing strategies to improve the quality of maternal and newborn care, including updating provider's knowledge and skills on Focused Antenatal Care, Basic Emergency Obstetric and Newborn Care, also provision of equipment.
These strategies are implemented in 15 health facilities in Kilimanjaro region including Pasua and Majengo where monitoring and mentoring through supportive supervision was done by the District Nursing Officer, District Reproductive and Child Health Coordinator, and Jhpiego Regional Program Officer

Objectives
The goal was to determine the effectiveness of close monitoring of performance through mentoring and supportive supervision on the improvement of maternal and newborn healthcare services.

Methodology
ANC exit interview with 60 clients, focus group discussions with 29 providers and 26 clients, document review, and quality improvement assessments tool.

Results
97% of the clients and 96% providers acknowledged that the quality of services has improved. 97% Clients expressed satisfaction with improved client/provider communication, particularly during labor and delivery. Providers feel more knowledgeable due to updated knowledge and skills, improved leadership, teamwork, commitment and supportive supervision from higher levels. Client attendance at ANC and facility delivery is increasing. Quality improvement assessments showed an increase in adherence to standards from 19% to 50% at Majengo and from 6% to 79% at Pasua.

Conclusions
Effective monitoring of performance through mentoring and supportive supervision has a great effect in improving the quality of care to women and their babies by creating a supportive environment and increasing client satisfaction.

Policy Implications and Lessons Learned
Updates in knowledge, skill and a conducive environment contribute to provider motivation, commitment, and satisfaction.

Abstract Title: **Partnership for Quality Improvement (PQI): A Strategy for Harmonization of QI Efforts in Tanzania**

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Project Background
Although the Ministry of Health and Social Welfare (MoHSW) promulgated its Tanzania Quality Improvement Framework (TQIF) in 2004, the process for health care QI still had many gaps, including variations in QI indicators, practices and tools across partners; low involvement of R/CHMTs and poorly defined reporting framework. To achieve more effective harmonization of QI efforts, in 2007, the MOHSW, the USAID Health Care Improvement Project (HCI), PharmAccess and other implementing partners (IPs) developed the PQI.

Objectives
To unify efforts and harmonize practices towards improving the quality of HIV/AIDS services, build capacity of R/CHMTs to implement continuous QI, and spread improvements nationally.

Methodology
Improvement Collaborative approach was applied using common QI priorities across regional partners working through existing MoHSW structures. The first collaborative was initiated in Tanga; thereafter, similar collaboratives were started in Morogoro, Mtwara, and Lindi drawing lessons from Tanga.

Results
The PQI initiative has resulted in improved capacity to implement QI, led by R/CHMT in collaboration with IPs, manifesting in improved services. Since June 2008, enrolment of HIV-positive pregnant women into CTC increased from 50% to 95%; provision of co-trimoxazole prophylaxis to HIV-exposed infants increased from 5% to 70%; while lost-to-follow-up among patients on ART decreased from 20% to less than 5%. Furthermore, there has been increased agility and mobilization of human and material resources for QI.

Conclusions
PQI has shown it is possible to operationalize the TQIF and achieve promising results in HIV/AIDS care.

Policy Implications and Lessons Learned
The PQI experience was used to revise the TQIF, harmonize QI indicators and develop a National QI Training Package to harmonize QI practice for nationwide spread.

Abstract Title: **Initiating Quality Improvement processes at health system and community level in Tandahimba district**

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Project background
Maternal and new-born MDGs 4 and 5 are still far from being reached despite of evidence-based, affordable and appropriate technical interventions. Obstacles persist on both the demand side (low utilization) and supply side (low quality and lack of services), across the continuum of care from pregnancy to postnatal care.
Expanded Quality Using Information Power(EQUIP) project aims to prioritize the mechanisms to bridge the "know-do gap" in maternal and new-born health by using quality management (QM)approach and community involvement, where both approaches benefit from continuous, locally generated, high-quality health data.

Objectives
1. In consultation with districts, national stakeholders, and community representative and based on results from the policy analysis and policy dialogue, develop a QM approach which is powered by high quality health information and community involvement.
2. Implement the EQUIP-intervention adapted to local context

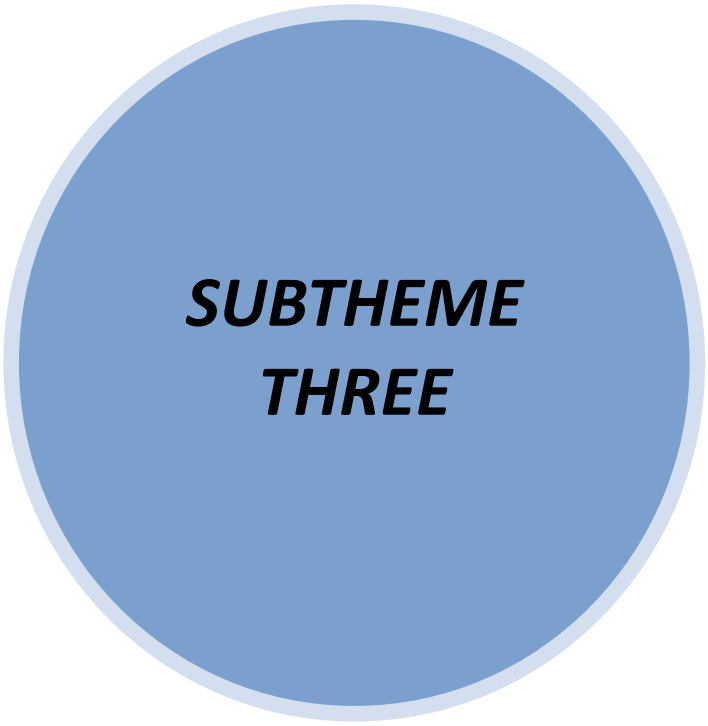
Methodology
Model for Improvement with PDSA and Collaborative Improvement network at both health facility and community level.

Results
15 health facilities in Tandahimba district have started piloting the methodology within continuum of care. CHMT has formed a quality improvement team with a main goal to enable them to support the health facilities to provide quality services and at community level four wards in Mahuta division were trained on the QI process but had to be modified to make it simpler for community to understand and start testing.

Conclusions
The model is well acceptable at district; health facility and community level although fine-turning is needed to improve the essential quality of care.

Policy implications or lessons learned
QI should be part of daily work for every employee at their work place; therefore the culture should start to be inserted from higher level down wards in order to ensure smooth implementation.

Promoting health facilities as "highly reliable institutions for provision of quality health care services;"



Ensuring patients and providers safety

Meeting internal and external client needs

Effective training of staff in provision of quality health care

Improving health workers productivity

Effective monitoring of performance through mentoring and supportive supervision

Abstract Title: **From voluntary CHF to compulsory CHF; views from the stakeholders in Liwale DC**

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Background
Tanzania faces challenges in financing its health sector due to the limited tax base and increasing health demands against other competing government priorities. Alternative to central government financing and external support are attractive; in Tanzania the voluntary scheme known as Community Health Fund (CHF) was introduced in 1995 with the aim of increase revenue, increase access to health care services, financial protection and to reduce dependency on government from the external support. However, enrollment is 6%; far from the target of 75% and hence limited risk pooling and thus majority of population left uninsured.

Objective
To explore the stakeholders' view on changing from voluntary CHF to Compulsory CCHF

Methodology
Study design was cross-sectional using both quantitative and qualitative methods. Multistage random sampling involving divisions, wards, village and households was used to select 387 study participants in a survey and 33 were purposively selected in interview. Questionnaires and interview guides were used to collect the data through face to face interview, FGDs and individual interview. Quantitative data were analyzed by using SPSS software. Content analysis was used to analyse qualitative data.

Results
CCHF was accepted by 56% in a survey and almost all participants in interview. The reasons were financial protection, improve quality of health care services, eliminate user fees and stigma. 44% didn't opinioned CCHF. The reasons were; CHF is yet understood among the community, forceful mode of payment, services are poor etc. Premium was not an obstacle to enrollment. Enrolment and renewal of members was suggested to be seasonal. Services under CCHF must have attractive packages with no copayments.

Conclusion
CCHF is acceptable. CCHF is mandatory for survival and sustainability of CHF schemes

Recommendations
CCHF need supportive environments for its implementation like; attractive benefit package, community involvement, reviews of regulatory framework and political and leadership commitment. Lastly, more studies focusing on the same topic are highly recommended.

Abstract Title: **Putting quality in the hands of providers: Using Standards Based Management and Recognition (SBM-R) approach for improving quality of Infection Prevention and Control (IPC) at Muhimbili National Hospital (MNH**)

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Project Background
The Ministry of Health and Social Welfare (MoHSW), in collaboration with Jhpiego—an affiliate of the Johns Hopkins University, is working with funding from USAID to improve the quality of infection prevention and control (IPC) in health facilities using Standards-Based Management and Recognition (SBM-R). Muhimbili National Hospital (MNH) is among six teaching hospitals implementing the SBM-R approach for IPC since 2009. MNH is unique in respect to the size of the facility (approximately 25 departments and 23 blocks), and the large number of healthcare workers transitioning through the facility. As such, MNH has had to implement specific interventions to address IPC gaps.

Objectives
To present the results of efforts to improve IPC practices at MNH and discuss change management strategies for large hospitals.

