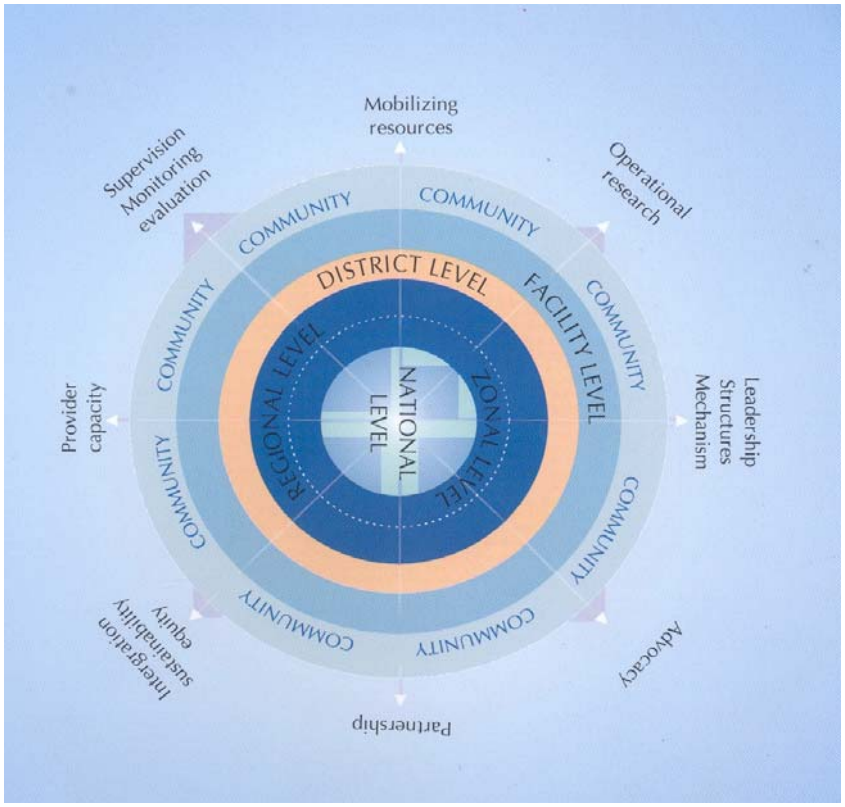
THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

TANZANIA QUALITY IMPROVEMENT FRAMEWORK

"Delivering Quality Health Services"



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Abbreviations

AMMP	Adult Morbidity and Mortality project
CE	Continuing Education
CBRCH	Community Based Reproductive and Child Health
CBW	Community Based Workers
CHF	Community Health Fund
CHMT	Council Health Management Team
CHW	Community Health Workers
CHSB	Council Health Management Team
CNO	Chief Nursing Officer
COPE	Client Oriented Provider Efficient Services
CMO	Chief Medical Officer
CQI	Continuous Quality Improvement
CQM	Comprehensive Quality Management
COMATAA	Community Action and Theatre against AIDS
DDH	Designated District Hospital
CHS	Directorate of Hospital Services
CHRD	Directorate of Human Resources Development
DPP	Directorate of Policy and Planning
DPS	Directorate of Preventive Services
DHS	District Health Services
EFQM	European Foundation for Quality Management
DMO	District Medical Officer
FLHF	Front Line Health Facilities (These are Health Centres and Dispensaries)
FGD	Focus Group Discussion
GTZ	German Technical Co-operation
IQCCE	Improving quality of Care through Continuing Education
HCs	Health Centres
HMIS	Health Management Information System
HRH	Human Resource for Health
HSPS	Health Sector Programme Support
HSR	Health Systems Research

HSSP	health Sector Strategic Plan
ISQUA	International Society for Quality in Health Care
LGA	Local Government Authority
MCHA	Maternal and Child Health Aides
MCH	Maternal and Child Health
MHCP	Management Health Care Programme
MoH	Ministry of Health
MSD	Medical Stores Department
MuHEF	Muhimbili Health Exchange Forum
NQIC	National Quality Improvement Committee
NGOs	Non-Governmental Organisations
NIMR	National Institute of Medical Research
OPD	Out Patient Department
PI	Performance Improvement
PLWA	People Living with HIV/AIDS
PORALG	President's Office Regional Administration and Local Government
QC	Quality Circles
QI	Quality Improvement
QIRI	Quality Improvement and Recognition Initiative
RHMT	Regional Health Management Team
RMA	Rural Medical Aid
RMO	Regional Medical Officer
SWAp	Sector-wide Approach
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFPA	Tanzania Food and Drugs Authority
TOR	Terms of Reference
TQIF	Tanzania Quality Improvement Framework
QM	Total Quality Management
USAID	United States Agency for International Development
VHW	Village Health Workers
WHO	Word Health organization
ZTC	Zonal Training Centre

Foreword

The central challenge for Tanzania is to achieve maximum possible quality of health care consistent with available resources and system-wide objectives of equity.

The Quality Improvement Framework marks a very important development in Tanzania's effort to respond to this challenge. The main message from the framework is that quality of health care cannot be taken for granted; it is essential that a system be put in place to plan for the provision of quality care and to gauge the standard of care on a continuous basis. The approach used to develop the framework began with an assessment of relevant quality initiatives on the ground in Tanzania. It built on findings, emerging experiences and lessons. The approach has increased the relevance and usefulness of the framework for Tanzania.

The framework has also taken into consideration information and lessons learnt from quality improvement experiences of other countries. Thus the framework reflects current global thinking on quality improvement in health care.

The framework will be of use to planners, programme managers, providers of health care at all levels and other stakeholders in the public and private sectors to develop a culture of quality in health care.

The framework calls for action on all fronts, innovation, strengthening of appropriate quality improvement mechanisms at all levels of the health system, capacity building and use of sensitive quality improvement indicators, such as maternal health, to monitor progress. Given that there are many quality improvement initiatives on the ground, rapid implementation of the framework to enhance their coordination and unity of purpose is critical.

Three factors will enhance successful implementation of the framework. First is the interest and active participation of many partners in the development of the framework. It is hoped that the momentum gained will be maintained in the mobilization of resources and implementation of the framework.

Secondly, all districts and other health institutions have basic components to improve quality of health care; some districts and institutions may be more advanced in some aspects. Given good leadership, innovation and adequate mobilization as outlines in the framework, most districts and institutions can realize considerable improvement in quality of health care immediately.

Finally, specific activities to advocate, improve skills and strengthening structures and mechanism will be carried out over the initial three years (development phase of the framework).

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Executive Summary

Background

Tanzania has achieved considerable expansion of health services since independence (1961). The Health sector Reforms initiated in 1993 have made some progress in improving health services. But concern with quality of health care is widespread and increasing among the public, MoH and health staff. Tanzania does not also have a comprehensive national system of surveillance or reporting one the state of health care quality. Similarly, few health institutions (public private) have established a system of information to inform them about the quality of health care they are providing. This is the context in which the Ministry of Health (MoH) and partners decided to develop and implement a countrywide comprehensive plan to improve the quality of health care as a matter of urgency.

Development of framework

Development of the quality framework was carried out in two interrelated steps. The first step was documentation (with the help of an assessment team) of examples, experiences and lessons, from initiatives for improving quality in health care in Tanzania and globally. Information for the assessment was obtained from: Examination of MoH plans and documents; Interviews with decision-makers and relevant staff, and field visits to specific QI initiatives. Findings and lessons from the assessment are contained in a report entitled "Towards a National Quality Framework in Health Care: Experiences and Lessons"[1]. A quality improvement framework was developed in the second phase, based on and in response to findings from the first phase and a SWOT analysis.

The Framework

The framework begins with background information on health services in Tanzania and on different approaches for improving quality in health care. A review of common terms, currently in use in Tanzania and elsewhere, and their definitions as used in the framework is provided at the end of the framework. Quality of health care is defined as the degree of performance in relation to a defined standard of interventions known to be safe and that have the capacity to improve health within available resources. Quality improvement is defined as a systematic process of assessing performance of health system and its services, identifying shortfalls and causes, and introducing measures to improve quality and monitoring impact. Quality improvement policy guidelines include the private sector. Next, the framework outlines its "content" namely vision, mission, values, objectives and strategies for improving quality of care. Key values are: Caring for patients/clients; respecting professional ethics, and ensuring access to health care by all, with focus on community involvement.

Two unit features stand out in the Tanzanian quality Improvement Framework (TQIF). First, TQIF incorporate relevant principles and criteria from other approaches in Tanzania and elsewhere, particularly Quality Assurance (QA), Total Quality Management (TQM), International Organisation for Standardisation (ISO) and the European Foundation for Quality Management (EFQM). Secondly, TQIF contends that QI will not just happen. A system to coordinate, nurture and consolidate efforts on QI is critical for success.

To this end, TQIF considers strengthening leadership, structures and mechanisms that will develop, implement and sustain QI as a priority area. All in all, there are eight priority areas, each with one or more strategies. Each strategy begins with issues emerging from SWOT analysis and discussions among stakeholders and ends with an outline of remedial action. For example, the first priority area: "Strengthening leadership, structures and mechanisms that will develop, implement and sustain QI", has thirteen (13) strategies and a considerable part of the section on priority areas is devoted to this priority.

Other (seven) priority areas are: To enhance interest and active participation of all partners; advocacy for quality in health care; enhancing integration, sustainability and equity in health care; enhancing provider capacity and performance (training and skill development, recognition, rewards, and enhancing professional ethics); strengthening supervision, monitoring and surveillance; and mobilizing financial resources for quality and to facilitate evaluation of quality in health care through operational research.

Way forward

Regarding the way forward, two interrelated and mutually reinforcing approaches will be pursued concurrently. First, action will be initiated in all districts rather than starting with pilot projects in three or more districts or with some programmes like curative care and then preventive care, then training and so on. A close look at the strategies in the framework shows clearly that there are many improvements that can be carried out immediately, within available resources. Examples include, environmental and occupational health, reinforcement of regulations, empowerment of communities, improvement in medical ethics and the fight against corruption. All districts and other institutions have basic components to improve the quality of health care. Some districts and institutions may be more advanced in some aspects. Given adequate mobilization and determination, most districts and institutions can make considerable improvement in quality of care immediately!

The second approach is an initial development phase (three years) during which implementation of key activities to strengthen quality improvement structures and mechanisms on the lines outlined in the last part of the framework will be intensified.

The development phase will take a comprehensive approach. This is the biggest challenge to TQIF. Action needs to be fast, targeted and tactical to enable the framework to 'lead from the from'. For example, certification of health facilities is mandatory for the private sector, including NGOs, but not for the public sector. NHIF is establishing a

system for identifying facilities to be recognized for providing care. There are also discussions on developing a system for accreditation of facilities to provide treatment with anti-retroviral to PLWAs. The challenge for TQIF is to move fast and establish mechanism that will meet these needs.

Most funds can be used to develop a holistic accreditation mechanism that will met these and emerging needs. The development has also to lay foundation for operational research to find solutions to difficult issues.

1.0 Introduction

Tanzania has a decided to double her effort to improve quality of care for two reasons. First, despite considerable expansion of coverage and access to health services, quality of care remains a major concern of the Ministry of Health, health workers and the public. Secondly, Tanzania does not have a comprehensive national system of surveillance or reporting on the state of health care quality. Similarly, few health institutions (public or private) have established a system of information to inform them about the quality of health care they are providing.

1.1 What is the purpose of the framework?

The TQIF has two main purposes:

- To encourage all health workers at all levels and other stakeholders in the sector to develop a culture of quality in health care.

- To outline what needs to be done (based on experiences gained to date) to improve and institutionalize quality of health care in Tanzania, in different settings.

The framework is a dynamic process. It seeks to encourage actors in the health sector to develop innovative approaches for quality improvement, to implement them and pool experiences as a basis for identifying lessons and best practices. Best practices and lessons will, in turn, be a source of countrywide information exchange and inspiration, leading to a continuous process of quality improvement.

1.2 How was the framework developed?

This framework was developed by the MoH with active support and participation of stakeholders, including: regulatory bodies, academic institutions, professional associations, the private sector, NGOs and donors. The framework was developed in two phases. The first phase was documentation (with the help of an assessment team) of examples, experiences and lessons, from initiatives for improving quality in health care in Tanzania and globally. Information for the assessment was obtained from: Review of global literature; examination of MoH plans, reports, studies/research findings; interviews with decision makers and relevant staff and field visits to specific QI initiatives in Arusha, Iringa, Mbeya, Manyara and Tanga. Findings and lessons learnt from the assessment are contained in a report entitled, "Towards a National Quality Improvement Framework in Health Care: Experiences and Lessons"[2]. The second phase was developed of the framework based on and in response to experiences and lessons from the first phase. The framework is organized in five sections.

