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TANZANIA DISTRICT HEALTH MANAGEMENT ACTIVITY: QUALITY IMPROVEMENT AS A MANAGEMENT PRACTICE IN THE LINDI REGION

Background on district health management in Tanzania:

Until recently, quality improvement (QI) activities in Tanzania were focused through the community level providers. Health workers from facilities, dispensaries, and district hospitals formed QI teams and learned to manage performance improvement to provide higher quality care and services, and to achieve better health outcomes. With marked improvements in care that QI efforts have achieved in Tanzania and other countries, the leadership of the Lindi Region hoped to also build QI capacities in their district management teams with support from the Ministry of Health and Social Welfare (MoHSW). The vision was that not only would management teams be able to improve their own performance as managers, but they would also lead the strengthening of QI capacities in their respective districts' facilities, thus collectively raising the level of quality care and services, while also improving health outcomes throughout the region. Improvement may remain contained or isolated within only a few supported sites without the leadership to guide the process and to harmonize improvements across each district and region. Supporting the regions and their council health management teams (CHMTs) in strengthening this area of leadership, it is hoped that Tanzania will institutionalize a culture of continuous improvement and be able to track the resulting better health outcomes.

Working group at Learning Session, Lindi Region, Tanzania, July 2013
Photo: Allison Annette Foster, URC

What are the objectives of the Tanzania district health management activity under the ASSIST Project?

- To use a multi-factored approach to QI, including human resources for health (HRH) improvements, within all six districts of the Lindi Region;
- To enhance the performance of Regional and Council Health Management Teams (RHMT) and CHMTs in their functional domains—supplies and logistics, information flows, regional planning, HRH support—and in their capacity to implement QI practices and to support QI activities in the health facilities of their districts;
- To strengthen QI capacities in the district (council) health management teams (CHMTs) so that they may lead the institutionalization of improving care and effecting better health outcomes throughout the 192 faciliites of the Lindi region.
- To provide knowledge and evidence on the best approaches that will most positively affect improvements at the management level, so as to consistently support local-level improvements and to sustain the resulting quality of care and better clinical outcomes.

What was the purpose of the Learning Session in Lindi Region, Tanzania between July 1-2, 2013?

The purpose of the July learning session was to bring together CHMT members from 12 health facilities (two from each of the six districts) that would be oriented on QI practices and principles. The session aimed to share experiences among CHMT teams on their own QI practices, while also orienting health staff from the 12 facilities to this new approach. Another objective of the session was to reinforce the QI competencies of the CHMT members and further

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Indicator	Baseline Data	Current Status	Qualitative Findings
1) % of facilities that submitted supply orders and reports on time to the CHMT	December 2010: 4%	March 2013: 95%	• Training on how to properly fill out the Requesting and Reporting forms minimized unnecessary errors and back and forth movement. • Initiating reminder calls ahead of quarterly deadline reduced the number of late submissions.
2) % of supply orders and reports which were processed by the CHMT within two weeks of receipt and sent to the RHMT	December 2010: 82%	March 2013: 100%	• Clarification of expectations among CHMT members resulted in assigning tasks and accountability for following up with district facilities and submitting reports to the regional level on time.
3) % of management teams that self-report improved competencies in QI practices	March 2011: 0%	March 2013: 67%	• A series of learning sessions (LS) and coaching visits were conducted to focus on areas that CHMT members noted weakness, and thus the competencies have improved over time. • A recent LS (July 2013) gave opportunity to CHMT members to train facilities teams on QI, and to mentor them as they prepared action plans for developing teams and measuring baselines for target indicators.
4) % of newly recruited staff that are retained at 6 months	March 2011: 70%	March 2013: 90%	• It was learned that new-hires frequently quit their posts shortly upon arrival.
5) % of newly recruited staff that received a technical orientation within two weeks of reporting	March 2011: 53%	March 2013: 89%	• Increased efforts have been concentrated on providing technical orientation to new staff. • Through LS and coaching visits, CHMT members shared experiences and adopted the most effective strategies to retain new staff, such as orienting new staff within two weeks of staff arrival and budgeting and providing living stipends to new staff until formally approved on the payroll.
6) # of facilities adopting QI as part of their processes to manage their performance in delivering quality care	March 2011: 6 facilities	March 2013: 30 facilities	• By helping facilities form QI teams, CHMT supervisors transform their supervision styles to implement a coaching approach so that they can partner with the QI teams to raise the quality care and services and improve the health of their communities. • Health facilities will become more pro-active in achieving desired indicators that demonstrate improvements and thus ease the supervision burden of the CHMTs

improve their competency development. The CHMT members mentored their facilities teams in understanding QI, in designing action plans for each facility to form QI teams, and in developing plans for measuring baselines for each of seven HIV indicators identified by the MoHSW. These seven indicators for tracking improved HIV services and care are:

1. % of pregnant women attending ANC who tested positive for HIV and enrolled into CTC per month
2. % of exposed children under 18 months receiving daily Cotrimoxazole Prophylaxis per month
3. % of HIV+ patients on ART that are lost to follow-up per month
4. % of HIV+ patients from CTC receiving CD4 testing once every 6 months
5. % of HIV tested by DNA/PCR by the age of two months
6. % of children born to HIV+ mothers in PMTCT who received confirmatory tests at 18 months
7. % of HIV+ children initiated on ART treatment

What are the next steps?

- QI Advisors under the ASSIST project will support the CHMTs in their expanded roles as QI coaches to the facilities.
- ASSIST Advisors will explore expanded retention strategies with the CHMTs as they establish an additional indicator to monitor how many new staff remain at their post beyond six months.
- During coaching visits, QI Advisors under the ASSIST project, in conjunction with the CHMT and RHMTs, will begin to explore ways that CHMT members can strengthen their role as change agents.
- ASSIST Advisors will hold discussions with the CHMT and RHMT members about their ability to engage community leaders and civil society to influence social norms, such as gender relationships and lifestyle behaviors that impact the health of the populations in their districts.
- CHMT members will use their experiences supporting QI teams in the 12 facilities to apply lessons learned and aim to begin developing QI teams in added facilities.

What lessons learned have been acquired thus far?

- RHMT and CHMT members have witnessed positive results from the introduction of QI practices, which have been applied at some of the district hospitals in Tanzania.
- During the Learning Sessions, interviews with CHMTs revealed the desire of supervisors to provider better guidance and mentoring to their facility teams.
- Improving performance is sometimes constrained by larger system factors that are outside of the direct control of the RHMTs and CHMTs.