Methodology
The Hospital Quality Improvement Team (HQIT) was trained on the implementation of SBM-R using the national IPC standards. With technical support from Jhpiego, the HQIT carried out at least three internal assessments in all departments of MNH. In addition, two external assessments were conducted by MOHSW of MNH. In between assessment, Jhpiego supported the MNH HQIT to develop and implement action plans based on performance gaps, advocate for improved adherence to IPC with hospital management, and solicit support for additional IPC supplies.

Results
Assessment results have shown improvement from overall scores of 10% in May 2010 to 66% in March 2011. Specific improvements were seen in the areas of hand washing, instrument processing, waste management and housekeeping. Significant improvements were seen in 13 departments. 8 still have far to go and 2 departments still face challenges.

Conclusions
SBM-R is a simple and easy to implement approach to quality improvement of IPC in that it allows the HQIT to lead the initiative and develop change management skills.

Policy Implications and Lessons Learned
The involvement of management and their commitment at all stages, adequate budget to ensure constant availability of IPC supplies, and motivation of staff through a recognition mechanism is crucial to success.

Abstract Title: **Effectiveness of Hospital Quality Improvement Teams (HQIT) on improvement of Infection Prevention and Control (IPC) practices in health facilities: Experience from six hospitals affiliated with medical schools in Tanzania**

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Project Background
Since 2009, Jhpiego in collaboration with Ministry of Health and Social Welfare (MoHSW), has been working with six teaching hospitals in Tanzania to improve quality of Infection Prevention and Control (IPC) practices under MAISHA project funded by USAID. These hospitals are Muhimbili National Hospital (MNH), Kilimanjaro Christian Medical Centre (KCMC), Bugando Medical Center (BMC), International Medical and Technical University (IMTU), Mission Mikocheni Hospital (MMH), and Dodoma Regional Hospital (DRH). The essential component of this approach is strengthening HQIT capacity to ensure institutionalization of quality improvement (QI) from the start.

Objectives
To compare and contrast the composition, functions and effectiveness of HQITs at six hospitals in relation to the achievement of IPC performance standards.

Methodology
HQIT members were trained, coached and mentored during onsite visits to support implementation of National IPC standards. Their role is to carry out periodic assessments, data management, define gaps and do cause analysis of the gaps, provide feedback to IPC/QI committee and the hospital management, and develop operational plans to address the gaps. Some were fulltime HQIT members, while others had other primary duties. Achievement of IPC standards was used as a criterion for assessment.

Results
HQIT teams at MMH, KCMC, MNH, DRH, and BMC had staff totally committed to IPC QI, were better staffed, well organized and had support of the hospital management. This was evident in March 2011 assessment whereby they achieved higher scores on IPC standards by 72%, 69%, 66%, 66% and 53% respectively. The IMTU a private hospital achieved the lowest score of 39 %. The data collected at various assessments showed positive correlation between the effectiveness of well-functioning QI team with higher achievement of IPC standards. However, it is not shown if the correlation was significant.

Conclusions
Having a designated, strong and a well-functioning HQIT at the larger facilities is key to improving the quality of health care services including IPC interventions.

Abstract Title: **Strengthening the health system for HIV patients through Quality Improvement at Makole Health Centre and Dodoma Regional Hospital, October 2009-2011.**

Author List: **Chaula Zainab, MD,MMED[1]; Mashombo Zainab, RN[1]; Godfrey Mtey, MD,MPH[1]; Morio Alex,Dip,BA[2]; Ndenge Mahmoud,AMO[2]; Mary Messay[3]; Salehe Mlangwa,MD[4]; Charles Mushi[4]; Eric van Praag MD,MPH[4]; Rebecca Dirks[4]; Bruno Bouchet,MD,MPH[4]**

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Project Background
HIV Care and Treatment clinics (CTC) in urban Dodoma have seen a rapid increase in patient attendance with over 1000 currently registered at Makole Health Centre and over 2500 at Dodoma Regional Hospital (DRH) leading to major operational and quality challenges. Through active involvement of CTC care providers, members of PLHA support groups and HBC program staff, key service delivery and systems issues affecting the continuum of care were identified, improvement objectives proposed and tested to identify best practices for replication to all service delivery units in the region.

Objectives
To improve efficiencies and effectiveness of the health system in response to HIV patients needs through a Quality Improvement Model.

Methodology
Using the Plan-Do-Study-Act cycle (PDSA), easily measurable indicators were developed for four change objectives. Actual changes were introduced like block appointments to improve waiting times, using community patient tracking coordinators to reduce lost to follow up and strengthen referrals and simple operational efficiencies introduced to improve an overall quality index of key services. Monthly measurements were conducted on a random sample of 30 patients' records and continuously referral forms and timesheets were assessed and all plotted on Xcel run charts.

Results
Patients receiving services in less than three hours increased from 67% to 93% and 63% to 100% in DRH and Makole HC respectively; lost to follow up decreased from 19% to 2% and 2% to 1%, respectively. Improved referrals between CTC and HBC, and HBC to CTC increased from 31% to 100% and from 77% to 83%. Lastly, proportion of clients receiving all eight essential care services (total quality index) rose from 13% to 57% and 30% to 60%, respectively.

Conclusions
Significant improvements in the performance of the health system for HIV patients can be achieved with a reasonable level of effort of health service providers and community and patients representatives.

Policy Implications and Lessons Learned
Regional and Council authorities should support small scale QI pilot programs that are driven by front line care providers in order to implement sustainable quality approaches to strengthen the health system.

Abstract Title: **Diagnosis and Management of Febrile Illness in the Lake Zone, Tanzania (TIBU HOMA**)

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Project Background
Case management training in the diagnosis and management of febrile illness using the quality improvement approach is effective in improving health facility management of sick children under five and ensuring referrals benefit from quality services. Infection Prevention and Control (IPC) practices are poor in most health facilities[1]. The Paediatric Hospitals Initiative (PHI) assessment in Tanzania revealed that only 43% of hospitals complied with IPC standards[2]. Quality improvement training ensures both good standard IPC practices and quality services at health facility. TIBU HOMA will train Quality Improvement Teams from health facilities to ensure adherence to IPC standards.

Objectives
To increase availability and accessibility to fundamental facility-based child health services; to ensure sustainability of child health activities; and to increase linkages within the community to promote healthy behaviours.

Methodology
The strategy involves training in case management of febrile illness, supply chain management and linking communities to health facilities. Selected health workers with complementary skills per facility will be coached and mentored as a team to solve quality issues in case management. The project will link community leaders /CHWs to health facility Committees for regular dialogue to address community health issues.

Results
To date, the project has collaborated with the MoHSW to revise and test the IMCI guidelines and completed advocacy meetings with regional and district health managers/teams.

Conclusion
TIBU HOMA, using the health facility and community as a key platform will increase access and availability of quality services ultimately reducing morbidity and mortality in children under-five years of age.

[1]Ref Pocket Book for health care provider (MOSW-2007)
[2]Baseline Survey of Quality of Paediatric care in Tanzania (MOHSW-2010)

Abstract Title: **Using QI Methodology to Improve Patient Outcomes at HIV Health Facility in Three Regions: The WRP Experience**

Author List: **Mvungi Jane[1], Memiah Peter[2], Komba Patience[3], Mongare Jane[4], Mutungi Robert[1], Mwakibambo Brown[1]**

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Project Background
The direction of MOHSW and implementing partners now is to improve quality of services for HIV C & T services. The MOHSW has several initiatives regarding quality improvement e.g. developments of CQI guidelines, CQI trainings to health care providers, follow up of indicators at site level in order to track progress and identify areas that need improvement.

Through a combined QI theory and experienced based learning 140 HC Providers from 3 regions were trained using the Tanzania National QI curriculum complemented by the University of Maryland CQI training guide focusing on using quality improvement (QI) methods, tools, and approaches for patient care; participants formulated action plans to implement at their HF.

Methodology
Trained HCP reviewed patient outcomes and identified areas of weakness e.g. poor TB screening, lack of CD4 check up after 6 months of ART, big number of Loss to follow up etc. They designed health improvement projects. Supportive supervision was done by WRP staff.

Results
Using QI methodology, the above health improvement projects from selected HF were completed; TB screening increased from 2.2% to 15%, LFTU decreased from 21% to 10%, CD4 check up increased from 31.5% to 47%; and better patient flow was observed in most clinics.

Conclusion
To successfully implement QI projects QI techniques must be formally taught and competency based training be emphasized. Lessons learnt from our experiences can be easily deployed and implemented in other programs.

Policy Implications
Introducing quality improvement (QI) methods and techniques into local HF is a major strategy currently underway by the WRP to enhance HCP/ CHMT and RHM teams performance and ultimately improve overall patient outcomes.

Abstract Title: **Strengthening Infection Prevention and Control: An experience of using Standards – Based Management and Recognition (SBM-R) Quality Improvement Approach in Six Medical School Affiliated Hospitals in Mainland Tanzania**

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Project Background
Since 2009, Jhpiego-an affiliate of Johns Hopkins University, in collaboration with the Ministry of Health and Social Welfare (MoHSW) has been working with 6 teaching hospitals in Tanzania to improve the quality of Infection Prevention and Control (IPC) Practices under the IPC-MAISHA project funded by USAID. These hospitals are Muhimbili National Hospital (MNH), Kilimanjaro Christian Medical Centre (KCMC), Bugando Medical Center (BMC), International Medical and Technical University (IMTU), Mission Mikocheni Hospital (MMH), and Dodoma Regional Hospital (DRH).