1.3 Who is the framework for?

The target audience of the framework include health providers, planners, programme managers, implementers, teaching/academic institutions, partners in public and private sectors and non-governmental organizations in the health sector. The framework will also be useful to health-related sectors.

1.4 What is in the framework?

The framework contains key elements for quality improvement in the health sector in Tanzania. The framework is laid down in eight priority areas. For each area of issue, recommended actions and activities are proposed (Table 2 shows a synopsis of the framework). Timely implementation of these activities will lead to a significant improvement of the health services quality.

2.0 Background Information

2.1 Approaches for provision of health services in Tanzania

After independence (1962), Tanzania adopted a health policy that aimed at providing health services to all Tanzanians free of charge. Focus was on construction of small health facilities (dispensaries and health centers), mainly in the rural areas, and training of large numbers of auxiliary staff to run them. However, increasing demands overstretched government resources, resulting in shortage of drugs and other logistical supplies, poor salaries and low staff morale.

2.2 Health sector reforms

2.2.1 Health Sector Reforms came about in 1993, implementation started in 1996. The second Health Sector Strategic Plan (HSSP) outlines national health policy objectives and nine strategies for the period 2003-2008[3].

2.2.2 **The vision** of health policy in the country is 'to improve the health and the well being of all Tanzanians with a focus on those at risk, and to encourage the health system to be more responsive to the needs of the people'.

2.2.3 **Policy objectives (2002)** are to: reduce the burden of disease, maternal and infant mortality and increase life expectancy; ensure that health services are available and accessible to all people in the country, urban and rural areas; sensitise the community on common preventable health problems; promote awareness on need for multisectoral action; create awareness through family health promotion; promote and sustain public-private partnership in the delivery of health services; and promote traditional medicine and alternative healing.

2.2.4 The nine strategies (under health sector reform) focus on district health services, secondary and tertiary referral services, role of central MoH, human resource development, central support systems, health care financing, public/private partnership and restructuring relationship with donors and HIV/AIDS.

2.2.5 MoH documents emphasise that Health Sector Reforms are a process with a long-term perspective.

2.2.6 The challenge for Tanzania is to provide health care within very limited resources. The latest available data shows that the per capita expenditure on health is US$ 9.6m, out which US$6.6m is public and the remaining is private expenditure[4].

2.2.7 HIV/AIDS is having serious effects on the health system. It has increased workloads and reversed the achievements in health improvement.

2.2.8 Growing interest in quality evaluation. A number of health programmes (including Laboratory, Reproductive Health, EPI and TB/Leprosy) have introduced aspects of quality improvement. There are also institutions (including, professional councils, Tanzania Food and Drugs Authority (TFDA), Government Chemist and Tanzania Bureau of Standards) that play a role in regulating standards of food, drugs and supplies, conduct activities of I to providers. More recently, some specific QI initiatives have been launched in Tanzania. Many of these are fairly new and it is, therefore, too early to assess their outcome.

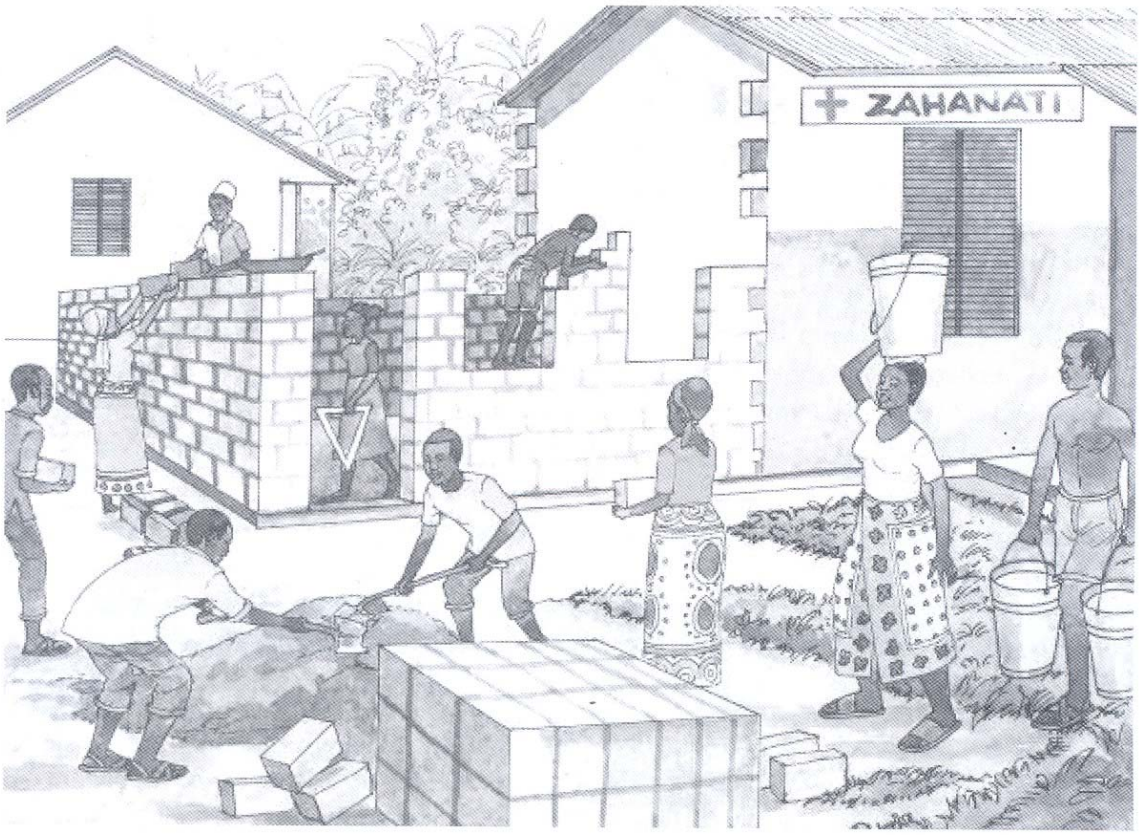
2.3 Approaches for improving quality of health care

The aim of this section is to enhance a shared understanding by partners on the concept of quality in health care and related approaches.

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

2.3.2 "Quality control" is mostly an external assessment, a form of inspection or "policing" (carried out by individuals or institutions outside the initiatives). The term "Quality Assurance" (QA) was introduced in the 1980s and has been in use since then. The concept of Total Quality Management (TQM) is more recent. QA has its origin from the medical profession and has been seen as mostly focusing on the assessment of clinical services. TQM has its origin in management and focuses on totality of systems, including services and management. Others see the word "assurance", as being presumptuous, promising something that one cannot deliver.

2.3.3 Terms used to describe approaches to improve quality of health care in Tanzania include: Improving Quality of Care through Continuing Education (IQCCE) at KCMC and Northern Zone; Managed Health Care Programme (MHCP) and TQM with the ELCT; Quality Improvement and Recognition Initiative (QIRI) in Iringa, Arusha and Manyara; and Comprehensive Quality Management (CQM) in Tanga.



Despite the use of different terms, the initiatives address a core of similar issues. These issues include rehabilitation and or construction of buildings for health facilities and staff, training of health workers, provision of equipment and supplies, support of supervision and monitoring systems, recognition of good performance and reward, prevention and control of infections, and community participation in health activities. This coherence in project activities reflects similarities in quality problems encountered in various parts of Tanzania. To avoid potential for the many terms confusing operational staff, it has been decided to use the term "quality improvement" throughout the framework (see glossary of terms).

2.4 Linkage of TQIF with other models

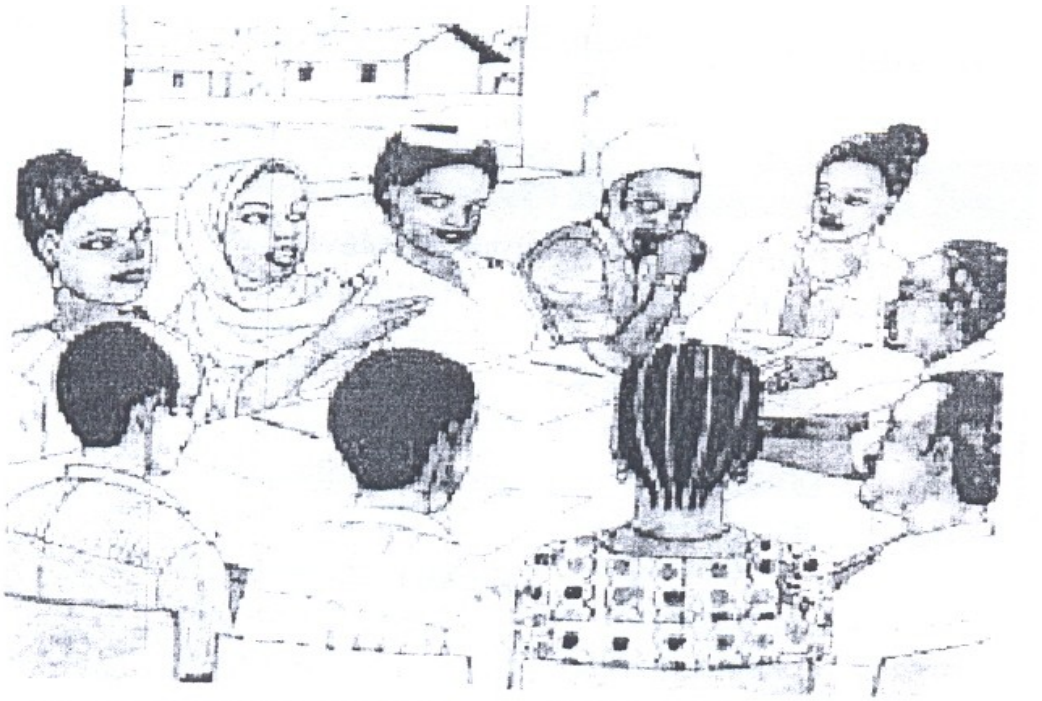
There are a number of approaches for quality improvement whose criteria are increasingly being "globalised" (used in a number of countries). These include ISO standards[5] developed by the International Organisation for Standardisation for use in the services industries. The standards have modified for use in health sector as quality management system standard ISO 9004: 2000. The second example is the European Foundation for Quality Management (EFQM)[6]. The MoH has reviewed the issue of whether Tanzania will adopt the global criteria or develop her own. It

has been decided that a Tanzanian framework 9TQIF) building on relevant principles and criteria behind different models should be developed.

It is clear from the above while the terms previously used to describe quality improvement approaches may have had different meanings, they are not increasingly used interchangeably or as synonyms in description of the activities of different or even the same initiative. The effectiveness of quality of health care initiatives depends heavily on context and how they are applied. Approaches used matter less than how and who uses them. Lessons from literature on concepts and terms can be summarized as follows: "The most important thing is to know what they do, not what they call it"[7].

2.5 Quality tools

There is a vast range of tools that can be used to assess and improve different aspects of the quality of health care. The specific tools used depend on local and national situation. They are part of a system of quality improvement and they cannot stand alone. The tools vary in extent of complexity, some are very simple. It is for the decision-makers to decide on appropriate tools from the menu in the context of their need and quality system. Common tools, including clinical guidelines, FGDs and quality circles, are defined in the glossary of terms.



Focus group discussion may play an important role in improving health services in the community.

3.0 Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

This section outlines the strengths, weaknesses, opportunities and threats from the pooled experiences collected in the first phase and discussions between stakeholders. Key issues that need priority attention are identified. Summary of SWOT analysis is presented in the following table. For detailed analyses, reference is made to the document entitled. "Towards a National Quality Framework in Health Care: Experiences and Lessons". It is available at the Quality Assurance Unit, Ministry of Health.

Table 1: Summary of SWOT findings: Strengths, weaknesses opportunities and threats

	Strengths	Weaknesses	Opportunities	Threats
National	• The development of QA scheme features strongly in Health sector reform, • Regular bodies exist, • Several QI initiative launched in the country, • Systems for recognition and rewarding good performance introduced for some cadres, • Several MoH programmes have initiated of QI.	• Lack of system to coordinate, nurture and consolidate QI. • QI initiatives are piecemeal, leading to 'tail wagging the dog' • Under-funding of health services, • Shortage of staff, inadequate motivation, • Inadequate skills for QI, • Sustainability in QI projects often an after thought • Supervision often inefficient and overworked, • New initiatives not taking advantage of existing efforts, • Negligible operational research.	• Changing role of MoH enhances its leadership role in QI, • Existence of MTEF for strategic planning on QI, • Existence of regulatory bodies, NGOs, health training institutions and growing private sector for enhancing QI, • Reinforcement/consolidation of various health Acts in favour of QI, • Existence of client service charter.	• Calls for more money and staff whenever QI is mentioned, • Profusion of terminologies and approaches by different initiatives with potentials for causing confusion, • Persistent under-funding of health services, • Decline in QI activities upon withdrawal of donor support.
	Zonal Training Centres: Service sin great demand.	• Clear definition of role of ZTCs not available yet.	• Ongoing discussions provide opportunity to define role.	• ZTCs trying to do everything.
Regional	• Mobilisation of public and private support for resources in some regions.	• Role of RHMT not clear, supervision not appropriate/targeted, • No organized system for QI, Poor feedback and exchange of information.	• Ongoing reform and discussions provide opportunity to define role of	• Prolonged delays on clarification of role.