Objectives
To improve the quality of IPC practice at these hospitals attached to teaching institutions not only to strengthen IPC practices for better patient care and providers' safety, but also be a role model to the students early in the formative years and prepare them as competent IPC practitioners.

Methodology
All hospitals implemented the National IPC Standards using Standards-Based Management and Recognition approach. The sites received technical assistance from Jhpiego to establish Quality Improvement Teams, conduct baseline and internal assessments, identify gaps, perform cause analysis and carry out interventions to minimize gaps. They also received targeted site- strengthening support for specific areas such as instrument processing.

Results
The results of baseline assessments conducted in May 2010 at the six facilities were as follows; MNH 10%, DRH 12%, IMTU, 20%, KCMC 35%, MMH 40% and BMC 39%. In the subsequent follow up assessments that was conducted in March 2011 (about 10 months post-intervention), remarkable improvements were observed in both the overall and area-specific standards. The overall scores increased by 56%, 54%, 19%, 34%, 32% and 14% for all six hospitals respectively. Instrument processing practices also improved significantly.

Conclusions
Providing clearly defined IPC performance standards results in improved provider performance and leads to overall improvement in services. Putting simple and easy to use quality improvement approaches into the hands of providers is a sustainable way to institutionalize quality improvement.

Abstract Title: **Laboratory services for HIV care and treatment: Quality improvement initiatives**

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Project Objectives and Background
Laboratory service is essential in the provision of quality HIV care and treatment. Under the guidance of the Ministry of Health and Social Welfare (MOHSW), ICAP has implemented targeted initiatives to improve the capacity and quality systems of laboratory services in meeting national guidelines for HIV services. Selected regional, district and selected lower level laboratories are equipped to enable a wide range of activities from HIV testing, immunological monitoring for ART, toxicity and response to treatment, and diagnosis of opportunistic infections.

Methodology
A baseline review of all lab facilities (n=55; 8 hospital; 25 district; 22 health centre) in ICAP regions (Kagera, Kigoma, Pwani) and Zanzibar was conducted using a standardized program tool. Characteristics reviewed included staffing, infrastructure, equipment, availability of SOPs, reagents, commodities, inventory and quality management systems. Results helped MOHSW identify priority capacity building areas.

Results
All three regional, one zonal (Zanzibar), five hospital and 25 district laboratories were renovated to WHO standards and equipped with CD4 machines, haematology analyzers, biochemistry analyzers, microbiology and bio safety components. In addition, 22 health centers were renovated and equipped with haematology and biochemistry analyzers and solar power where there was no permanent electricity supply. Bugando Hospital was supported to conduct PCR tests for early infant diagnosis.

Laboratory capacity improved on the following dimensions: Specimen collection/integrity; turnaround time; supply of kits and reagents; timely equipment maintenance and repair; daily internal quality controls; external quality control; and documentation.

Policy Implications and Lessons Learned
ICAP's laboratory technical support contributed to improved management and quality assurance systems in 58 laboratories. Two laboratories at zonal level (Mnazi Mmoja, Bugando) and one district laboratory (Kisaware) are now in the process of applying for ISO and WHO accreditation which is expected by 2012. The four regional laboratories and an additional five district laboratories are planned to be supported toward accreditation in 2013.

Abstract Title: **Strengthening institutional capacity for delivery of quality services, Experiences and lessons from Tanzania police and prison workplace program**

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Project Background
Poor infrastructure, lack of trained medical personnel, funds and laboratory supplies have hampered the capacity of more than 200 police and prison health facilities from providing quality health care services in Tanzania. Until 2008 only one police and one prison HF provided HTC and HIV care and treatment services. The services were offered to police and prison staff, their families and prisoners only, excluding civilians. Quality of services was poor and did not meet the minimum standards of the National Care and Treatment Program. Medical supplies were procured directly from private pharmacies and not through MSD. In 2008, PharmAccess received grant from USAID to strengthen the health care system of forces to deliver quality services

Objectives
Develop institutional capacity to provide quality HIV prevention, HTC, care and treatment services including laboratory support**,** Improve knowledge and skills of staff, linkage with other institutions and communities for continuum of care and support

Methodology
- Assess, renovate and equip one police and one prison HF in each of the 26 regions in Tanzania, including Zanzibar and Pemba to deliver HIV/AIDS services.
- Train 4-6 staff from each of the HFs in HTC, C&T, PMTCT, TB/HIV, Laboratory, M&E according to MOH curricula.
- Strengthen linkage between HFs and R/CHMT,
- Promotion of service utilization through organized groups of women in the communities

Results
Comprehensive quality HIV care and treatment services have been established in 36 police and prison HFs in 18 regions of Tanzania. More than 60,000 persons have accessed HTC and more than 6,000 PLHIV enrolled on care and 3,000 on ART.

Conclusions
The forces in Tanzania have a network of HFs. With capacity they significantly increase access of people to quality care as the HFs are open to the general public.

Policy Implications and Lessons Learned
Prevention activities if linked with care, treatment and support , makes a workplace program more effective.

Abstract title: **Experience from health facilities: opportunities and challenges**

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Project background
Singida regional hospital started implementing 5-S activities on 28th August, 2009 after the tot training conducted at Mbeya referral hospital in June 2008. We started by dissemination of 5s-cqi-tqm concepts followed by training of managers and other staffs.

We formulated 5 QIT members and 2 wits for pilot target areas to create ownership of QI programme and commitment. By June 2011 we scaled up to 10 QIT members and 8 wits while each wit had 3 members.

Roles of the QIT
1. To conduct situation analysis; 2. Plan, implement and monitor the progress of 5s activities; 3. Provide technical support, 4.mentoring and coaching to wits; and 5. Training on 5s to staff. QIT was equipped with digital camera for photograph taking before & after 5-s implementation. Also, to meet regularly to identify, analyze and solve problems to improve outputs of their working area; wit has responsibility for conducting monitoring & evaluation of day-to-day 5-s practices that are suggested and executed within their work place or recommend them to the management.

Objectives
To understand and practice 5s-cqi-tqm approach

Methodology
We conducted sort-set-shine activities at targeted areas. We do monthly monitoring & evaluation by using check list; the results are shared among staffs. The implementation started with sensitization and training of staffs, QIT and wit formulation followed by selection of the target areas to started sort-set-shine activities. We finalized by doing monitoring and standardizing activities.

Results
5S-CQI-TQM has improved our physical environment, timely delivery of services, and has proved to bring positive attitude among health workers, strong leadership and management structures at facility levels.

Conclusions
5S-CQI-TQM is an appropriate approach for delivering obtainable best hospital services, positive attitude among health workers, strong leadership in health facilities and management structures at facility levels. 5s-cqi-tqm when well institutionalized improves staff performance and brings cohesiveness among all workers.

Abstract Title: **Assessing and improving quality of primary health care through improved quality assessment tool**

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Project Background
The Tool to Improve Quality of Healthcare is one of the quality improvement initiatives that use a performance approach to improve the quality of services available at health facilities. Within this approach, the services available at health facilities are compared with the expectations on these services, as defined by the national standards of care and community preferences. Performance gaps are identified when the observed services fail to meet these expectations.

Objectives
This approach was introduced in Kilombero valley with the main objective of assessing and monitoring trends of quality of care provided in health facilities with the aim of establishing the root cause of performance gaps hence develop workable solutions within health facilities and the Council.

Methodology
A yearly comprehensive evaluation of the quality of health care provision in all health facilities in the district is done. The tool assesses performance in six areas namely physical environment and equipment, job expectations, professional knowledge and skills, management and administration of the facility, staff motivation and clients' satisfaction. Feedback sessions and results dissemination involve all important health governing structures in the district.

Results
At the baseline, weak performance prevailed with regard to professional knowledge and skills of healthcare personnel. Low quality was also manifested in shortage of trained staff, lack of basic equipment and failure to apply basic infection prevention and control measures. A comparison of the baseline and follow-up assessments shows improvements in these indicators. The approach has influenced the Councils to plan for activities that address quality gaps identified.

Conclusions
Improvements in the delivery of healthcare services can quickly be achieved if proper and comprehensive quality assessment tools are used in collaboration with the health governing structures and providers and if proper feedback is given.

Policy Implications and Lessons Learned
Comprehensive routine assessments give a structured and informed picture of the quality of care situation. District health authorities need to be nuclear of the assessment team and adapt the tools to their specific situation and capacities and provide resources to health facilities.

Abstract Title: **Building capacity for quality Family Planning research to National Research Institution**

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Project Background
In resource limited countries such as Tanzania, much of the basic and operational research on family planning (FP) programs is initiated and led by international organizations. Yet there is a need of national organizations to conduct this research themselves. In-country organizations understand the local context, norms and regulations. Unfortunately, local research organizations rarely initiate and lead research on FP. Building local capacity to conduct FP research and ensure research utilization is an important part of sustaining the FP agenda. In Tanzania, the National Institute for Medical Research (NIMR) has expressed a need for FP research capacity building. The NIMR generates scientific information that can be used to enhance the management, prevention, and control of diseases in the country. The NIMR is also an institutional member of the MOH's technical committee; this puts the NIMR in a prime position to influence the decision makers at the MOH.

Objectives
To strengthen FP research capacity of the NIMR in order to generate evidence-based, practical solutions for the advancement of FP policy and services

Methodology
The first phase involved the institutional identification of strengths, weaknesses, opportunities, and threats (SWOT) analysis. Followed by the development and implementation of capacity building plan to address the SWOT. Activities included basic research seminars, practical application mentorship program to improve research and FP knowledge, technical assistance when applying for external funds, assigning co-investigator roles to NIMR-MMRC staff and strengthening NIMR-MMRC's relationship with FP stakeholders.

Results
NIMR has recently become a member of National FP Working Group, has so far responded to 3 FP research calls, participated in 1 FP study as a lead investigator and in 3 as co-investigators.

Conclusion
Building national institutions capacity for FP research could lead to a sustainable way of ensuring availability of quality FP evidence based information to inform service delivery and policy makers.

Policy Implications and Lessons Learned
In-country research institutions can take lead in FP research.

Abstract Title: **Focused mentoring in pediatrics as direct Quality improvement and tool to inform QI activities**

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Project Background
The Elizabeth Glaser pediatric AIDS Foundation supports 5 regions in Tanzania in implementing Care and treatment for HIV. Although combination antiretroviral therapy (cART) reduces mortality in HIV-infected infants and children, ART initiation rates remain unacceptably low in many districts, despite training. Data to inform specific quality improvement activities are sparse

Objectives
Gather data on why pediatric performance is low, directly start improvement through on site mentoring and integrate it into QI-assessments

Methodology
We piloted a 5-day clinical mentoring intervention in three districts focused on paediatric cART enrolment rates at rural clinics by experienced clinicians in cooperation with Apsire (USA).In March 2010, 3 Tanzanian district/regional sites were identified for intervention. Assessments included quality improvement (QI) reviews, direct observation of care, and discussions with staff. Gaps identified resulted in same-day targeted mentoring interventions. Mentoring topics included conventional clinical knowledge/skills (e.g. early infant diagnosis [EID], staging, growth charts, safe ART prescribing, weight-based dose adjustment) and systems-strengthening activities (e.g., documentation).

Results
Baseline QI review found that 35% (130) of eligible children had not started cART. Through provider mentoring, 51 (39%) of these children were found and initiated on treatment; 79 (61%) were lost to follow-up. After mentoring, providers reported increased confidence in EID, staging, initiating cART, and dose adjustment. QI-activities conducted in other districts where streamlined according to the experiences gained and produced similar findings and results.

Conclusions Short term (5 day) targeted clinical mentoring can help identify focus areas for mentoring and parallel increase provider competence and confidence in paediatric cART, and increase paediatric cART initiation.

Policy Implications and Lessons Learned Experiences gained by focused mentoring informed QI activities performed in other districts and help to increase pediatric ARV-uptake.. Interventions to improve identification of infants and children eligible for treatment and to retain them in care are urgently needed.

Abstract Title: **The use of Most Vulnerable Committees to Reinforce Application of the National Quality Standards is making a difference in the lives of Most Vulnerable Children: Experience in Bagamoyo.**

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Project Background
Tanzania has defined National Standards to benchmark the implementation of the National Costed Plan (NCP) for Care of the Most Vulnerable Children (MVC). Implementation of the plans is at various levels supported by various partners and agencies. However routine performance measurement and demonstration of a difference at level of children wellbeing has posed some challenges. We piloted use of MVC Committees as QI Teams ensuring compliance to the standards, testing and apply innovation in closing quality gaps in the implementing the NCP in three wards in Bagamoyo district.

Objectives
To investigate programmatic implementation of MVC Standards and results on children wellbeing

Methodology
We conducted a rapid assessment to define the quality gap in the implementation of the NCP using the National Standards as performance measures in three wards in Bagamoyo District. This was followed by development of training and communication tools, definition and orientation of MVC Committees as QI teams and guidance to test and apply changes narrowing the quality gap identified.

Results
In the course of 6 months established 25 MVCC QI Teams in 3 wards in Bagamoyo that are applying the standards to benchmark efforts in implementing the NCP for MVC care. The teams meet monthly to share experiences and performance in mobilizing resources for MVCs. The efforts have demonstrated notable changes on MVC wellbeing. Access to adequate shelter improved from 43% to 85%, provision of ITN improved from 15% to 64% and the proportion of MVC whose growth curve on the growth monitoring card was considered normal improved from 35% to 96%.

Conclusions
The use of MVCC as Quality Improvement Teams is a promising intervention that will increase the impact of programs on improving children's lives.

Policy Implications and Lessons Learned
The MVCCs if well supported can improve the quality of MVC services with demonstrable impact at client's level.

Abstract Title: **Use of Clinical Mentors at district level, a way to improve Quality of pediatric care**

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Project Background
Although Tanzania has made considerable progress in scaling up PMTCT, an estimated 14,000 infants annually are still HIV-infected (of which, less than 1,000 are identified). The integration of EID services into child health clinics has improved the identification but not the treatment (ART) of Infants with HIV. The Elizabeth Glaser Pediatric AIDS Foundation Tanzania introduced clinical mentors in the 31 supported districts to improve especially pediatric care from 2008 onwards.

Objectives
To improve quality of pediatric care as measured by identification, enrollment and treatment

Methodology
Routine EID and Care & treatment data, (results given to parents/guardians, referral, enrollment and ART initiation of infected infants, age range of children initiated on ART) were collected. Districts were asked to identify experience, knowledgeable clinicians and nurse who attended a one week training in mentoring and the national Pediatric HIV-training. District authorities received support for transportation of mentors to LLHF. As data did not show a clear improvement theses mentors additionally received a two weeks hands-on training in comprehensive pediatric HIV treatment.

Results
Program performance between July 2009 and March 2011 was evaluated indicating that EID uptake increased (952 to 1653 exposed infants/quarter or 24.7% to 48.1% of all exposed infants), percentage of guardians/parents receiving positive DBS results increased from 43.2% to 82.8% and 96.3% of these were enrolled in care. Clinical mentoring increased percentage of enrolled infants receiving ART from 48% to 92.4%. The number of children started on ART increase throughout the period from 290 to 381/quarter or 8% and 10% of all new on ART respectively. The percentage of children <2years of age increased from 21.4% to 27%.

Conclusions
Clinical mentors are an effective tool to improve quality of pediatric care and treatment in settings where there are no specialists.

Policy Implications and Lessons Learned
Buy in of district authorities and a national framework is needed.

Abstract Title: **Measuring the capacity of Quality Improvement Teams to implementing Continuous Quality Improvement interventions:** ***An experience of using a standard CQI site capacity assessment tool***

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Project background
Maryland Global Initiative Tanzania (MGIT), one of four consortium members of AIDSRelief (AR) Tanzania is an implementing partner strengthening HIV/AIDS care and treatment services in Mwanza, Mara, Tanga and Manyara regions. AIDSRelief program has focused on providing comprehensive quality HIV/AIDS care and treatment. Technical assistance (TA) and mentorship to Quality Improvement Teams, Hospital Management Teams (HMTs), CHMTs and RHMTs to implement continuous quality improvement (CQI) strategies is also provided. An important determinant of the success to these initiatives is the presence of capable QI teams at the facility level who can use data to determine performance gaps, and implement appropriate CQI activities.

Objectives
To examine the impact of technical assistance provided to the facilities by assessing the capacity of the teams to effectively implement CQI interventions

Methodology
A **pre and post** comparison of the capacity of CQI teams to implement CQI interventions was done using the AIDSRelief **"CQI site capacity assessment tool"**. The tool, used in 6 other AIDSRelief countries, assesses various aspects of QI implementation including quality structure; quality planning; performance measurement; implementation status of QI activities; staff and patient involvement; training needs and evaluation of QI program.

Results
30 AIDSRelief supported facilities have been assesed to date. In 2009 a baseline assessment was conducted and all facilities had a score ranging from 0% to 22%. Following continued mentorship and support a consequent assessment in 2011 showed an increased CQI site capacity score ranging from 11% to 70%. This showed a marked improvement with health facilities still aiming for 100% score.

Conclusion
Technical support offered to facilities CQI teams through onsite mentorships, trainings, networking and benchmarking, can improve the capacity of the teams to implement CQI interventions at the facility level. Strengthing the CQI capacity of managers and supervisors (HMTs, CHMTs and RHMTs) enhances ownership and sustainability of the CQI program.

Abstract Title: **Improving public health facilities' operations and business performance through Total Quality Management; a case study of the Mbeya Consultant Hospital**

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Project background
The Tanzanians have being experience unsatisfactory health quality care services, but they fail to put an impetus for improvement. Asia-Africa Knowledge Co-Creation Programme (AAKCP) for TQM for better hospital Services; is the Holistic Approach to utilize the existing resources for achieving the purpose. This approach differs from traditional type of training programs which aim at technical transfer.

Objectives
The objectives of the study were to investigate the degree of TQM implementation through involvement of employees, the success of the TQM and the barriers to its successful implementation and the level of clients' satisfaction.

Methodology
This work is to a large extent quantitative research with some qualitative descriptive research aspects via semi-structured questionnaires and focus group discussion. Target population consists of 9 top management members, 127 health workers and 140 patients.