Summary of SWOT findings: Strengths, weaknesses opportunities and threats
(continued)

	Strengths	Weaknesses	Opportunities	Threats
District	• Availability of budgets for running costs and drug-due to existing health basket funding, • Autonomy given at district level in planning, implementation, monitoring and evaluation, • Defined roles and responsibilities of CHMT.	• Relative neglected of environmental health problems as highlighted by endemicity of cholera, • Inadequte attention to certain areas, such as mental health, overall clinical skills, and non-communicable diseases.	"New" RHMT. • Pilot test on viable logistics for ensuring constant drug supply (ADDO).	• Power 'gets such at district level', • QI taken for granted.
Hospital, Health centers and Dispensaries	• Better supply of drugs, • Some hospitals have local mechanisms for staff skill development, • Benefit from additional resources, including basket funds.	• Shortage of staff, • Weak community focus, targeting (mostly) those coming to health facilities, • Ethical lapses/deficiencies, • Large proportion of untrained staff, • Exemption mechanism reported to be non-functional; high cost of drugs expensive in private sector.	• Successful initiatives in other sectors, • Existence of initiatives on which accreditation can build, • Infection prevention protocols in some health facilities (can build on).	• Hesitancy by CHMT to devolve power, • Inadequate capacity for planning, M/E at FLHFs.
Community	• Community mechanisms in place in health financing such as CHF, cost sharing etc, • Existence of community representatives in health facility governing committee and district health board.	• Weak community focus, minimal community participation and satisfaction, partner support uncoordinated, • Existing gender, socio-cultural inequalities and inequities hinder access to health services, especially reproductive services, • Community unaware of their rights.	• Growing public concern on QI, • Formation of boards/committees enhances community participation, • Local Government reform structures.	• Persistence of piecemeal support to community level, • • Inadequate capacity of providers to support community initiatives.

4.0 The Framework

TQIF reinforces the outlined strengths and opportunities while addressing weaknesses and threats. The framework also builds on information in the background and extensive consultations among stakeholders. The framework indicates: vision, mission, values, policies, objectives and strategies to improve quality of care.

4.1 Vision, mission, values, policy and broad objective for quality in health care

4.1.1Vision

The vision of quality in health care is to have a level of performance of health services that are effective, equitable, sustainable, affordable, gender-sensitive and user-friendly.

4.1.2 Mission

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

4.1.3 Values for QI

The values for quality improvement is to ensure that health services are provided efficiently with the following in mind:

- Care for patients/clients,
- Respect for professional ethics,
- Equitable access to health care by all with focus on community involvement and participation.

4.1.4 Policy guiding principles for QI

The TQIF involves both the public and private sector. MoH will provide leadership to enhance quality of health care, centred at individual/family and community levels. Capacity of infrastructure and leadership for QI will be strengthened at all levels of the health system so as to provide continually improving quality health services. Providers will undertake quality improvement in a holistic and integrated manner. MoH will advocate a stipulation in the constitution to ensure that health is a human right in Tanzania. This calls for Tanzania to ratify Article 3 of the Convention on Human Rights and Biomedicine.

4.1.5 Overall objective for QI

The overall objective of the National QI Policy is to provide essential health care to all Tanzanians at all times. This health care should be of quality, sustainable, of proven effectiveness, of acceptable safety and at a price that the individuals and the community can afford.

4.2 Priority areas and strategies

There are eight priority areas (4.2.1 – 4.2.8), each with one or more strategies. Each strategy begins with issues emerging from SWOT analysis and discussions among stakeholders. Table 2 shows a synopsis of the framework.

Table 2: **The Tanzania quality improvement framework**

Concerns	**Priority issues**	**Strategies**
Quality improvement is assumed to be everybody's responsibility. Lack of system to coordinate, nurture and consolidate efforts on QI.	1. Strengthening leadership, structures and mechanisms that will develop, implement and sustain QI.	1. To ensure that strong and transparent leadership in quality comes from all levels. 2. To establish QI Committee. 3. To Strengthen MoH technical focal pint. 4. To develop national resource centres. 5. To strengthen the role of RHMTs. 6. To strengthen the role of CHMTs. 7. To strengthen the quality of care in hospital 8. To strengthen the quality of health centers and dispensaries. 9. To strengthen community level action. 10. To strengthen environmental and occupational health 11 To strengthen quality focal persons/facilitators. 12. Strengthening referral system. 13. To support formation of maintenance/technical service teams.
Existing key actors lack vision while potential key actors have inadequate capacity for QI.	2. Enhancing interest and active participation of all partners to improve quality of health care.	To support MoH to pay a leading role in advocating QI and initiate and scale up dialogue with key actors.
Implementation of QI has been taken implicitly.	3. Advocacy for QI	To organize advocacy campaigns for QI with a focus at facility and community level.

Strategies for integration not adequately implemented. Most QI initiatives have sustainability issue as an afterthought. Ineffective exemption mechanisms lead to inequity in accessing health services.	4. Enhancing integration, sustainability and equity in health care.	1. To enhance integration of services. 2. To enhance sustainability of QI at all levels. 3. To intensity monitoring of equity in health care delivery.
Health facilities staffed by inadequate personnel in numbers and skills; lacking motivation; and eroded ethical and moral values.	5. Enhancing provider capacity and performance.	1. To intensify training and skill development for quality in care. 2. To introduce quality auditing. 3. To enhance recognition and reward for performance. 4. To enhance professional ethics and morality.
Supervision done but emphasis is on quantity and not quality. Standards and indicators for QI are lacking in the existing monitoring and surveillance systems.	6. Strengthening supervision, monitoring and surveillance.	1. To strengthen (supportive) supervision. 2. To strengthen monitoring system. 3. External monitoring to be carried out by higher level officials or assessment teams formed by the MoH and regulatory bodies. 4. To strengthen sentinel surveillance on quality of health care. 5. Facilitate dissemination of technical information and exchange of experiences.
Gross and chronic under-funding at all levels.	7. Mobilising financial resources for quality.	To design innovative resource mobilization strategies coupled with intervention strategies that enhance community empowerment and aim at tangible achievements that will appeal to stakeholders.
Agenda for research is weak and not based on needs. RHMTs and CHMTs lack capacity to conduct operational research.	8. Facilitate evaluation of quality in health care through operational research (learning by doing0 for QI.	To enhance capacity for operational research among members of the RHMTs and CHMTs.

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

Experience shows that while QI is everybody's responsibility, it is essential to define clearly who and what mechanism will do what.

4.2.1.1 To ensure that strong and transparent leadership in quality comes from all levels

Issue

Strong leadership, correct mindset and commitment by political leaders and senior managers to advocate, foster and participate in quality improvement are crucial for the success of QI. Interviews with leadership at different levels showed that many of them were either not familiar with or were not playing an active role to enhance QI.

Actions

MoH will provide overall leadership for quality in health care. MoH will work closely with partners in mapping and defining, on a continuous basis, the roles of different institutions, desired future quality of health care and the values that will guide actions along the way.

With the collaboration of partners, MoH will support different institutions and levels to carry out their responsibilities in QI. There are responsibilities that will be assumed by ZTCs, RMOs and RHMTs, DMOs and CHMTs, councils, hospitals, front-line health care providers, communities and individuals.

These institutions will be encouraged to develop their own QI initiatives that should be part of their annual work plan with their own budgets (in line with the ongoing health sector reforms). These initiatives should be guided by and be within the national framework and nationally agreed values, standards and indicators of quality of care.

Leadership at all levels is expected to inspire and motivate all involved in the provision of health.

4.2.1.2 To establish National Quality Improvement Committee

Issue

SWOT analysis showed that most quality of health care initiatives were piecemeal and not sustainable. Secondly, there is no mechanism to spearhead, guide and co-ordinate countrywide quality improvement efforts.

Actions

A National Quality Improvement Committee shall be formed to spearhead and guide the development and implementation of the framework. The committee will also spearhead action related to integration and equity.

The main functions of the Committee shall be to:

- Formulate and update periodically a National Quality Framework and enhance its implementations.
- Formulate national standards of services and processes and enhance compliance.
- Ensure that appropriate QI mechanisms are established at different levels.
- Support quality improvement mechanisms at different levels.

Advocate and support development of capacity and guideline and tools to enhance quality improvement at different levels.

Membership

The composition of National Quality Improvement Committee shall be determined by the Ministry of Health.

Secretariat

The Quality Assurance Unit (which is based in the CMO's Office), with the support of focal persons from each directorate of MoH, shall be the secretariat for the committee. The committee shall meet at least quarterly in the first three years.

4.2.1.3 To strengthen MoH – Quality Assurance Unit

Issue

Implementation of the framework calls for considerable coordinated technical capacity. Quality of some guidelines and technical materials prepared by different programmes is questionable.

Actions

The Quality Assurance Unit (QAU) will spearhead the QI process and support the QI committee. The QAU will incorporate key functions, including inspection, health system research, regulation and sentinel surveillance of QI issues, including equity. It will also be responsible for reviewing the framework to accommodate changes and new developments.

Specific functions include:

- Coordinating supportive supervisions to all levels in regard to QI issues.
- Collection and dissemination of national and international experience, techniques, data and references in regard to quality.
- Preparation of standards and guidelines.
- Review of all MoH-issued guidelines and publications to ensure adequacy of standards and compliance with policies.
- Coordination of Medical Audit procedures.
- Coordination of the resource centers.

- Coordination of QI related training at all levels.
- Developing IEC materials in regard to quality.

Strengthening the Quality Assurance Unit

Currently, the unit has a staff of two (a medical doctor who is a public health specialist and a nursing officer). To enable the unit to carry out the above tasks, it will be strengthened with key staff. The unit will also co-opt expertise from other departments/MoH institutions as need arise.

Each directorate should have a QI focal person. The head of the Quality Unit will coordinate the work of focal points related to quality improvement.

4.2.1.4 To develop National Resource Centres

Issue

Countrywide implementation of the framework will require extensive technical support. For efficiency and sustainability, it is essential to use existing structures (strengthened and mobilized as necessary) to provide the required support, avoiding (as much as possible) the creation of new institutions.

Actions

The resource centers will consist of all the zonal training centers, National Institute for Medical Research (NIMR), Ifakara Health Research and Development Centre (IHRDC), referral and teaching hospitals and the RHMTs. This network of resource centers will be coordinated by the QAU in issues related to quality improvement. Zonal Training Centres (ZTCs) have been charged by MoH with the responsibility for training and providing continuing education to health workers in their respective zones, with particular emphasis on capacity building for CHMTs. Whereas research institutes and some of the ZTCs have the capacity to conduct research relevant to improving quality of health care, RHMTs have the mandate to supervise CHMTs in the provision of health care services. Through the network, these institutions will be able to support each other and share experience in the development of training modules, conducting various courses and operational research.

The main function of resource centres in relation to QI will be to support the Quality Assurance Unit in the areas of capacity building, preparation of guidelines, carrying out appropriate assessments, operational research and dissemination of technical QI information within the Tanzania Quality Improvement Framework.

4.2.1.5 To strengthen the role of RHMTs

Issues

Aspects of the role and structure of RHMTs in the ongoing Health and Local Government Reforms are still under discussion between MoH and PORALG. CHMTs and lower levels require extensive QI advocacy and technical support. Such support is best decentralized, integrated into existing structures and provided by skilled and experienced staff.

Actions

RHMTs will play a leading role in supporting CHMTs. There will be a focal person in each region who, together with other members of the RHMT and competent staff at the regional hospital, will support district and hospital QI systems. RHMTs will carry out training, spot checks (including exit surveys), and operational research and provide feedback to MoH headquarters.

In additional to monitoring the performance of CHMTs, they will also sensitise political leaders, government officials and influential people at regional level. Considerable training and orientation of RHMTs on the new role for quality in health care is essential.

4.2.1.5 To strengthen role of CHMTs

In contrast to RHMTs, the role of CHMTs is well defined and has received extensive reviews by different bodies, including the Joint Health Sector Technical Review.

Issues

While quality of health care is mentioned in comprehensive council health plans (CCHP), there is no clear indication of specific strategies to monitor quality improvement. Integration/co-ordination of activities is weak. Some components of health care – including environmental and occupational health, control of some diseases (like cholera), clinical services and mental health – n districts are particularly weak. Quality making from CHMTs to health centers, dispensaries and communities remains problematic. Inputs of facility staff to the definition of policies and strategies at higher levels are minimal. While health strategies call for community-centered health care, experience from the field showed that supervision of facility staff concentrates on technical competence and qualitative goals.

Actions

There will be a QI focal person from the CHMT who will ensure inclusion of QI issues into the comprehensive council health plan in close collaboration with the CHMT. The Council Health Service Board will be involved in the elaboration of the quality-related issues to be included in the CCHP. To enhance efficiency CHMT, in collaboration with other stakeholders and staff at the district hospital, will co-ordinate/integrate activities (for example to supervise hospitals, health centers and dispensaries nearest to them, even where some belong to other agencies).

MoH, PORALG and CHMTs will advocate and make rapid effort to devolve power from CHMTs to health centers and dispensaries and community level. Persistent calls for decentralization from the district to FLHFs and community levels have been made over the last 30 years without a breakthrough. What is needed is a paradigm shift that will empower communities and FLHFs and focus action, resources and achievements at that level. This is one of the major challenges that the health sector reforms faces.

Special effort will be made to improve clinical skills of FLHFs. The new initiative for "Rehabilitation of health facilities"8 and establishment of Joint Rehabilitation Fund (JRF) provide unique opportunity to empower from line health facilities. Village governments will manage funds for rehabilitation.

The role of communities will be expanded to overall management of facilities and quality in health care. The CHMT will also develop an organized effort to enhance ethics and fight against corruption.

4.2.1.6 To strengthen the quality of care in hospitals

Issues

The poor quality of many hospitals is a widespread source for people's complaints. Poor quality at this level often results in dramatic or even fatal results. The population is particularly interested to see better quality of hospital services. Most hospitals do not have quality improvement systems. Skills among hospital staff to analyse and interpret routine data are inadequate. HMIS has a special system for routine data collection for hospitals. Experience shows a wide variation in levels of success in monitoring systems among hospitals. But there is no organized effort to pool and share experiences.

Actions

The role of MoH will be to set national standards for all facilities, including hospitals. MoH will provide a format for QI in hospitals, including national indicators and standards, building on available experiences and lessons. Individual hospitals may add other indicators and standards. The hospital board, through a focal person/QI Committee, will

carry out a situational analysis, and develop and implement a hospital quality monitoring plan. There are a number of standard formats/tools that can be used to monitor key processes.

The MoH will promote the Hospital Reform Process as described in the Hospital Reform Document. Furthermore, hospitals will be encourage to establish hospital development plans and action plans.

The establishment of Hospital Development Plans will guide the hospital management in their medium or long-term perspective for quality improvement, including infrastructure and rehabilitation. These plans, based on a thorough situation analysis, will contain sound and realistic objectives and activities aimed at achieving significant quality improvement over the timeframe of several years in a setting of limited resources.

Action plans will include QI activities for hospital management, for the client and for the providers. Planned activities for continuing education for all staff and earmarking a day in the week for continuing education sessions on selected topics will be included for the later.

Hospital Boards and QI Committee/quality circles will be found in all hospitals to facilitate a continuous process of quality improvement. Particularly committed staff members who want to see things changing will be encouraged to become members of QI Committee/quality circles regardless of their cadre. They will institute local mechanism for recognition and rewarding "best performance" by individuals and teams.

Plans to enhance ethics and to fight corruption and malpractice will also be prepared and implemented.

Training institutions will develop a specific training module for QI in hospitals. Hospital management will plan and budget for hospital staff to undergo such courses

4.2.1.7 To strengthen quality of care in health centers and dispensaries

Issues

Traditionally, health centres and dispensaries work on directives from higher levels (particularly CHMTs) – with negligible planning tasks. The work of staff mostly focus on providing care to those who come to facility with minimal outreach and population responsibilities. Technical competence of staff is weak in some areas, particularly clinical tasks. Low morale leads to low performance, which is visible to patients and community. The public made many allegations of corruption against staff in the field visits.

Adequate drugs and medical supplies are essential requirements for quality health services provision.

Actions

The capacity of facility health workers to develop plans that will involve the community will be strengthened. Shortage of staff limits outreach and community level support activities. This is an important factor but much more could be done given more training and support to facility staff. Training of facility workers will give priority to cadres that have been relatively neglected, for example clinical, environmental and mental health staff. FLHF staff will conduct self-assessment based on guidelines developed at higher levels. Strategies to make facilities user-friendlier will be designed with the assistance of the CHMTs. These may include starting on information board to display important information to the public on the work of the facility. Most health centers are quite large and some have premises that are scattered. This might require labeling of important places to enable patients locate them.. Where affordable, posting a medical attendant at the OPD – whose duty will be to direct and attend patients requiring assistance – will be considered. Finally, leadership at this and higher levels will develop and implement strategies to fight unethical and corrupt practices.

4.2.1.8 To strengthen community level action

Issues

Experience from field visits showed that leadership role of communities in health activities is generally weak as evidenced by low level of participation in planning, coordination, management and monitoring of local level health activities. In addition, gender inequalities existing in the community hinder access to health services i.e. adolescents and women. Support activities of different agencies are not integrated; making it difficult for communities to know the extent of support, coordinate it and participate fully.

Actions

With support from CHMTs, FLHFs will intensify involvement of the community infrastructure, including religious institutions, schools, traditional midwives, traditional healers, women's organizations and youth clubs in assessing quality of health care and development of community health action. An innovative example related to this approach is the formation of pressure groups through Community Action and Theatre Against AIDS (COMATAA).

The process begins with a village assembly at which the importance of a problem is outlined/discussed and followed by formation of six working groups (Adults: one male and one female; youth: one male and one female; school children: one male and one female.

All levels of the health system (particularly FLHFs) will make special efforts to support communities to increase their level of knowledge on important health problems and of remedial actions. Examples include malaria, HIV/AIDS, reproductive health and cholera.

Communities will also be supported to develop indicators, standards and monitor performance of health activities at the community level. For example, communities – with support of health centers and dispensaries – might assess whether all eligible children are immunized, all expectant mothers attend ANCs and whether exemption mechanisms are effective.

Communities will play a bigger role in the management of resources at health centers and dispensaries (through the facility governing committees and Council Health Services Board) and their own efforts. Facility governing committees will be strengthened to effectively voice community concerns about quality. In areas where the CHF has been started, members will be given authority to monitor staff performance as well as drug availability. All stakeholders will develop the culture of transparency, informing and involving communities in planning and management of activities, which they support.

The community needs to be empowered in planning, implementation and monitoring health services to achieve quality services in their locality.

Communities will be empowered with the understanding of their rights and responsibilities to help them negotiate and dialogue with service providers on quality of health care. This can be achieved by strengthening the local government participatory approaches and health sector reforms in addressing quality improvement through a right-based approach.

4.2.1.9 To strengthen environmental and occupational health

Issues

Whereas in other areas – such as Reproductive Health - considerable successes have been observed, with high antenatal and vaccination coverage rates, problems particularly persist in the area of environmental and occupational health. Disposal of human excreta is a slum area often takes place in open places and fields. This leads to contamination of water, which is a serious of disease, as evidenced by persistence of cholera. Most urban sewage is discharged untreated into nearest waterway.

There is inadequate clean water supply, both in urban and rural areas, and poor health care wastes management of all categories. Factories and mines release large quantities of heavy metals, toxic chemicals, solid, liquid, gaseous and hazardous waste into water. This leads to environmental pollution. Cases of poisoning have been reported in some fishing areas. The cause of poisoning is not clear. It might be due to shellfish poisoning caused by red tides, alga blooms that float in a brownish-red or dark green mass or other causes.

Residents and employees are exposed to hazardous toxic environmental and occupational pollutants but epidemiological information and environmental data management is weak. Air pollution from automobiles is increasing in the big towns and cities.

There are also some problems in human settlement development, including housing and inadequate private sector and community participation. Compared to other areas, environmental and occupational health issues have received less attention in the past.

Actions

MoH partners will analyse reasons for the present unsatisfactory situation followed by identification of remedial measures. It is crucial to assess the quality of cholera control activities, reasons for persistence and ways of overcoming current failures.

Cholera is a sensitive tracer indicator of environmental health. Other important areas that need analysis are impact of industrial pollutants on residents (particularly in urban areas) and health hazards in working environments.

Owing to the need for a serious “push”, urgent and intensified action in the area of environmental and occupational health, MoH will set up a high-powered task force to spearhead response. A new Environmental Management Bill will be tabled soon. Advantage need to be taken on the passing of the bill to launch an intensified initiative on environmental health.

4.2.1.10 To strengthen quality focal persons/facilitators

Issue

Quality improvement is often regarded to be everybody's responsibility without indicating who will do what and when.

Actions

To facilitate the implementation of QI activities at different levels; RHMT, CHSB/CHMT and hospital boards/management will appoint someone known as QI focal person or facilitator to coordinate quality monitoring (on a rotating or permanent basis). He/she will have the respect of staff, and have ability to facilitate teamwork.

They will also be allocated sufficient time to devote to the activity. Focal persons and directors of hospitals will be given priority for training and exposure to QI.

4.2.1.11 Strengthen referral system

Issue

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

Actions

Due to the complexity of the problem, situation analysis needs to be done to establish the nature and the cause. This will then be followed by the development of intervention strategies to be instituted at all levels of health care provision. These strategies may refer to the questions of how to deal with self-referred patients at hospitals level and how people referred by FLHF can be followed up at hospital level. This is a vital step for improving access to health services.

4.2.1.12 Formation of maintenance technical teams

Issue

Many hospitals have medical equipment that do not function due to lack of maintenance. This undermines provision of quality services. Medical equipment require specially trained technicians to service and perform minor repairs. While technical teams existing at national level are weak thus offering inadequate support to the lower level facilities, there are scattered efforts to form such teams in the zones and regions.

Action

Formation of maintenance technical teams should be encouraged while the existing ones, at national and zonal level, should be supported and strengthened.

4.2.2 Enhancing interest and active participation of all partners in effort to improve quality of health care

Issues

There is no shared vision, values and strategies for QI among stakeholders. Many potential key actors do not play an active role in quality improvement. These include professional associations.

Ability of many statutory reinforcement mechanisms is weak. Weakness in the private sector include, mushrooming of health facilities that are openly operated by business people with paramedical staff.

Many pharmacists and assistants dispense (prescribe) medicines that require prescriptions by physicians, sub-standard medicines and sell these drugs at high cost[9]. These presence of multiple (presently there are 13) legislations and guidelines which are not harmonized (some contradicting each other) add to the weakness.

Actions

MoH will intensify dialogue with regulatory bodies and associations, pointing out the unsatisfactory ethical and other professional deficiencies and need for rethinking prompt and sustained action. MoH will promote and support collaboration among regulatory bodies through the formation of a forum for exchange of information and experience.

In collation with stakeholders, MoH will review existing legislation and guidelines with a view to consolidating them and reducing their number. Already, the Private Hospitals Act of 1977 and the amendment of 1991, the Private Health laboratory Act of 1997, and Guidelines for the Establishment of Maternity Nursing Homes are being merged.

The Private Hospital Act of 1977 (amended in 1991) provides for the establishment of a Board responsible for registration, control and regulation of the business of private hospitals and of persons and organisations running private hospitals. Formation of the Board and related structures under the above and other Acts is evidence of a move from top-down, rule-setting approaches to more collaborative models of regulation on the lines recommended by researchers in this area[10]. However, the capacity of MoH will be strengthened to lead the process. The danger of the market leading the process has to be avoided. Statutory inspection on issues of quality covered by legislation will be intensified.

MoH will also enhance collaboration with the Tanzania Health Consumers Association, Dar es Salaam Health Boards Association and other NGOs in QI and related areas. MoH will advocate formation of Association/s on QI that can link with International Society for Quality in Health Care (ISQUA).

The stakeholders' QI forum (which has facilitated active participation, exchange of experiences and provided extensive input for the assessment of the present situation and development of the TQIF) will be continued at least for the next three years. Other relevant stakeholders (who have not participated so far) will be invited to future meetings.

4.2.3 Advocacy for QI

4.2.3.1 To organize advocacy campaigns for QI with a focus at facility and community level

Issues

Quality improvement is the cornerstone of Health Sector Reforms. Several strategies aiming at improving health services in general have been introduced. In the implementation of these strategies, quality has been taken implicitly. As a result, it has not been possible to ascertain the impact of the strategies on quality of care and no particular attention has been given to quality improvement.

The problem seems to be worse at the lower levels of the health care delivery system. QI advocacy issues include: health care as a human right, leadership, monitoring (indicators and standards) at community and other levels, equity, fighting exclusion (particularly women and adolescents) and integrated community health care.