Results
The findings show that the success of TQM at the Mbeya Consultant Hospital was high. Healthcare services improvement 125(80.5%), work environment improvement 126(99.2%) and better availability of drugs and supplies 124 (97.7%) were among the achievements of the TQM implementation, the majority of patients 123(89.13%) were satisfied with the service and care received. In the regression analysis, the time taken by the patient to wait for the health care service and the number of clients at the station of healthcare delivery showed a positive effect, (p-value < 0.01).

Conclusions
To conclude, the research found limited but encouraging evidence that TQM programs produce positive effects on service quality, work place environment, the operation of services, and patients' satisfaction.

Policy implications or lessons learned
The implication of this study is that, although it was conducted at the Mbeya Consultant Hospital, it is anticipated that the findings may well have relevance on the broader scale and could benefit other health care facilities.

Abstract Title: **Introduction of Quality of Care Standards in a Hospital in Arusha, Tanzania**

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Project Background
Standards for hospital care in Tanzania have typically focused on availability of resources. Standards do exist for physical size, quality of hospital buildings, optimal staffing levels, and for a standardized hospital formulary and Standard Treatment Guidelines. However, standards for quality of clinical services delivered are lacking or limited for the hospital setting.

Objectives
1. To establish practical measurements of quality of care being delivered in Arusha Lutheran Medical Centre
2. To choose those variables which lend themselves to ease of monitoring
3. To track changes in measures of quality of care
4. To compare these local measures to national and international standards
5. To suggest institutional quality care standards for hospitals in Tanzania

Methodology
Potential measures of Quality of Care were developed by consensus between clinicians and management. IT was consulted for assistance with monitoring in results in the computerized medical record of the hospital. A final list of twelve basic measures was agreed upon and monitoring began in April 2011. Monthly summaries are collated and circulated among the clinicians and management.

Results
Results presented demonstrate the patterns of change in the twelve measures of Quality Improvement introduced into the hospital over the past six months. Quantitative improvements are reported on a majority of the measures which were considered. These results suggest that there are a number of directly measureable variables of quality within ALMC.

Conclusions
1. Quality Improvement is only possible with a proactive plan in place to attempt to measure changes in quality.
2. Such measures are possible to identify and to track in local hospitals.
3. Attempting to measure quality improvement contributes positively to the overall awareness and concern for quality improvement in the hospital setting.
4. Measures of direct quality of individual treatments by individual clinicians are very difficult to assess in this experience.

Abstract Title: **Implementation of quality improvement approaches for maternal and newborn care in Southern Tanzania**

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Project Background
Despite child mortality improving rapidly in Tanzania, newborn mortality (deaths in the first month of life) is still high and its pace of reduction is slow. Improving Newborn Survival in Southern Tanzania (INSIST) is a study aiming to evaluate the impact and cost of scalable package of interventions at community level with health system strengthening in terms of quality improvement, with the overall goal to improve neonatal survival in Lindi and Mtwara regions.

Objectives
To strengthen health care provision using **a quality improvement approach** in implementing essential interventions in antenatal, perinatal and postnatal care in health facilities which should be sustainable and scalable at national level.

Methodology
The Model for Improvement; multiple Plan-Do-Study-Act (PDSA) cycles and Improvement Collaborative Network

Results
The QI approach was tested in Mtwara rural in four health facilities, Mahurunga, Tangazo, Mbawala and Nanguruwe and was able to increase health facility deliveries from a monthly median of 46 to 65 in six months of pilot. In Ruangwa district where we spread to all dispensaries and health centres health facility deliveries increased from a monthly median of 110 at baseline to a median of 161 in 17 months. The change package included giving individual birth plan and complication preparedness counseling to all pregnant women attending ANC clinic and conducting meetings with community members (TBAs, villagers, village officials) in order to sensitize them to use health facilities for delivery.

Conclusions
The QI intervention helped to improve processes in essential RCH interventions in health facilities which led to an increase in institutional deliveries, improved data recording and strengthened the health care providers' professional relationships to regular collaborative meetings.

Policy Implications and Lessons Learned
QI initiatives should be seen as an integral part of health care provision, with a new approach to supervision at primary care facilities based on coaching and mentoring. All health staff should have two jobs, their job and the job of improving their job. The QI process works well when the QI teams self initialize the process and do not see it as an outside project.

Abstract Title: **Coordination and integration of QI approaches at Different Levels**

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Background
Quality improvement approaches i.e. 5S CQI-TQM- KAIZEN and IPC were integrated and the immediate outcome and its impact is observable as an evidence of quality improvement through its concepts. The **i**ntegration further provided an opportunity for training and seminars to health providers.

Objectives
Minimized client time waste to visit facilities for care, treatment, and support services by integrated services within the health system for quality assurance

Methodology
Observations, provider interviewed, process evaluation by use of checklist on the currently practices.

Results
Reformation of quality improvement team to accommodate the subject. Sensitization, mobilization through negotiation, advocacy & lobbing for improved working environment, proper waste for infectious materials was initiated, should be a continuous process for quality improvement
Outcome of care in terms of recovery observed.

Meetings were held by stakeholders and beneficiaries, plan were laid down including group constitution to special groups for care and supportive services. Integration of the services within the same umbrella also enabled some of the beneficiaries to open up and utilize the facilities. Another outcome was the for quality improvement IPC , 5S KAIZEN TQM approaches including others being integrated for quality improvement towards care, and treatment and infectious control

Conclusions
Healthcare delivery should become client -centered, Safety and Quality minimized from both patients and professionals. Responsiveness and equity are the core components. All categories and ranks of the hospital staffs, the full participation of the employees is encouraged through accumulation of small successes in the routine work. Customer oriented leadership, empowerment, continuous improvement, elimination of waste no clutters exist crudely. Quality measurement is crucial to system management.

Policy implications or lessons learned
Quality is long life.

Abstract Title: **Standardizing delivery of HBC services in Tanzania**

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Project Background
There has been changing scope of HIV/AIDS interventions including HBC from time when the epidemic started to date coupled with increased efforts to scale-up. To ensure quality, it is imperative that services should be provided according to evidence-based standard operating procedures (SOP) and best practices. It is for this reason, the MOHSW and HBC partners are working to develop SOP to provide information to providers and managers in the field on procedures for delivery of quality HBC services.

Objectives
To evaluate current scope of HBC services associated roles and responsibilities across stakeholders to inform development of SOP for HBC program.

Methodology
A descriptive cross-sectional study was done in Tanga city to systematically analyze HBC practices from perspective of providers, patients and implementing partners. Quantitative data on demographic and health characteristics of patients and HBC workers and on the details of home visits and qualitative data on expectations and perceptions of HBC services from all perspectives and perceived problems facing delivery of HBC services from HBC workers, implementing partners and clients was collected.

Results
88% of interviewed clients were females so were 77% of HBC providers. Most commonly provided HBC services include: medicines, nutritional counselling, adherence counselling, hygiene and sanitation education, and psychological/emotional support. On the other hand, referrals among facility and community providers, education on prevention of new infections for both PLHIV and their families and IGA support groups are barely provided.

Conclusions
Many outstanding needs in the current context of HBC needs for clients are not being met through ongoing HBC practices due to lack of practical guidance.

Policy Implications and Lessons Learned
Development of SOP will be crucial in standardizing and integrating HBC practices and ultimately ensuring provision quality HBC in settings with similar findings.

Abstract Title: **Innovative approaches to improving sustainability of QI at health facility level in Kenya: A case of Coast province**

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Project Background
Under the leadership of NASCOP, quality improvement work was conducted in Coast region of Kenya in five HIV Quality Improvement (HIVQUAL) facilities. Improving the quality of care is a priority for Kenya however, quality improvement methods including systematic quality measurement remains novel. To address this, NASCOP brought in HEALTHQUAL-International as a model to build capacity in quality improvement.

Objectives
The core objective of HIVQUAL model is to systematically assess and improve the quality of care and treatment services provided to people living with HIV and AIDS in Kenya.

Methodology
National HIV quality performance indicators were developed covering adults, pediatrics and HIV infected pregnant women in HIV care. Fifteen facilities including five in coast conducted baseline performance measurement in June 2010. Each site chose one indicator to improve using the baseline data.

Results
In coast, three sites chose to improve CD4 monitoring whose baseline results were; 32.5%, 37%, and 44.5% for Kilifi, Malindi and Likoni District hospitals respectively while two facilities chose to improve treatment adherence assessment whose baseline results were; 83.5% and 90.7% for St. Luke's and Coast PGH respectively. At interim measurement, the CD4 sites all noted improvement; Kilifi 32.5% - 57%; Malindi 37- 70%; and Likoni 44.5% - 60%. St. Luke's treatment adherence assessment project started high at 83.5% improving to 97%. Coast PGH started very high at 90.7% treatment adherence assessment but decreased during the interim measurement to 73%.

Conclusions
Having targeted clinic process diagnosis discussions can help sites understand the most common reasons for gaps in their care system. Matching those reasons with the most fitting interventions compliments standard Quality Improvement methods and can help motivate quality improvement efforts.

Policy Implications and Lessons Learned
HIVQUAL/HEALTHQUAL model of quality improvement is a viable initiative that should be scaled up and mainstreamed. Having a strong clinical information system is an important component in quality improvement.