Actions

National level will develop advocacy and IEC materials on quality improvement for countrywide dissemination. Advocacy and IEC materials will be pre-tested to suit local needs and with the ultimate goal of raising awareness about quality in health. Training of facilitators and staff, and consensus-building approaches are outlined under the section: 'Enhancing provider capacity and performance, The Quality Assurance Unit in collaboration with the Health Sector Reforms Reform Advocacy Unit and the Health Education Unit of MoH will carry out monitoring and evaluation of the effectiveness of quality information messages at the national as well as district level.

Dissemination of quality improvement information throughout the country will target community and frontline facilities using media that reach the target groups most efficiently. These may include radio, television and newspapers. Consideration will be given to starting a QI newsletter. The newspaper will carry information that is interesting and relevant to the target groups e.g. Performance assessment results for health workers, ethical disputes and disciplinary measures for the general community.

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

4.2.4 Enhancing integration, sustainability and equity in health care

4.2.4.1 To enhance integration of services

Issues

Despite MoH having integration strategies, implementation remains weak. CHMT traditionally consists of a team of 'specialists' for different programmes such as reproductive health, environmental health, TB/leprosy and clinical services.

This organization of tasks, which has been in operation for more than 20 years, has had a number of achievements. A big disadvantage has been 'verticalism' leading to inefficient use of resources and some programmes falling behind. A number of donors and external agencies advocate and support vertical programmes.

Initiatives by MoH to enhance of health services are generally weak. Most national health programmes have their own set of guidelines; there is no clear mechanism to coordinate development and standards of guidelines.

Action

Special effort will be made by MoH to enhance collaboration between different programmes in the development of guidelines and other products. The National Quality Improvement Committee and the Quality Assurance Unit will oversee the quality of guidelines.

A learning by doing initiative to improve integration of services will be carried out in 3 – 4 districts. The objective of the operational study will be to find more efficient ways of organizing tasks carried out by CHMTs. Among other things, the study will find out if it is more efficient and practical to assign individual members of CHMT with responsibility for geographical areas in a district. The assumption is that assigning a clear responsibility for all HFs within a geographical area to individual CHMT members will increase their commitment, effectiveness and job satisfaction.

4.2.4.2 To enhance sustainability of QI at all levels

Issues

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

Actions

MoH will emphasise that in the development of interventions, sustainability will be among the major priorities. QI will be integrated into the existing roles and responsibilities of all staff, but with clear definition of who will do what. MoH will specifically discuss with stakeholders on ways of ensuring the initiatives that they support, and others are sustainable.

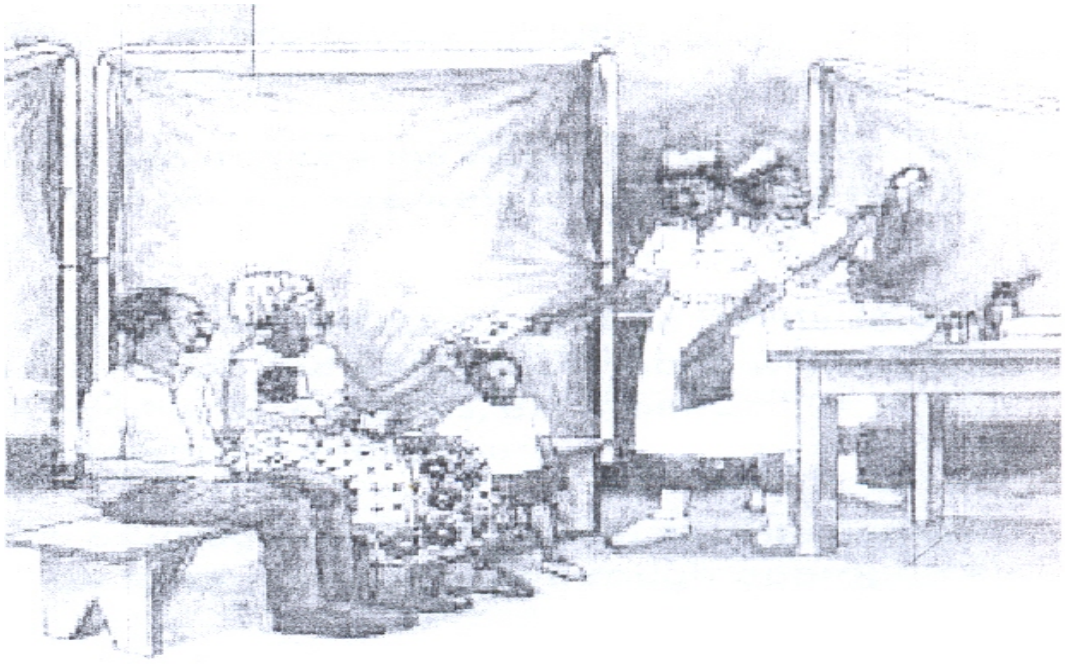
4.2.4.3 To enhance equity in health care delivery

Issues

The critical issue in equity is about eliminating unnecessary and unfair inequities in health and health care. Data on utilization of health care by social class (poor, poorest of the poor, the rich) and between risk and non-risk geographical areas in not available. The little data that is available shows that the situation is not satisfactory[11].

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

Available data shows that exemptions have not been successful in preventing exclusion of the poor from services[12,13]. A study in another country claims that health sector reforms are causing "sustainable inequities'[14].



The benefits of Community Health Fund (CHF), CHF members receive quality services.

The findings on equity in the literature are contradictory: One study concludes that in Tanzania "the current liberalized health care market displays a pattern of exclusion, impoverishment, abuse and poor quality care alongside substantial patches of accessibility and probity, while the government has few resources for inspection and control"[15]. Another study concludes that "With 23% of the total population exempted and getting free access to health care it can confidently be concluded that CHF programme has taken care of the equity issue"[16].

The issue here is that one cannot be sure that those exempted are the poor. *Studies in many countries show that it is the rich who are often exempted!* Yes, in another study poverty was cited by district officials as a major reason for people's failure to enroll into CHF[17]. In this study, exemption guidelines were reported to be neither understood nor followed by service providers.

A growing problem with cost sharing is that some health facilities also have another unsanctioned, "under the table" fee that goes to the pockets of health workers. This is part of the growing problem of corruption. The end result is that the patient pays two cost sharing arrangements.

Equitable financing basically means that the bottom 20% of the population pay no more than 20% of the total health expenditure.

Actions

The policy of Tanzania is to ensure that all Tanzanians have access to essential health care – those who can afford it will have access to additional services. Monitoring the implementation of this policy and impact of health sector reforms on equity in health and health care will be carried out using HMIS supplemented by sentinel surveillance.

MoH will review carefully results of the above and other studies as input to decision making results. MoH will also advocate and support the resource centers and other institutions to carry out ad-hoc studies in this area.

Review of the effectiveness of exemption mechanisms will be followed appropriate action. Consideration will be given to issuing exemption certificate/s (by villages), valid for use at all levels. These mechanisms will be enforced with by-laws.

Since exemption is a government policy, (but this can damage the viability of the community health fund and other insurance schemes) MoH will explore ways of cushioning this by paying for the poor through a special budget[18].

The government will further explore ways of expanding the resource base for the sector, for example, by promoting a National Health Fund. The Ministry of Health will seek to develop a mechanism for ensuring that such additional resources, e.g. from CHF or NHIF, can be fed back into the sector for quality improvement endeavours.

Other barriers to access to health care – such as geographical distance, communication problems and socio-cultural barriers – will be taken into account through appropriate measures.

MoH shall launch targeted intervention to address the rampant corruption, which also can be a barrier to health, against health care providers as part and parcel of TQIF.

4.2.5 Enhancing provider capacity and performance

4.2.5.1 To intensify training and skill development for quality in care

Issues

The approach to quality improvement, as outlines in the framework, is new to most health workers.

Training capacity regarding quality improvement is inadequate. There is also a rapid turnover of staff. Many basis training programmes for health workers do not include QI concept.

Guidelines are available for many areas but minimal for clinical care. Dissemination and communication on clinical care standards in inadequate.

Actions

Training will use a cascading approach. The national level training will concentrate on the development of a critical mass of health personnel who can provide leadership and technical support to the local level. Priority will be given to key staff at central level, Resource centers, RHMTs, and directors (and facilitators) of hospitals to participate in such training programmes, resource centers and RHMTs will in turn train CHMTs and later support training for the lower levels. Given the urgency of the matter, the first training for ToT for members of the Quality Assurance Unit, focal persons at central level and key members of the resource centers will be conducted by consultants.

For the purpose of sustainability resource centers and in particular Zonal Training Centres and RHMTs, will conduct and coordinate all quality-related training activities.

The QAU, in collaboration with the Human Resources for Health Department, will develop training material or training modules for quality improvement in the country.

One or two-day consensus building and training activities will be organized for all levels of health care personnel, including the top management. In order to ensure all staff is trained in a cost-effective way, on-the-site training will be conducted to all staff by their immediate supervisors.

Attitude and ethical issues in health care will feature in all training and consensus building activities. A culture of leaning, making continuing education to be seen as the responsibility of the individual health workers, needs to be developed. Collaboration with various councils, institutions and health professional associations are essential for the development of such a culture. Professional advancement must be seen as mandatory and a system of re-registration to ensure compliance with standards' needs to be instituted.

Emphasis will be on training teams (this is essential for sustainability) rather than individuals. In addition to building providers' capacity on medical ethics, emphasis will be placed on the providers' roles and responsibility as a "duty bearer" and rights of the user/client as a "right holder".

Training institutions will be encouraged by Quality Assurance Unit to prepare training modules and sample reference materials on QI. Besides the specific skills of QI, other areas, including medical ethics and operational research, will also be included. Theory and practice of QI will be incorporated in medical and paramedical training institutions' curricula.

Resource center will be encouraged and supported to develop, adapt, revise and disseminate clinical guidelines and standards.

The large burden of training for the expansion of QI on the lines demands much attention, innovation (in such areas as training design), co-ordination and mobilization of adequate resources. There is no doubt that advocacy and training are key challenges to TQIF. A working group of stakeholders on training and mobilization of required resources will be created.

4.2.5.2 To facilitate introduction of quality auditing

Issues

Maternal health is a good indicator of quality of health services offered. In Tanzania, maternal mortality has remained quite high for a considerable period. Clinical meetings are reportedly being conducted in hospitals. However, the effectiveness of these meetings remains obscure. Laboratory quality auditing system was once on exemplary model. With time, the system has deteriorated leaving referral hospital with the responsibility but without the necessary support.

Action

Quality auditing should be introduced for the various services offered, starting with areas that have shown some effort i.e., clinical and laboratory services. Quality auditing for maternal health and mortality will be intensified. Experience accrued should then be used to implement quality auditing in other areas.

4.2.5.3 To enhance professional ethics and morality

Issue

Ethics and morality are dropping drastically.

Actions

Professional associations will be required to declare their values, explicitly, so that their members can be clear about what the organization stands for.

The role of regulatory mechanisms, including health professional councils in quality improvement, will be made more explicit and a complimentary strategy (to the framework) development.

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

Teaching institutions will play an active role in finding out some of the root causes of the lapse on ethics. For example, is adequate training in this area provided? What is the role of peer examples?

Furthermore, the culture of medical audits after each case of death will be promoted by the hospital management teams. Appropriate actions will be taken case of professional negligence.

Furthermore, the culture of medical audits after each case of death will be promoted by the hospital management teams. Appropriate actions will be taken in case of professional negligence.

In addition, communities need an effective structure/body (for example the hospital/facility governing committee) to which they can address their complaints.

4.2.6 Strengthening supervision, monitoring and surveillance

4.2.6.1 To strengthen supportive supervision

Issues

Lessons from the field showed that supervision is done at all levels. However, emphasis of supervision was more on quantity (number of visits) rather than quality.

The term “supportive supervision” is used by supervisors with little understanding of its content. Consequently, supervision was found to have little impact on performance improvement.

In other districts, supervision seemed to be overworked with paperwork. This involved filling in lengthy checklists instead of focusing on supporting and imparting knowledge and skills through continuing education. In addition, the capacity of CHMTs to conduct adequate supportive supervision is inadequate.

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

Actions

Zonal training centers will take a leading role in training members of council health management teams on a continuous basis. ZTCs will organize short courses. CHMTs will plan and budget locally for members to participate in the short courses.

Guidelines for supervision will be revised to include supportive supervision. Districts can delegate supervision of dispensaries to health centers that have adequate capacity. Supportive supervision will not be overworked with lengthy evaluation activities for awards. The guidelines will specially the roles of supervisors at different level.

The Ministry of Health shall coordinate the development of tools to facilitate and improve the process of supervision, such as – assessment and peer – assessment.

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

National trainers will take part in the dissemination of the guidelines to the regions and district. The MoH and RHMT will monitor effectiveness of supervision through 'spot checks' and evaluation (see monitoring and evaluation). Best performers will be rewarded accordingly (see rewarding and motivation strategies). Operational research in regard to such topics as different ways of enhancing the quality of supervision will be encouraged.