Abstract Title: **Improving Interpersonal Communication skills of facility based health care providers to improve malaria prevention and case management**

Author List: **Mdee Rebecca Mdeme – MSc ; Kariuki Ruth Muthoni - DrPH**

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Project Background:
While technical and clinical competences are essential for delivering quality health services, effective interpersonal communication (IPC) translated into practices save lives. The Communication for Malaria Initiative in Tanzania (COMMIT) program in collaboration with Ministry of Health and Social Welfare (MOHSW) is implementing sustainable strategies for improving IPC skills of health providers to transmit messages on prevention and treatment of malaria to pregnant women and children under five years old in 51 districts in Tanzania.

Objectives
To develop training materials, train health providers on IPC skills and supervise them.

Methodology
Meetings with key COMMIT and MOHSW partners, conducting baseline assessment, development and dissemination of training materials followed by supervision.

Results
About 4,500 flipcharts, 439,000 brochures, 480,700 reminder cards and 9,400 pregnancy wheels were developed, and disseminated to targeted 240 health facilities. Consequently 886 health workers and 200 nurse tutors were trained on IPC and 335 health workers were trained on supportive supervision skills. Follow-up survey shows improvement on clients' satisfaction with counseling on effects, prevention and treatment of malaria and increased utilization of health services.

Conclusions
Building capacity of health providers in interpersonal communication is a strategy which results in improved communication between providers and client that leads to client satisfaction, recall of instructions and compliance with treatment. However, poor provider- client communication is a barrier to quality health services.

Policy Implications and Lessons Learnt:
Interpersonal communication training and follow-up contributes to provider commitment, social interactions and improved relationships (provider to client) and motivates clients in utilization of health services.

Abstract Title: **The lecturing tour of 5S in the southeast area of Tanzania**

Author List: 1. **Noriyuki MIYAMOTO; 2. Youichi TORIUMI; 3. Chiaki YAMANAKA; 4. Yashio MURAKAMI 5. Takashi UTSUGI**

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Project Background
JICA volunteers are practicing "5S" activity in each assigned work place. From our experiences so far, we recognized that many health workers now know "5S approach", however, it is not clearly understood. We thought a visual textbook for "5S approach" could help them to understand more and improve their approach.

We developed "Visual Teaching Material Vol.1" which is included a lot of photos and movies, and tested in series of workshop called "The lecturing tour of 5S in the southeast areas of Tanzania", conducted in Tandahimba District Hospital, Newala District Hospital, Masashi District Hospital and Nachingwea District Hospital in August, 2011. This is to share our experiences using this material and discuss improvement of knowledge on "5S".

Objectives
Dissemination knowledge and skills of basic "5S" concept to various health workers in hospitals

Methodology
Lecture, Activity (5S game), Practical training, Group discussion and presentation

Results
The total number of participants was about 140 from the four hospitals. Pre and Post assessment were conducted before and after the training. The results of post showed better results than pre. And during the practical training, the participants applied their knowledge, which gained through the lecture and game. Furthermore, we recognized that our teaching material and methodology are effective to teach "5S".

Conclusions
JICA volunteers developed "Visual Teaching Material Vol.1" and conducted "The lecturing tour of 5S in the southeast areas of Tanzania" from 2nd to 5th on August, 2011. We visited 4 hospitals and conducted training about basic 5S concepts to the hospitals. Components of our training were lecture, activity, practical training and group discussion. We could recognize that these steps were effective to be able to improve capability of 5S practice. Furthermore, the material is too good method to teach 5S activity and strongly impress 5S concepts to trainees.

Policy Implications and Lessons Learned
The effective methodology of 5S training.

Abstract Title: **Implementing a Sustainable Quality Improvement Plan: an experience in five health facilities in Nyanza Province, Kenya**

Author List: **Aguda, Matu and Muthama.**

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Project Background
The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) has been supporting HIV prevention, care and treatment services globally since 2000. Currently, the Foundation supports over 153 sites in Nyanza Province with services to prevent the vertical transmission of HIV/AIDS and offer pediatric and adult HIV/AIDS care and treatment services in both tertiary and primary care level in Nyanza Province. EGPAF works closely with the Ministry of Health and follows all national guidelines and policies in relation to services supported. EGPAF promotes use of health and programme data to meet patients and program need. This abstract presents the findings of a QI assessment using the HIVQUAL at five facilities in Nyanza Province, Kenya

Objectives
To assess quality of care using the national standard of care indicators, to conduct gap analysis and set priorities for improvement at the facility level.

Methodology
A cross sectional multicenter assessment using a purposive sampling technique for facilities enrolling more than 100 adult clients on HIV care and treatment. 5 facilities out of 17 facilities randomly sampled. 30 files in each facility randomly selected and reviewed on the documentation of standards of care for the period between March and September, 2011. QI plan developed with each facility team based on the findings.

Results
Partner testing, client retention and HIV monitoring scored below 50%, while tuberculosis screening and cotrimoxazole prophylaxis scored above 95% overall.

Conclusions
Defining performance measurements for quality improvement and performing assessment of care leads to the identification of gaps and implementation of self-driven improvement steps in addressing the identified problems.

Policy Implications and Lessons Learned
The quality of health care delivered in a health facility is determined by how its services are organized, leadership and monitoring systems, infrastructure and human and material resources.

Abstract Title: **Use of 'data dialogue days' to improve quality of care (QOC) in a busy HIV clinic in western Kenya**

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Project Background
HIV clinics in high burden settings face several challenges linked to limited resources. Quality of care (QOC) denotes professional practices and health outcomes conform to some standard. Measuring QOC is scientifically proven method of problem identification.

Objectives
To determine the utility of "data dialogue days" in improving QOC in a busy HIV clinic.

Methodology
The facility has 10000 active patients with an annual average of 5 appointments translating to daily patient volumes of 193. The first continuous quality improvement (CQI) initiative was implemented in October 2010. Quarterly HIVQUAL Kenya Indicators for Adult HIV care and treatment were assessed before and after a data quality assurance (DQA) report was prepared and disseminated to HIV clinic health workers during a data dialogue day; collaborative strategies were then formulated and implemented.

Results
Dimensions of QOC before and after the DQA were; CD4 monitoring rate of 47% and 74%, ART initiation rate of 74% and 80%, treatment adherence rates of 97% and 86%, cotrimoxazole prophylaxis rate of 100% and 100%, and TB screening rates of 77%, 20% and 87% in the 3rd and 4th and 1st quarter of 2010 and 2011 respectively. No data was documented on partner testing and clinic visits. Recommended standard QOC indicators for care in Kenya are; CD4 monitoring rate of 85%, ART initiation rates of 65%, treatment adherence rates of 95%, cotrimoxazole prophylaxis rate of 100% and a national average 77% TB screening rates.

Conclusions
Data dialogue days identified challenges in the provision of care which when addressed enhanced the QOC.

Policy Implications and Lessons Learned
Data dialogue days address the gaps identified in the Kenya National AIDS strategic plan III (KNASP III) without additional resources and are in line with the KNASP III communication strategy. Planned structured clinical audits are lead to improvement in QOC.

Abstract Title: **Report Back of a Workshop to Strengthen the Capacity of Use of Cohort Data for Quality Improvement of HIV Programs**

Author List: **Packel, Laura, PhD[1]; Barker, Joseph, MPH[2]; Myrick, Roger, PhD[1]; Aberle-Grasse, John, MPH [2]; Patel, Sadhna, MPH[3]; Jonas, Anna, MPH [4]; De Klerk, Michael, MPH [4]; Smith, Nathan, MPH[1].**

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Project Background
Routinely collected data are vital to monitor clinical outcomes of client cohorts receiving HIV services and for quality improvement (QI) of patient care.

Objectives
To strengthen capacity and QI for HIV program services, UCSF and CDC developed a workshop on the use of cohort data for program improvement. The workshop was piloted in Namibia with input from the Directorate of Special Programs (DSP) and CDC Namibia. A second pilot has been proposed for Tanzania, and will be tailored to the new patient monitoring system recently implemented.

Methodology
The workshop included didactic methods, group work, case studies and application of concepts to country data. Participants reviewed key concepts, data flow and management, systems and the use of data to improve health outcomes. Participants completed a capacity building plan for use of cohort data as a QI tool.

Results
Participants reported increased knowledge and capacity for use of cohort data for program improvement, particularly at regional levels. DSP is working with regional data clerks to measure progress of their capacity building and QI plans. To date, national cohort data collection are still in the pilot stages; quality outcomes measures are in practice.

Conclusions
Materials from this workshop can be adapted for unique country contexts and can be an effective tool for setting capacity building goals and action plans.

Policy Implications and Lessons Learned
Capacity building for analyzing and using ART cohort data must be integrated into broader contexts of national SI, QI and program strategic plans. To ensure application, it is essential that 1) participants work with their own country data, and 2) to work with in-country facilitators when developing training tools and sessions.

There is a need to further build sub-national capacity for use of cohort data for quality improvement and decision-making. Future efforts will provide support for Training of Trainer opportunities to increase the reach.

Abstract Title: **Working improvement at Makole Health Center**

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Project Background
Benjamin Mkapa HIV/AIDS Foundation in collaboration with the Ministry of Social Welfare and ILO conducted 10 days workshop on how to improve the working conditions of health workers for six facilities of Dodoma and Kondoa. Makole health centre used Healthwise methodology learned at the workshop to conduct research which showed that many problems were related to poor working environment. Therefore, workers and management team decided to organize local resources, to improve the environment.