4.2.6.2 To strengthen monitoring system

Issues

There are no explicit national standards and indicators for monitoring quality improvement.

The HMIS is a routine data collection system aimed at measuring performance of health services at various levels. There, also, exit numerous systems for routine data collection for specific programmes/projects. Some vertical programmes utilize data collected for monitoring performance at the national level. The use of data collected at district level in monitoring performance (quality improvement) is limited. Collecting a lot of data that is not used de –motivates health care workers.

Weak monitoring for millennium and PRSP goals

If progress is made in implementing the eight strategies of this framework, a contribution towards the Millennium Development and PRSTP Goals is expected. However, current monitoring systems to measure this progress remain weak.

Existing indicators have quality improvement aspects though not explicitly. Some of the key data on QI cannot be obtained through the HMIS because it would be too costly to collect it countrywide.

Actions

MoH will establish national standards and tracer indicators for quality improvement in consultation with various specialties. Individual Institutions also need to establish their own standards within the national framework. There is need to harmonise information systems and support utilization of data. There is also need to develop indicators for monitoring performance (quality improvement) to serve the purpose of national level. This will involve, identifying regions/districts and areas that need special attention.

Indicators may include availability of drugs, maternal health, client satisfaction (quality circles/FGDs), utilization of services by population groups (geographical and social stratification) and other tracer indicators of quality in health care.

As an arm of the MoH in the new set up, the regional level will use national level indicators in monitoring performance (quality) improvement in the respective regions. It will incorporate indicators in the appropriate source of data by revising the HMIS.

From time, to time information that requires more expertise will be contracted out to National Bureau of Statistics and research institutions.

HMIS/NSS guidelines would be revised to include QI indicators and its use. CHMTs skills will be developed to enable the development of indicators that will be used them in monitoring performance. ZTCs and other training institutions will offer short courses in monitoring and evaluation that will include the use of data to improve quality of care. ZTCs will facilitate the development of indicators of local relevance at the council level. With facilitation from the ZTCs, CHMTs will support health centers, dispensaries and community to identify their own indicators. For quality to work, people need information about their own practice, clinic or hospital, about best practices and about how to adopt them.

Thus, internal monitoring (self-assessment) will be carried out by institutions themselves to measure the degree of compliance on standards established locally or at higher levels. Among other things, monitoring at the village level will include areas of weaknesses that require targeted support. Monitoring at the district level include identification of villages and areas lagging behind.

For a at various levels for peer review, in which health workers will share results in performance (quality) monitoring and experience behind successes, will be created.

Special efforts will be made to generate adequate data for monitoring and evaluation of health components of the 13 Millennium Development Goals and Targets.

Relevant data from different sources, particularly Population and Housing Census and Poverty Monitoring System (PMS), will be generated.

At the national level, MoH mechanisms - such as National Quality Improvement Committee (NQIC), SWAp, HSR secretariat, Basket Financing Committee, Ministerial Management Meeting, Bilateral and Multilateral Forum, HSPS Steering Committee; National Health Research Forum, RMO's Annual Conference, Professional Association's Annual Conferences, Joint Review Missions, and Strategy Co-ordinators Meeting will monitor their performance (quality) improvement regularly.

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

4.2.6.3 External monitoring to be carried out by higher level officials or assessment teams formed by the MoH and regulatory bodies

Issue

There is no overall accreditation mechanism that is valid for the public, private and voluntary providers in the health sector.

Activities

Through licensure and other mechanisms, facilities will be assessed on the extent to which they meet standards. Information on standards and indicators for external monitoring/assessments as well as results from the assessment will be widely disseminated.

Regulatory bodies will promptly address deficiencies emerging from external assessments. (See also section on capacity building).

Accreditation, the most commonly used external assessment mechanism, is a programme/process by which an authorised national body/mechanism assesses and recognises that a health care institution meets applicable, pre-determined and published standards.

Accreditation decision is made following a periodic on-site evaluation of a health care institution/facility by a team of peer reviewers, typically conducted every two to three years. Because accreditation is a requirement of many re-imbursement schemes, many health care provider institutions have moved quickly to obtain them. In contrast to licensure (which focuses on meeting minimum standards to assure public safety), standards are set at a higher level to stimulate improvement over time.

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

There are about 33 accreditation programmes in 29 countries (end of 2001), mostly in Europe and Americas. Global experience shows three options for accreditation mechanisms:

- Voluntary/independent bodies as in Australia, Canada, USA and South Africa (the Council for Health Services Accreditation of Southern Africa (COHSASA);

- "Integrated model" where membership and funding comes from government and other sources, as in the case of the Zambia Accreditation Council.

- Bodies that are completely external to, but funded by, government (France, UK, Japan, Indonesia and Thailand).

After review of different options it has been decided to adopt the integrated model, modified as necessary. The advantage of this option is that it builds on existing mechanisms.

An Accreditation council (comprising of representatives of existing regulatory mechanisms including medical, nursing and other councils as well as other individuals selected by the Minister of Health) will be established as a matter of urgency.

The council will be responsible for the accreditation of hospitals and other health facilities for general care and for special care, such as ARV treatment for people living with HIV/AIDS. Quality of facilities, staff and activities will be among the key requirements.

4.2.6.4 To strengthen sentinel surveillance on quality of health care

Issue

HMIS sites will be used for surveillance of some of the components of quality of health care. At the same time, it will be too costly to collect all the required data countrywide.

Actions

Sentinel sites will be used to collect date that will supplement that from HMIS. The National Sentinel Surveillance System has a number of sites scattered across the country. Data will be obtained through existing sentinel sites as much as possible. Aspects of monitoring related to the Millennium Development Goals and targets will be included in sentinel surveillance, where appropriate.

4.2.6.5 Facilitate dissemination of technical information and exchange of experiences

Issues

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

Actions

MoH Resource Centre will make special effort to collect available data on quality in health care from different sources - including HMIS, AMMP, TEHIP, Global Literature and other sources. Data will be analysed and disseminated. Tanzania is not an island. The country can benefit through dissemination of success stories from other countries.

In the facilitation of information, the MoH need to capitalise on the use of electronic medical records. Advantage will be taken on existing efforts, such as the Muhimbili Health Exchange Forum (MuHEF) established by the Muhimbili University College, to disseminate information. Regular annual report on quality of health care will be prepared and disseminated to relevant stakeholders. The MoH will examine potentials of a newsletter. Exchange visits between regions and districts will be encouraged and supported. Finally, there is the MoH need to advocate and support districts to document and exchange experiences between villages.

4.2.6.6 To enhance efficiency in the use of resources

MoH has developed a formulae for resource allocation. The formulae relates to population size and burden of disease.

Issues

There is no systematic assessment of how resources are used to highlight opportunities for more efficient allocation. Areas of possible waste include: inappropriate admissions, delays in carrying out investigations and clinical procedures, wastage of drugs, and medical errors.

Faced with many competing bids for internal resources, managers tend to stick previous levels of allocation with minimal consideration of how efficiently resources have been used in the past.

Action

Intensify assessment of resource usage through utilisation reviews. Reviews will include assessment of hospital bed use and percentage of bed days that were inappropriate.

4.2.7 Mobilising financial resources for quality

A number of good examples of initiatives to mobilise the private sector to provide additional funding were observed in the field. Secondly, basket funding is proving a success in solving operational issues like availability of drugs. Two inter-related issues emerged from SWOT.

Issues

First, there are calls for more staff, more drugs, equipment and money whenever an issue of quality in health care is raised. Secondly, there is gross and chronic under-funding of services at all levels.

Actions

MoH and stakeholders will emphasise innovation to address QI improvement issues. Experience shows that many deficiencies observed in the field could be corrected by simple and inexpensive methods such as better use of available time, data and guidelines. Secondly, given good leadership it is possible to mobilise resources to improve quality.

A good example from the held is the rehabilitation of health facilities in the Arusha Regional Hospital, and elsewhere, with funds mobilised from the private sector.

Development and implementation of TQIF will mostly use available staff; the challenge will be to mobilise adequate leadership, training providers and to establish required structures. Appropriate amounts of funds for the development phase will be mobilised and budgeted for.

Better financial management and accountability in health services require skills personnel.

Chronic under-funding of health services works against overall improvement of quality. This issue is a permanent agenda for MoH. But time has come for stakeholders to rethink the issue of chronic under-funding of health services and identify ways of mobilising additional resources, including establishment of a health fund that could be used to support key quality improvement activities in both the public and private sectors. It will be useful to examine possibilities of establishing a National social Health Insurance Fund in future.

The later is difficult in the present economic situation. Experience from a neighbouring country (Kenya), which is in the process of establishing a National Health Insurance Fund, will be of great interest to Tanzania.

A paradigm shift in the health sector, giving prominence to community empowerment and visibility to tangible achievements at the community level (see section on 'Strengthening community level action') is likely to be appealing to stakeholders and enhance provision of additional resources.

4.2.8 To facilitate evaluation of quality in health care through operational research (learning by doing) or QI

Issues

General aversion to operational research/learning by doing. "We are so busy, we want to implement, and we have no time to waste'.

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

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

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

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

Actions

Given scarcity of resources, large volume of health problems and their urgency, it is understandable that the preoccupation of leaders and providers of health care is on implementation. The danger with an exclusive focus on short-term activities is a ping-

pong movement moving from one crisis to another. It is important for leaders to invest in operational research to find solutions to difficult issues. Even if some findings cannot be implemented immediately, they will indicate the direction of effort.

Research information will be widely disseminated from a central location and the library. Development of a Website will be encouraged. MoH will also collaborate with established initiatives such as Tanzania Website, and Muhimbili Health Exchange Forum (MuHEF).

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

Operational research to facilitate informed decision-making will be developed at all levels. Complex issues and those of national interest will require research at the national level.

Basic operational skills will be included in the provider capacity building within TQIF. Initially, support will be focused to the resource centres and RHMTs.

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

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

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

ZTCs and other training institutions will be supported to offer short courses in operational research/research methodology.

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

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

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

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

5. Implementation and Way Forward

The challenge of TQIF implementation is at crossroads. The first route is to extend existing initiatives and or start new ones over the coming years, monitor progress and use findings to extend coverage countrywide. The second route, which is the one selected, is immediate countrywide expansion.

Majority of QI issues identified, such as cleanliness of facilities, accessibility, working hours of facilities, availability of drugs, availability of laboratory services and privacy in facilities, unethical behaviour and corruption can and will be addressed by relevant health services levels and institutions immediately. Secondly, experiences gained from various initiatives in Tanzania provide adequate information and tools for all districts to build on. Finally pooling of experiences, as has been done in "towards" document, provides lessons upon which individual initiatives can act.

Two mutually supporting approaches will be used concurrently to advocate and support implementation of the framework. First, once MoH has launched TQIF, copies will be sent to all RHMTs, CHMTs and other relevant institutions with covering memos calling for action in relevant areas. All districts and other institutions have basic components of QI, some districts and institutions may be more advanced in some aspects. The framework provides a roadmap with several elements. But progress is unlikely to be uniform in all elements and hence the need to monitor each element. Given adequate mobilisation and determination, most districts and institutions can make considerable improvement in quality of care now!

Secondly, specific activities (See section 6) to advocate, improve skills and strengthen structures and mechanisms will be carried out over the next three years (development phase). The development phase will take a comprehensive approach. This is the biggest challenge to TQIF. Action needs to be fast, targeted and tactical to enable the framework to enhance comprehensiveness and "lead from the front". For example, certification of health facilities is mandatory for the private sector, including NGOs, but not for the public sector. At the same time, a number of programmes have or are considering establishing systems for accreditation of facilities to provide special types of care. The challenge for TQIF is to move fast and establish a framework that will meet these needs.

6.0 Key Activities on Tanzania Quality Improvement Framework

Priority 1	**Strengthening Leadership, Structure and Mechanisms that will Develop, Implement and Sustain Quality Improvement**			
Level	**Activities**	**Timeframe**	**Responsible**	**Indicator/s**
National	A. **Establish National Quality Improvement Committee: A committee of major stakeholders will meet regularly (at least 4 times a year) to oversee implementation of the framework.**		CMO's office	
	1. Preparation of ToR.	1st year	CMO's office	ToR available
	2. Regular meetings.	Continuous	CMO's office/Professional associations	Number of meeting minutes in a year
	3. To map and define, on continuous basis, the role of different institutions' desired future in quality of care and values.	1st year	CMO's office	Number of meetings where minutes shows roles of various institutions discussed.
	4. Identification of members of committee and orient them on their roles & responsibilities.	1st year	CMO's office	Names of members appointed/orientation report.
	B. **Strengthening of National Quality Assurance Unit**			
	1. Provide QI training for QAU members.	1st year	CMO's office	Number of staff trained in QI At least 75% of QAU members trained on QI.
	2. Develop/review guidelines on the role of FLHFs and community levels in quality improvement.	1st year	CMO's office	Reviewed Guidelines available.
	3. Provide training in operational research for local persons.	1st year	CMO's office	At least X % of focal persons trained in operational research.
	4. Review/develop national standard guidelines for quality of care. Develop/review guidelines for vertical programmes to enhance integration of services.	1st year	CMO's	Reviewed Guidelines available.