Objective
To ensure safety at work. To improve quality and performance. To conduct joint monitoring for continuous quality assurance.

Methodology
HealthWISE is a participatory methodology adapted by ILO and WHO to assist healthcare organizations in improving working conditions and workplace safety. Makole Health Centre used the Bottom up Strategy which is a low cost and sustainable means of identifying and solving problems by involving all stakeholders.

Results
The working environment in Makole is improved leading to efficient provision of services to clients. Client load has increased from 600 to 1013 average per day which has increased the income of the facility from Tsh 700,000 to Tsh 3,400,000 per month. With this income the facility is able to purchase medicines to supplement Government's supply.

Conclusion
Working conditions and quality of services can be improved through involvement of workers, locally available materials and small income generation.

Policy Implications and Lessons Learnt
Quality and sustainable improvement of provision of services comes when workers are fully involved in identifying and resolving their challenges.

Abstract Title: **Patient waiting time as a measure of quality of health care: results from a preliminary patient flow analysis at the New Nyanza Provincial General Hospital Patient Support Center (NNPGH PSC)**

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Project Background
HIV is a chronic condition for which patients require frequent clinic visits. NNPGH PSC receives high patient volumes- up to 200 daily- served by an average staff of 6 clinicians leading to prolonged waiting time. Patient satisfaction is related to quality of the wait experience. Patients had complained about prolonged waiting times. The defaulter rate was 7% (August 2011) against a recommended 6% (AIDS Relief).

Objectives
To assess patient clinic encounter time and determine events that contribute to the longest wait time.

Methodology
PFA (Center for Disease Control and Prevention) was used to calculate PSC patient wait times. Patient registers were distributed by the lead clinician to a all consenting patients on 2 clinic days.

Results
Waiting times for 79 out of 109 patients who had a similar pattern of patient flow were analyzed. The mean waiting time (for 79 patients who moved from the reception, weighing bay, nurse, clinician, pharmacy and reception again) was 169.24 minutes (+/- 58.62 minutes), 90.06% of which was spent waiting. The average nurse and doctor wait time was 39.33 minutes (+/- 17.47 minutes) and 48.18 minutes (+/- 36.47 minutes) respectively. The average nurse and doctor encounter time was 3.03 minutes (+/_ 1.55 minutes) and 7.39 minutes (+/- 3.26 minutes) respectively. The weighing bay wait time was 46.30 minutes (+/_17.03 minutes).

Conclusions
The weighing bay, nurse and doctor waiting times contributed to the longest waiting time. To decrease waiting time at the weighing bay, patients can be weighed at the reception, at the nurse-intake desk, nurse workstations can be reorganized for the nurse-counselor to sit for specified hours a day, and at the clinician's room, an express- desk can be introduced for drug refills. This analysis was limited by a short evaluation period, non-synchronization of clinic watches, lack of facility patient-arrival times, staff utilization data and other patient flow patterns.

Abstract Title: **Coordination and integration of QI approaches at health facility level**

Author List: **Janeth Joshua Sabuni**

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Background
Coordination is the act of coordinating, making different people or things work together for a goal or effect to fulfill desired goals in an organization. Coordination is a managerial function in which different activities of the business are properly adjusted and interlinked.

Objectives of coordination
The purposes of coordination are:

- To coordinate the development, implementation, and evaluation of the hospital's overall Quality Improvement (QI) program, which includes all ancillary, nursing, and medical staff departments,
- To identify trends, prioritize and recommend improvements,
- To assess the facility's needs for development and maintenance of an on-going Quality improvement program
- To develop appropriate systems to assure that on-going QI activities occur
- To plan QI activities

Methodology
This work will be presented in PowerPoint Slides in poster format, explaining how to coordinate, advantages of good coordination in QI, 5s activities at the facility. A progress report of QI activities at the facility will be displayed.

Conclusion
This will base on how QI program has improved quality of care at the facility.

Abstract Title: **Promoting health facilities as 'highly reliable institutions for Provision of quality health care service: 5S Kaizen experience at Mbeya Consultant Hospital**

Author List: **Adela Mvula, Dr Msafiri Leonard Birigi and Dr Humprey Kiwelu**

Affiliations: **Mbeya Regional Hospital**

Background
Mbeya Consultant hospital which is located in southern Highlands in Tanzania, is implementing a continuous quality improvement project called 5S-Kaizen since 2007. The project involves all staffs from the top management to the cleaning crew.

Objective
The introduction of 5S-kaizen project at the Mbeya Consultant Hospital was in response to internal and external pressures to improve quality and value of services rendered by the hospital.

Methodology
The implementation of 5S Kaizen started by training of staffs, setting standards and performance monitoring tools. Supportive supervision and mentoring is performed monthly. Performance reports (including photos) are collected every 3 months and analyzed. Cross-sectional studies on the perception of Providers and Clients on the quality of health services was performed using semi structured questionnaire and Exit interviews respectively. This work is to a large extent quantitative research with some qualitative descriptive research aspects via semi-structured questionnaires. The target population consists of top management members, staffs at the Mbeya Consultant Hospital and patients looking for health care services at our hospital.

Results
Healthcare services improvement was found to be 80.5%, Work environment improvement was high (99.2%), Availability of drugs and other hospital supplies was found to (97.7%). Patient's satisfaction with the services and care received scored (89%) The waiting time for the health care service and the number of clients at the station of healthcare delivery showed a positive effect, ($p< 0.01$). Surprisingly, the revenue collection has risen by 165%. **Conclusion:** 5S-Kaizen though based on making little changes on a regular basis: always improving productivity, safety and effectiveness while reducing waste. 5S kaizen do not require external forces to be implemented. Most of the 5S Kaizen activities are accomplished by well trained and motivated staffs.

Conclusion
The 5S-Kaizen process may sometimes be discounted as 'just a housekeeping process' but it has much wider application to address the energy and time wasted in organizations hunting for things. Making it sustainable one needs to encourage his staffs to have many small and few large Kaizen process in each department.

Abstract Title: **Patient Satisfaction as an indicator of the Quality of care at MNH**

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Background
MNH is aiming to provide quality care which will guarantee fair access and high quality services. After reform clients were complaining on shortage of resources, delay of services, high costs of treatment and investigations, poor hygiene in the wards, and negative attitudes of staff towards Patients. MNH initiated clients' feedback as a strategy to improve quality of services rendered.

Objectives
1. To meet patients expectations
2. To improve quality of care

Methodology
MNH put in place 67 suggestion boxes, clients complaints office, patients satisfaction questionnaire, and sensitization to healthcare workers, HQIT collects questionnaires from suggestion boxes and from the complaints office on weekly basis. Using patients' opinion the team develops working plan for intervention and continual monitoring.

Results
There is a substantially fewer patients complaints. Reduction of treatment and investigation cost, Clean environment of the hospital.

Conclusions
All this activity done for the purpose of improving the quality of healthcare services and make Muhimbili national hospital an Island of quality care.

Policy implications or lessons learned
Healthcare providers' commitment is crucial in improving quality of care. Availability of essential and reliable resources meets client expectation.

Abstract Title: **Ensuring safety**

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Affiliations: **Newala District Council Hospital**

Project background
Formerly Newala District Hospital laboratory did not have extensive infection control practice. It was only bar soap hand washing and all people allowed to enter the laboratory internal and external customers. There was no organogram.

Objectives
To improve infection prevention control.

Methodology
- Training of laboratory manager and Quality officer.
- Orientation of CHMT, HMT, Laboratory staff and Hospital staff.
- On the job training to lab and hospital staff.
- Display of standard operating procedure.
- Mentoring and 5S steps approach.

Results
- Improved laboratory safety.
- Safety signal, limited traffic, use of protective gears(boots coats apron gargles).
- Segregation of waste.
- Zoning, SOP.

Conclusions
In order to improve laboratory service delivery safety should be prioritized.

Policy implications or lessons learned
In order to achieve the goal it needs effective communication and team work spirit and commitment.

Abstract Title: **ART Ordering Cycles: Experiences from Partner side and Districts / Sites**

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Background
All authorized health facilities in Tanzania obtain HIV/AIDS commodities from the Medical Stores Department (MSD). Timely submission of consumption reports is critical for decision making and correct quantification of procurement needs at all levels.

Objectives
ART ordering cycles were established to improve supply chain management systems nationally.

Methodology
The Supply Chain Management System (SCMS) project supports the Government of Tz in ensuring sound management and distribution of high quality HIV/AIDS commodities to meet needs of the rapid scale up of AIDS treatment. SCMS and MSD jointly developed ordering cycle schedules in 2010. ARV ordering cycles cover both ordering and refill designated health facilities. The aim is to ensure on-time product deliveries, spread workload for health facilities and use limited resources efficiently (i.e. storage, transport, human capitol). Ordering facilities, typically hospitals, obtain supplies directly from MSD while lower level refill facilities order from ordering facilities.

ICAP works with stakeholders in the selected regions with district and health care workers to comply with these cycles to ensure constant commodity supply to the program through training on ARV commodity management, mentoring and supportive supervision activities in Kigoma, Kagera and Pwani regions. SCMS has deployed Supply Chain Monitoring Advisors (SCMAs) at each zonal MSD stores (Tabora, Mwanza, DSM) to track performance of regions, districts and individual sites.

Results
Monthly reporting compliance for ARVs improved from <50% to 70-90% in three regions. Timeliness of reporting remains a challenge. The improved trend partly was an outcome of joint efforts between NACP and partners leading to the development of A Pharmacy Mentoring Toolkit for facility health care workers. Roll-out training to Regional and District Council Health Management Teams is in progress throughout the country.

Conclusions
Implementation of ART ordering cycles assists regional and district managers in tracking performance of health facilities. They also facilitate identification of unscheduled orders and sites that are not in reporting compliance so targeted interventions or support can be provided. Continued mentoring is required to improve the timeliness of reporting. By way of expanding the system, SCMS has deployed SCMAs focusing on laboratory supplies in all nine zones, MSD central and NACP.

Abstract Title: **Diagnosis and Management of Febrile Illness (TIBU HOMA)**

Author List: **V. Masbayi, F.Kalokola**

Affiliations: **URC**

Background
- Case management training and quality improvement is critical to improved facility health service.
- Hygiene standards impact infection prevention to patients and providers[3]
- Infection Prevention and Control (IPC) practices are poor in most health facilities[4]
- A PHI hospital assessment[5] revealed that only 43% of hospitals complied with the set IPC standards[6]

Objective
- Increase availability of and accessibility to fundamental facility-based curative and preventive child health services
- Ensure sustainability of critical child health activities
- Increase linkages within the community to promote healthy behaviors thereby increasing knowledge and use of child health services

Methodology
- The strategy combines case management training, improving supply chain management and linking communities to health facilities and is executed within the framework of IMCI using the PHI concept.
- It applies the Improvement Collaborative Model that involves Learning sessions and coaching.
- The focus is to collaborate with CHMTs to improve public and private health services to children under five.

Results
- The project and MoHSW have revised and tested the IMCI guidelines
- Implementation on improving case management, QI and community linkages to HFs in seven districts is ongoing.
- Baseline data collection is in progress

Conclusion
TIBU HOMA PROJECT is addressing the health facility as a key platform for the delivery of quality health services. This will increase access and availability and reduce morbidity and mortality in children under-five years of age in the Lake Zone.

[3] infection prevention and control guidelines for health care Services in Tanzania-(MOHSW 2007)
[4] Ref Pocket Book for health care provider (MOSW-2007)
[5] Baseline survey of quality of pediatric care in Tanzania (MOHSW-2010)

Abstract Title: **Introducing a quality assurance tool to improve HIV and AIDS care in Tanzanian hospitals**

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Background
In many Tanzanian hospitals quality of HIV and AIDS care is below the expected standard. The aim of this project was to design a feasible and practicable tool to assess hospital based quality of HIV and AIDS care. Results demonstrate areas of strength and those in need of improvement and serve as a basis for continuous quality improvement.

Methodology
In a participatory process a set of quality indicators was identified, based on international publications and national guidelines. Independent observers measured structural, process and outcome quality of HIV and AIDS care. Structural and process indicators were measured using a 0 to 2-item scale. Interviews with staff and patients were held to understand the findings as well as to assess staff attitudes and motivation. A pilot study conducted in the CTC in Bombo Regional Hospital in Nov 2010 confirmed that the indicators were practicable and reliable.

Results
The assessment tool proved to be fast and feasible. Structural quality in CTC was 71% of the expected standard. Process quality ranged from 24% (History taking) to 83% (Lab performance) with a mean performance score of 52%. Too little individual attention and little confidentiality were considered areas of concern. Low motivation and high workload was named as influencing factor for low performance quality.

Discussion
Process results can only be partially explained with high workload and low structural quality. More attention to the individual patient, motivation and commitment of staff, remain crucial for a good quality of care and need to be improved.

Abstract Title: **Quality Improvement in Mtwara Region supported by GIZ (TGPSH)**

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Project background
Generally, hospitals are considered as centrepieces of health services in the districts. These services are considered to be insufficient and both result and cause for poverty. Therefore the Tanzanian-German Program to Support Health (TGPSH) supported the establishment of a quality improvement programme in all hospitals of Mtwara region.

Objectives
To enable the major health facilities within Mtwara region to deliver efficient and comprehensive service provision tailored to the needs of the population.

Methodology
Establishment Quality Improvement Teams (QITs) in all hospitals.
The work of the QITs is linked with an element of hospital assessment, executed with a quality assessment tool developed by TGPSH, which allows specific measurement of the quality of service delivery in defined key areas of the hospital.

Results
Development of Action Plans, which gives orientation to HMT. The tool is also suitable for monitoring development and change in areas of need. This also shall lead to higher staff and patients satisfaction.

Conclusions and Policy implications or lessons learned
Positive outcome: Many identified gaps were rectified, which most likely would still be in place without QI activities. Therefore work environment of staff, service delivery and drug availability has improved
Challenges: Negative attitude. Staff often does not see the overall value of a QI program, think only individuals benefit from it. Therefore difficult to find committed QIT members. QITs and HMT do not strongly emphasize on implementation measures. Nowadays raising confusion through existence of various QITs within 1 hospital. Sometimes delay of funds to implement activities in time.
Overall: Slight Improvements over the years can be notified. However, big changes are not yet seen!

Abstract Title: **Routine data quality assessments (DQA): An essential component to improving quality of data for reporting and use.**

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Background
The Elizabeth Glaser Pediatric AIDS Foundation (the Foundation) has supported the Ministry of Health (MOH) of Tanzania in provision of prevention of mother-to-child transmission and HIV care and treatment services (C&T) since 2004. Enabled through PEPFAR funding, this support extends to 1,000 PMTCT and 165 C&T service facilities. In 2009 a baseline Data Quality Assessment conducted by the Foundation and CDC in 126 health facilities (75% of C&T health facilities) revealed data discrepancies in 98% of facilities. A 45% average discrepancy was discovered between reported and observed numbers. In response to structured interviews and survey questionnaires 80% of staff reported minimal data use and knowledge of data management.

Methods
Following this DQA, specific activities were implemented to address the gaps identified. A data management department was created to improve the quality of data recording and reporting. This department commenced with creating job descriptions and contracts for facility-level data clerks to clarify their roles and responsibilities. Supported data clerks to maintain the functioning of electronic equipment and databases, assessed the status of data entry in each facility and updated the care and treatment database. Together with M&E department, they created standard operating procedures for data management and provided performance feedback, on-the-job training and supportive supervision to address gaps and weaknesses. This support was provided to 50 data clerks and 180 clinical staff in all 165 sites.

Results
In 2010 repeat DQA in 97 health facilities reported a 25% increase in the number of facilities with accurate reporting. The average rate of discrepancies reduced from 45% to 6%. Furthermore 80% of staff interviewed displayed improved knowledge of data use and management, evidenced through improved reports and survey responses.

Conclusion
Implementing supportive supervision structures to support data management and use at facility level in combination with regular DQAs improves staff capacity to use high quality data.

Abstract Title: **Improving HIV/AIDS program performance through systematic and routine data analysis in the Elizabeth Glaser Pediatric AIDS Foundation -Tanzania**

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Background
Since 2004, the Foundation's Tanzania program has supported the Ministry of Health in 1,062 facilities, testing and counseling 1.37 million women, providing HIV care and treatment (C&T) to 138,534 and 68,996 patients, respectively. HIV/AIDS services coverage is quickly rising and quality of care is of increasing importance. The Foundation enables systematic quality assessment by analyzing routinely collected data during a dedicated quarterly data analysis week (DAW).

Method
After reporting quarterly data to donors, data is analyzed by technical staff in all offices. The data review integrates all service areas of PMTCT, early infant diagnosis, and C&T. Levels of analysis include facility, district, regional and national trends in performance over time. Data reports are prepared by the Strategic Information Team, led by technical teams, for analysis. Staff collectively identified strengths and gaps, developed improvement plans and strategies, provide feedback and initiate improvement activities with service providers and stakeholders. Progress is continuously documented and reviewed.

Results
Six months following the DAW (from March to September 2010), improvements in service delivery were observed. The percentage of partners tested increased (13% to 30%), infants enrolled onto ART increased (57% to 77%), and initiating ART increased (50% to 71%).
The DAW increased staff data use, leading to greater awareness of gaps, and improved prioritization of interventions, providing a platform for evidence-based decision-making.

Conclusion
By enabling program staff and services providers to understand their performance in relation to national targets, data reviews enable identification of gaps and prioritization of improvement.

Abstract Title: **The Development of Health Laboratory Services in Tanzania.**

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Scientific medicine was introduced in the East Africa region by European powers that divided the continent into possessions (colonies0 at the berlin conference in 1884. Tanganyika Ruanda and Burundi became German territories. The German colonizers built the first hospital in East Africa at Ocean Road in 1893. Dr. Koch built the first pathology laboratory at the hospital in 1897. During the German and British periods, the health laboratories were headed by the Principal Pathologist, who had a vote to run the services. This vertical service was inherited at independence in 1961.

After independence several administrative changes introduced removed the autonomy and separate vote for pathology services. Currently they form part of Diagnostic services headed by an Assistant Director under the Director of Hospital Services at headquarters.

Their operation, like most health services, are greatly underfunded and inadequately staffed. There is no proper referral system; their ownership is divided between the health department, local authorities and private entities. The quality of test results has deteriorated so much that this threatens the validity of hospital diagnoses and statistics on which our health planning should be based.

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