LEVEL **National**	**C. Strengthening QI focal persons:** **The MoH will organise regular meetings to be attended by local persons, one from each department, agency, zonal training centre and referral hospital. Focal persons will be trained, preferably local, with support from institutions in Tanzania and neighbouring countries. ZTCs will act as an aim of the MoH in the training and retraining of health staff on QI issues. They will thus make their own plans that will be supported by the MoH headquarters.**			
	1. Identification of departmental and zonal local persons.	1st year	CMO's office	Appointment by name/designation available.
	2. Quarterly meetings for local persons.	Continuous	CMO's office	Meeting minutes/documents available or in place.
	3. Zonal training centres planning meetings.	1st year	Heads, ZTCs	Meeting minutes/documents available or in place
	4. Facilitate QI training for local persons.	1st year	CMO's office	X % of staff trained in QI
	5. Facilitate training for local persons in operational research	2nd year	CMO's office	X % of staff trained in operational research
	D. Establish resource centres: ZTCs and selected institutions will form a network that will be supported to ensure that they have capacity to fulfill their roles according to findings from a needs assessment.			
	1. Identification of institutions other than ZTCs.	1st year	Quality Improvement Committee	List of institutions identified available.
	2. Conduct needs assessment in order to identify the strengths and weaknesses of the various resource centres.	1st year	CMOs office	Needs assessment report.
	3. Strengthen the weak institutions to enable training on QI.	1st year	CMOs office/DHTF	Amount of fund for QI activities advanced to institutions.
	4. Develop tool to be used for community advocacy and empowerment on QI and health as human right.	1st year	CMOs office/Advocacy unit	Advocacy tool, plan and report in place.

	E. Develop Task force for implementation of environmental and occupational health strategies			
	1. Developing TOR for the task force.	1st year	CMOs office/OPS	TOR document
	2. Identification of members of the task force.	1st year	CMOs office/OPS	Task force members named.
	3. Stakeholders meeting to chart out way forward.	1st year	CMOs office/OPS	Meeting report.
	4. Support implementation of the strategies.	2nd year	CMOs office/OPS	Amount of funds disbursed.
	F. Conduct situational analysis to establish the nature and cause of referral problems			
	1. Conduct situation analysis of the nature and cause of referral problems	2nd year	CMOs office	Situation analyses report
	2. Develop implementation plan to address referral system for patients/clients as well as problem issues	2nd year	CMOs office	Plan containing problem issues.
	3. Support implementation of the plan	3rd year	CMOs office	Amount of fund disbursed.
	G. Formation of maintenance technical services teams			
NATIONAL	Support the existing team at national and zonal centres	Continuous	CMOs office/DHS	Amount of fund disbursed.
REGIONAL	Support formation of technical services teams in the regions	Continuous	CMOs office/DHS	Number of technical service teams formed and functioning.
REGIONAL **Regional Health Management Team**	**A. Strengthening capacity for QI implementation: This will include 4 RHMT members and 4 from the regional hospital (Voluntary regional hospitals to be included). In regions with training institutions, more members can be incorporated. To increase capacity of the members to perform, the regional will budget for them to attend short training on various QI - related issues. Training QI has been incorporated into the cascade training in the section entitled "Enhancing performance".**			
	1. Identification focal persons.	1st year	RMOs	Presence of local person
	2. Formation of QI sub-committee.	1st year	RMOs	Committee formed and working
	3. Develop plans and budget for QI.	1st year	RMOs	Plans containing QI issues.
	4. Quarterly meetings.	Continuous	RMOs	Minutes containing QI issues

	B. Building Capacity of regional QI sub-committee to conduct raining of QI-related issues:			
	1. Needs assessments in the region.	1st year	RMOs	Needs assessment report
	2. Training member of RHMT and focal persons on QI.	1st year	RMOs	X % of RHMT's/Focal persons trained on QI.
	C. Capacity to conduct research on QI:			
	1. Training support staff in operational research.	2nd year	RMOs	X % for support staff trained on Operational Research
COUNCIL **Council Health Management Teams**	**A. Strengthening capacity to implement OI: This will include 7 members of CHMT and a selected number from the district hospital (the number will vary by district depending on presence or absence of adequate hospital staff). The councils will budget for the implementation QI activities in their council's health plans. They will also set a budget for the QI sub-committee and other CHMT members to attend QI and QI related training to be offered through ZTC and other institutions.**			
	1. Identification of fofal persons.	1st year	Council MOs	Appointment letters of local persons by names and designations.
	2. Formation of QI sub-committee.	1st year	Council MOs	Subcommittees formed and working.
	3. Conduct situation analysis on QI with support from ZTC/RHMT.	1st year	Council MOs	Situation analysis report.
	4. Develop implementation plan for QI.	1st year	Council MOs	Plan containing QI issues
	5. Conduct advocacy to FUHFs and communities on QI.	1st year	Council MOs	Advocacy report.
	6. Advocacy and initial training of Qi sub-committees and CHMT members on quality improvement.	1st year	Council MOs	Number of QI subcommittee trained.
	7. Conduct continuing education to health facility staff on QI-related issues.	2nd year	Council MOs	Number trained.

HOSPITAL Level	**A. Strengthening capacity to implement QI: A team of about 7 people will form QI Committee that will serve as a sub-committee of the hospital board. Members to come from hospital management team, hospital board and neighbouring institutions.**			
	1. Identification of local person	1st year	Hospital in-charge	Presence of focal person
	2. Formation of sub-committed	1st year	Hospital in-charge	Sub-committee formed and working (meeting minutes)
	3. QI Committee: to set plans, strategies and budget.	1st year	Hospital in-charge	Plan containing QI issues.
Level	**Activities**	**Timeframe**	**Responsible**	**Indicators**
	4. Training of methodology to conduct assessment of quality including client exit interviews.	2nd year	Hospital in-charge	Number trained.
	5. Training QI focusing on sell assessment, inspection and control (ethics).	2nd year	Hospital in-charge	Number trained.
FRONTLINE HEALTH FACILITIES (Health centers & dispensary)	**B. Strengthening capacity to implement QI: A team comprising of the HF incharge and 2 members from HF Committee to form to form at HF sub-committee responsible for QI issues.**			
	1. Identification of focal person by CHMT.	1st year	HF in-charge	Appointment letters of focal persons by names and designations.
	2. Formation of QI sub-committee.	2nd year	HF in-charge	Sub-committee formed and working (meeting minutes)
	3. QI Committee: to set plans, strategies and budget.	2nd year	Council MOs	HF QI issues featuring in the CCHP.
	4. Training on QI focusing on self-assessment, quality control and ethics.	From 2nd year	Council MOs	Number trained.
COMMUNITY	**A. Strengthening capacity to implement QI: Members of Village Health Committee to spearhead QI activities in the village**			
	1. Sensitisation meetings.	2nd year	Council MOs	Number of sensitization meetings held.
	2. Participate in developing IEC materials.	From 2nd year	Council MOs	IEC material development by CHMT with involvement community.
	3. Involvement in environmental sanitation monitoring.	From 2nd year onwards	Council MOs	Environmental Sanitation Monitoring reports.
	4. Training members of VHC on QI focusing on self-assessment, quality control and ethics	From 2nd year onwards	Council MOs	Number trained.

Priority 2	To Enhance Interest And Active Participation of All Partners in Effort to Improve Quality of Health Care			
Level **NATIONAL**	**Activities**	**Timeframe**	**Responsible**	**Indicators**
	A. Support QI among Associations: Professional associations to be supported to enable them develop plans and meet regularly.			
	1. Conduct meeting of professional associations to formulate a network in order to have a joint forum.	1st year	CMO's office	Meeting report.
	2. Support planning meeting of the network.	1st year	CMO's office	Plans containing QI issues.
	3. Support network strategies.	1st year onwards	CMO's office	Proportion of planned activities implemented.
	4. Support association meetings with QI themes.	2nd year	CMO's office	Proceedings featuring issues.
		1st year	CMO's office/Association heads	Meeting report.
	B. Support regulatory bodies: Weak regulatory bodies to be supported financially, materially and human resource in developing plans for QI and implementing some of the strategies.			
	1. Conduct a meeting of regulatory bodies to formulate a network.	1st year	CMO's office/Registrars	Meeting report.
	2. Support planning meetings of the network.	1st year	Quality Implementation Committee	Plans containing QI issues.
	3. Support the regulatory bodies' network strategies.	2nd year	CMO's office	Amount of money disbursed X% of planned activities implemented.
	4. To have regulatory bodies up to council level to control malpractice and patient complaints.	Continuous	CMO's office/Registrars	Number of districts with regulatory bodies.
	Enhance active participation of stakeholders by Maintaining the ongoing stakeholders meetings at least once a year.			
	1. Stakeholders meetings.	Continuous	CMO's office	Meeting reports.

Priority 3 **Level** **NATIONAL**	**STRENGTHENING ADVOCACY: (To be done at national and local levels), in order to maximize efficiency, advocacy campaigns need to be done during cascade training on QI. However, since the target for advocacy is wider and the number of days are few, a separate budget will be prepared at national, hospitals, FLGFs & community levels. Similarly, dissemination activities will be integrated with other QI information – such as standards, performance and research findings.**			
	Activities	**Timeframe**	**Responsible**	**Indicators**
	1. Develop tools and conduct needs assessment.	1st year	Advocacy Unit –HSRS	Needs assessment report.
	2. Develop & pretest advocacy materials on QI and strategy for dissemination.	1st year	Advocacy Unit – HSRS	Materials and strategy development.
	3. Launching of framework with advocacy materials.	1st year	CMO's office	Launching done.
	4. Advocacy meetings for staff at MoH.	1st year	Advocacy Unit – HSRS	Meeting reports.
	5. Advocacy during annual meetings (OMOs, RMO conferences, RCHS, professional associations, health institutions)	1st year and Continuous	CMO's office	Proceedings containing QI issues
	6. Stakeholders' meetings.	Continuous	CMO's office	Meeting reports.
Level **REGIONAL**	Advocate for QI through regional consultative meetings.	1st year Continuous	RMOs	Meetings reports.
DISTRICT	Stakeholders meeting through existing consultative meetings (to include CHMT, CMT, Council Health Board, Council Social Committee).	1st year Continuous	Council MOs	Meeting reports.
HOSPITAL	Advocacy meetings for HWs at Referral and regional hospitals 9include voluntary and private hospitals)	1st year Continuous	Hospital in-charge	Meeting reports.
FRONTLINE HEALTH FACILITIES (Health Centres & dispensaries)	Initiate advocacy meetings for HWs at FLHF by CHMTs.	1st year	Council MOs	Number of advocacy meetings.
COMMUNITY	1. Regions and councils to start creating community awareness on QI through village assemblies.	1st year	Council MOs	Number of CHMTs assisted
	2. Advocacy meeting to community on QI and health as a human right.	1st year and Continuous	Council MOs	Number of meetings held.

Priority 4	**Enhancing Integration, Sustainability and Equity in Health Increase Access to Health Care Services: Deliberate efforts targeting the vulnerable groups (poor, disabled, women, youths, children, elderly) to access health services. Access should take into consideration aspect of physical, social, and financial access to health services.**			
Level	**Activities**	**Timeframe**	**Responsible**	**Indicator/s**
NATIONAL	**1**. Conduct literature reviews of existing studies on sustainability and equality to health services and draw appropriate conclusions to improve equity.	1st year	CMO's office	Report.
	2. Design effective mechanisms ot improve access to health services, including exemption mechanism.	1st year	Director PP	Revised exemption guidelines.
	3. Conduct quarterly meetings for vertical programmes' managers.	2nd year then Continuous	CMO's office	4 meetings held in a year.
Priority 5	**Enhancing Provider Performance (Training on QI Issues):** Targeted to key actors such as ToT, focal persons, in-charges. Training to be conducted in modules with initial training focusing on QI followed by subsequent training on other QI-related issues such as health management, supportive supervision, monitoring and evaluation, and research methodology. CE courses to be prepared by ZTCs and other institutions, CHMTs and hospitals to budget for their staff to attend the course. A technical group of stakeholders will oversee and mobilize resources for activities.			
Level	**Activities**	**Timeframe**	**Responsible**	**Indicators**
NATIONAL	1. Form stakeholders' working group on capacity building: • Training ToTs on QI (a team totaling about 50 ToTs from MoH, ZTCs RHMTs, and teaching hospitals). • Consensus meeting on national quality indicators 9these will include equity indicators) and monitoring mechanisms. • Development of protocols. • Develop training manuals. • Develop facilitation guidelines. • Revise curricula to include QI and QI related issues e.g. supportive supervision, monitoring and evaluation.	1st year	DHRD	Materials development.
	2. Start to Strengthen the capacity of ZTCs to be able to address QI issues with consultants	1st year	DRHD	
	3. Incorporate QI issues in pre-service training curriculum.	2nd year	DHRD	
	4. Dissemination and distribution plan for manuals and guidelines.	2nd year	DHRD	

	5. Zonal and National TOTs to train HWs at referral hospitals.	2nd year	DHRD	
	6. Continuing education on:			
	- Supportive supervision	2nd year onwards	DHRD	Number trained.
	- Research methodology.	"		
	- Use of routine data for monitoring, evaluation and decision-making.	"		
	- Quality management	"		

	- Other courses to be decided based on the needs assessment and trained by ZTCs, other training institution, and RHMTs e.g. Teaching methodology, management of district health services.	"		
REGIONAL AND COUNCIL	CHMT (including Council focal person) and co-opted staff to train FLHF staff with support from zonal and RHMT TOTs.	2nd year	Council M's	Training reports.
HOSPITAL	1. Zonal and National ToTs (from hospitals) to train HWs at referral and regional hospitals.	2nd year	CMOs office	Training reports.
FRONLINE HEALTH FACILITY	1. Councils ToT to train FLHF staff with support from Zonal, RHMTs and National ToTs.	2nd year	Council MOs	Number trained.
	Introduction of Quality Auditing: Meeting to be held to discuss maternal and infant mortality will be enforced and the result will be evaluated at regional and national level.			
NATIONAL	1. Support Quality audit meetings on maternal and infant mortality at district level by national experts.	2nd year then Continuous	CMO/QAU	Quality audit meeting report/document in place. Reduced MMR and IMR at the district (long term).
	2. Logistics support for laboratory/clinical/preventive services quality control at regional and district level	1st year Continuous	DHS	Amount of money disbursed.
DISTRICT	Logistics support for laboratory/clinical/preventive services quality control at regional and district level	Continuous	Council MOs	Amount of money budgeted for laboratory QC in CCHP.
	Remuneration, Rewarding and Ethics (Designing incentive schemes): General packages to be developed and implemented at national level. Specific strategies to be developed and implemented at Council level.		Director HRD	Amount of money budgeted for laboratory QC in CCHP.

NATIONAL	1. Advocate appropriate remuneration	1st year	CMO/DAP	Revised document implemented.
	2. Designing appropriate incentive schemes: general packages to be developed and implemented at all levels.	1st year	CMO/DAP	Incentive scheme in place.
	3. Revise existing incentive and rewarding mechanism (e.g. timely promotion).	1st year	CMO/DAP	Revised incentive schemes.
	Recognition, incentives and reward: Development of tools has been incorporated in the section 'Monitoring and Evaluation'. However, districts will have to adapt the mechanisms to fit their local situation.			
	RECOGNITION, INCENTIVES AND REWARDS		DAP	
NATIONAL	1. Develop models for rewarding and motivation of staff.	1st year	Council MOs	Document developed and disseminated to councils.
COUNCIL	1. Develop models for rewarding and motivation of staff.	2nd year	Council MOs	Assessment tool developed and used.
	2. Identification of best performers.	2nd year onwards	Council MOs	Best performed identified.
	3. Procure materials rewards.	"	Council MOs	Prizes procured
	4. Support rewarding ceremonies.	"	Council MOs	Best performers rewarded.
	ETHICS			
NATIONAL	1. Regulatory bodies to develop/review professional code of conduct and disseminate widely.	1st year	CMO	Proportion staff accessing code of conduct document.
	2. Ethics subject to be incorporated in pre-service training curriculum & CE.	1st year	CMO/DHRD	Curriculum for various health professionals contains 'ethics'.
	3. Regulatory bodies should be given autonomy.	1st year then ongoing	CMO	Bill giving regulatory bodies autonomy.
	4. Professional associations be supported in advocating ethical issues.	Continuous	CMO	X % of professional associations supported financially/materially for advocacy of ethical issues.
	5. Encourage regulatory bodies to conduct assessment to identify roof causes of ethical erosion.	Continuous	CMO	Assessment Reports.

Priority 6	**Strengthening Supervision, Monitoring and Evaluation**			
Level	**Activities**	**Timeframe**	**Responsible**	**Indicator/s**
NATIONAL	**A. Strengthening effectiveness of supervision:** ZTCs and other training institutions to establish courses on management of health care services that includes supportive supervision as one of the major components. RHMTs and CHMTs to budget for their participation in the course.			
	1. Revised and hamonise supervision guidelines.	1st year	CMO/QAU	Revised supervision guidelines.
	2. Orient regional and district levels on new supervision guidelines.	1st year	CMO/QAU	Number of CHMTs oriented.
	3. National team, RHMT & ZTC to support councils to conduct supportive supervision.	2nd year onwards	CMO/QAU	Number of CHMTs supported.
	B. Strengthen capacity for monitoring and evaluation: This includes development of relevant tools and training. The latter was incorporated in the section on 'Enhancing Performance'. Note that RHMT (with the assistance from the ZTC staff) will support, through coaching, CHMTs in conducting effective supervision after the initial training.			
	C. Development and implementation of QI tools:			
	1. Identify indicators for implementation of the 8 priority areas of the TQIF.	1st year	CMO/QAU	List of indictors available.
	2. Revise/adapt/develop guidelines & standards and the respective indicators for quality improvement at all levels.	1st year	CMO/QAU	Standard tools and indicators developed and disseminated.
	3. Develop self assessment tool.	1st year	DAP	Self assessment tool developed and disseminated.
	4. Develop performance assessment tool.	1st year	CMO/QAU	Performance assessment tool developed and disseminated.
	5. Revision of the HMIS and NSS tools to incorporate QI indicators.	1st year	DPP	Revised HMIS and NSS tool disseminated.

Level	Activities	Timeframe	Responsible	Indicators
	6. Support internal monitoring for QI and self-assessment.	2nd year onward	CMO/QAU	Assessment report.
	7. Facilitate orientation of health workers at all levels on the use of performance tools and self assessment tools.	2nd and 3rd year	CMO/QAU	Number of facilities oriented.
	8. Conduct/contract evaluation of QI activities.	3rd year	CMO/QAU	Evaluation report.
	D. Develop accreditation system: Accreditation council to be formed using the integrated model. The Council will require support from the MoH.			
	1. Formation of the Accreditation Council	1st year	CMO/DHS	Document showing a list of names of members appointed to the Council.
	2. Preparation of Council working plan.	1st year	CMO/DHS	Working plan available.
	3. Conduct regular meetings.	Continuous	CMO/DHS	Number of regular meetings conducted.
	4. Conduct site visits to evaluate health facilities.	2nd year then continuous	CMO/DHS	Number of HFs evaluated/quarterly reports.
	5. Publication and dissemination of reports primary health care.	3rd year then continuous	CMO/DHS	Quarterly/Annual report.
Priority 7	**Mobilising Financial Resources for Quality**			
	Activities	**Timeframe**	**Responsible**	**Indicators**
	1. Conduct need assessment to determine resource needs: - human - financial - supplies/equipments infrastructure	1st year	CMO/DPP	Needs assessment Report.
	2. Explore new approaches for increasing the resource base in the sector e.g. National Health Fund, National Social Health Insurance Fund, CHF.	2nd year	CMO/DPP	Document detailing new approaches for increasing resource available.
	3. Mobilise community, including private sector, to contribute in improving the quality of primary health care.	1st year	CMO/DPP	A strategic document for mobilization available and or mobilization reports
	4. Lobbying to political leaders to provide resources for QI.	1st year	CMO/DPP	Lobbying strategic plan/document available.
	5. Improve resource utilisation by harmonizing similar health activities.	1st year	CMO/DPP	Harmonisation activities or report in place.

Level	Activities	Timeframe	Responsible	Indicators
	6. Mobilise internal and external partners to contribute resources to improve quality to health services.	1st year	CMO/DPP	X % of internal/external partners contributing to Improved quality health services.
Priority 8	**To Facilitate Evaluation of Quality in Health Care through Operational Research (Learning by Doing) for QI**			
NATIONAL	**Supportive operational studies:** Funds will be required to support operational research at all levels. Training on Research Methodology for regional, district level and hospital staff has been included in the section on 'Enhancing Performance'.			
	1. Identify areas of priority for operational research for QI.	1st year	CMO/DPP	List of priority areas for operational research.
	2. To encourage Contract agencies to conduct operational research in QI.	Continuous	CMO/DPP	Studies reports.
	3. Budget and conduct operational research based on local problems	Continuous	CMO/DPP	Studies reports
COUNCIL	1. Budget and conduct operational research based on local problems.	2nd year onwards	Council MOs	Studies reports.
	Dissemination Of Information And Reports Strategy: This includes dissemination of QI general and technical information as well as reports from monitoring, evaluation and operational research.			
NATIONAL	1. Launching of QI initiative.	2nd year	CMO	Number of workshops conducted.
	2. Disseminate information on QI through various media:	From 2nd year onwards	CMO	Name and type of media used.
	- Workshops.			QI issues in Website/s.
	- Mass media			
	- Website (Collaboration with MuHEF/Ifakara).			

	Enhance exchange of experience among peer groups and disseminate relevant information to stakeholders and general population.			
Level	**Activities**	**Timeframe**	**Responsible**	**Indicators**
NATIONAL	1. Support peer review meetings at national level.	2nd year	CMO	Meeting reports.
	2. Establish network through website.	2nd year	CMO	Network established.
	3. Dissemination of standards, indicators and assessment results.	2nd year	CMO	Document showing where and to whom the standards, indicators and assessment results were disseminated.
	4. Preparation and dissemination of annual reports and newsletter.	2nd year	CMO	Annual reports prepared and disseminated to stakeholders.
REGIONAL	1. Conduct peer review meetings at regional level.	2nd year then Continuous	RMOs	Meetings reports.
COUNCL	1. Conduct peer review meetings at district level.	2nd year then Continuous	Council MOs	Meeting reports.

Glossary of Terms

Clinical governance (which has its origins in United Kingdom) is a system through which national health service organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating on environment in which excellence in clinical care will flourish.

Clinical practice guidelines are standards and guidance to improve medical practice. The guidelines are developed, through consensus, by MoH of by specialist societies, councils or associations and endorsed by MoH.

Community consists of people, living in the same area (for example rural or urban communities), with similar occupations or interests (such as farmers, pastoralists, fishermen, employees and self-employed small and big business people) or the same origin (Europeans, Asians) or tribes[12].

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

European Foundation for Quality Management (EFQM) made is non-prescriptive framework that recognises that there are many approaches to achieving sustainable excellence. The model's framework is based on nine criteria: Leadership, policy and strategy, people, partnership and resource, processes, customer results, people results, society results, and key performance results. Using these nine criteria, the quality performance of any institution, firm or authority can be evaluated.

Indicator is a measurable variable or characteristic that can be used to determine the degree if adherence to a standard or achievement of quality goals. Examples of indicators (for different aspects of health care) are: Bed occupancy rate (overall and by clinical disciplines), average length of stay (overall and by clinical disciplines), percentage of deliveries by caesarian section, percentage of outpatients, undergoing x-ray examination, percentage of children below one year who had

completed third dose of DPT immunisation, percentage of visual defect detected among Standard 1 school children, and passing rate of examination.

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

Statutory inspection is a process carried out and enforce compliance with laid down policies, regulations and standards. It is usually a one way process (in contrast to supervision which is ideally a two way process).

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

Quality improvement (QI) is a systematic effort to improve the quality of health system development and the delivery of health care services, including all methods of performance assessment of the people. It involves a systematic process to called information on performance of the health system and services, assessing performance trends, identifying shortfalls between performance and standards, determining the cause of shortfalls, introducing remedial measures to improve quality, and involving communities and other partners in this process in order to establish ownership and its sustainability.

Quality circles (QC) are small group(s) of workers (about 6-10_ persons) who meet regularly on a voluntary basis to identify, select and analyse work-related problems, focusing on those they can solve. The group(s0 act on the problems they can solve and put forward suggestions on solutions (for difficult issues) to the management for consideration and decision. Subsequently, they implement the decisions of the management.

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

The concept of **Continuous quality improvement** (CQI) emphasises continuity of effort and active identification of weaknesses as opportunity for improving quality.

The concept of **Quality care development** (introduced by the European Regional Office of the World Health Organisation in the early 1990s) is a dynamic process that encompasses the concepts of QA, CQI and TQM.

Total quality management (TQM) is a management approach, based on participation of all members of an organisation and aimed at long-term success through customer satisfaction and benefits to all members of the organisation and society.

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