

**THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH**

**Quality assurance
training guidelines for
Health workers**

August, 2000

Foreword

The mission of the Ministry of Health is to provide the highest affordable quality of Health services. This quality assurance training guidelines for health workers have therefore come at an opportune time when the MOH has instituted the Health Sector Reforms which aim at improving the quality of health services delivered in the country.

This training introduces health workers to the concept of quality and it is hoped that after their training the management staff at the regional, district and facility levels will immediately institute quality improvement plans and endeavour to cultivate a sustainable culture of quality in the daily activities.

Continuous quality improvement will benefit the health sector in the following ways: Quality assurance focuses on assisting health workers to achieve full potential through improvement of the systems and processes through which health care is provided. Its primary goal is to support health workers rather than blame individuals for poor quality.

Application of quality of care methods enhances the performance of health personnel, helping to bring about more efficient use of the resources at their disposal even if the inputs are minimal.

Attention to quality of care helps to improve communication between health providers and users. This enables health providers to better appreciate the needs and expectations of the community and for the community to better understand what problems confront health workers and how the community may help health workers. Trust is thus built through the improved communication and this brings credibility to the health care delivery system.

It will nurture a team approach and build a team spirit among health workers on the one hand and between health workers and the community on the other. Improving team work and co-ordination will in turn, improve efficiency and performance of the health system. In so doing the morale and motivation of health workers will be enhanced and the confidence and co-operation of the community will be strengthened.

It will encourage commitment and sustained support for improved quality of health care beginning at the highest levels of management and extending throughout all strata. With time this will create a philosophy and culture of continuous quality improvement in setting standards and sustaining high levels of performance.

Through quality of care interventions, health systems and institutions can ensure greater satisfaction for their clients, better utilization of health facilities and a greater impact on the health of individual patients, communities and populations.

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Acknowledgement

The Ministry of Health would like to thank all the individuals and institutions who contributed towards the production of this Quality Assurance Training Guidelines for Health Workers. It is not possible to mention all of them as they are many. However, the Ministry of Health would like to acknowledge the following:

The Danish International Development Agency (DANIDA) for their financial support through the Health Sector Programme Support (July 1996- June 1999).

Heads of departments and sections in the Ministry for their active participation from the onset to the completion of this work.

The zonal centres for continuing education and Health institutions, i.e. CEDHA, Public Health Nurse School - Morogoro, MATC - Kigoma, PHC Institute - Iringa, Bugando Nursing School Mwanza and Mtwara which provided individuals who gave valuable inputs to the guidelines.

The members of the DHMT in Njombe district and the PHC Institute Iringa who pre-tested the document, for their commendable work and their valuable comments and suggestions. The ministry also appreciates the work of all individuals who invested much of their time to edit the various drafts of the document.

Finally, the MOH acknowledges the contributions and dedication of the following people whose hard work lead to the production of this document: Dr A Hingora, Ms Rose Shija, Mrs D Mbuya, Ms Linda Hanai, Ms Grace Mbekem, Dr A. O. Mwakilasa, Mr Moses E. Fusi, Mr M. Mdoe, Mr Rogers M. A. Shetui, Dr E. N. Chenya, Ms Mary Magomi, Dr V. Kipendi, Mrs Margreth Chitanda and Mrs I. Nyalusi. Special thanks go to Ms Mariam Kihangi and Ms Mariam Mkomwa for their secretarial services.

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ABBREVIATIONS

ARI	- Acute Respiratory Infection
ANC	- Antenatal Care
CBDS	- Community Based Distributors
DANIDA	- Danish International Development Agency
DD	- Diarrhoea Diseases
DMCHCO	- District Maternal and Child Health Coordinator
DMO	- District Medical Officer
DED	- District Executive Director
FHP	- Family Health Project
FIFO	-First In First Out
FEFO	- First Expired First Out
HSR	- Health Sector Reforms
STD/HIV	- Sexual Transmitted Disease/Human Immunodeficiency Virus
HMIS	- Health Management Information System
IMCI	- Integrated management Childhood Illness
IEC	- Information Education Communication
IMR	- Infant Mortality Rate
MMR	- Maternal Mortality Rate
MOH	- Ministry of Health
MTUHA	- Mfumo wa Taarifa na Uendeshaji Huduma za Afya
OPD	- Out Patient Department
PHC	- Primary Health Care
RHMT	- Regional Health Management Team
TB/L	- Tuberculosis and Leprosy
TBA _s	- Traditional Birth Attendants
VHW _s	- Village Health Workers

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Introduction

Tanzania is currently engaged in a process of reforming the Health Sector for improved quality of care.

The focus of the 1995/1996 Health Sector Reform Proposals were on improving the quality of health services offered to clients, community and the public in general which had deteriorated significantly. Quality deficiencies can be found at all levels of a health care system. Poor quality reduces the benefit to clients, frustrates and demoralizes health care providers and wastes valuable and often scarce health resources. A need to improve quality is therefore an essential component of an effective, efficient and responsive health care system. Also, since health services are now being paid for through the introduction of cost sharing, it is therefore important that the health system guarantees health services being offered to users meet the minimum acceptable standard of quality care.

With decentralization of health services to the district, the concept of quality assurance is now being introduced and being given a priority in the context of the reforms. The RHMT/DHMT will be trained in the concept so that they use it during their supervision. They will also be responsible for equipping the same to all the health care workers within their working areas.

This manual therefore is intended to guide trainers of the health system especially the districts in equipping them with sufficient knowledge attitude and skills on implementing quality care at all levels when training health workers at every health facility.

OBJECTIVES OF THE GUIDE

- To sensitize, district health teams/supervision teams on the concept of quality assurance in the context of the Health Sector Reforms.
- To improve the quality of health services system at all levels.
- To guide DHMTs in training and supervising health workers on Quality assurance aspects at all levels
- To assist health workers to apply the basic principles of improving quality care in order to deliver better health services to the users.

TRAINING DESIGN

This training is designed such that a multiplier effect on quality of care/quality assurance will be maximized from the national and regional levels down to the peripheral health care workers. The training should assume an integrated team teaching approach and encourage problem based and problem - solving approach which encourages and taps the vast experiences of individual team members. Exercises and examples given should relate to practical experiences relevant to participants' work environment and everyday work challenges and problems. Participatory group learning methods with hands-on-practical exercises should be encouraged. It is assumed that the trainers will be people with basic teaching skills to enable them to understand not only on "what to teach" but also "How to teach". Minimum training resources required under each unit are indicated to help the trainers and trainees teaching/learning process for better understanding and comprehension.

ORGANISATION AND CONDUCT OF TRAINING

Health reforms are calling upon decentralization therefore all the districts will be fully responsible for all the health activities within their districts.

Support will be given to the regions and districts for the initial training of quality assurance. Thereafter districts will include quality assurance training in their annual comprehensive district health plans. Therefore DHMT will be fully responsible for conducting training activities for the health workers at their working places at the facility level according to their district training needs and plans.

TRAINING OBJECTIVES

After the training the trainees should be able to:

1. Identify the strength and weaknesses of specific areas in the health facilities e.g. infrastructure, staff performance and availability of materials and equipment.
2. Apply the concepts and principles of Quality Assurance in solving the identified problems of health services area.
3. Develop inventory of the health facility in terms of human resource (number of staffs required, current position and staff qualification), materials and equipment and to make sure that these are according to the required standards.
4. Develop team work among the managers, facility health workers and facility workers with the community

DURATION OF TRAINING

The training will last 5 days of theories and practical exercises. Training will be conducted at places of work for the facility health workers. Training on site meets the learning needs of the staff and it makes it easier for trainees to apply newly acquired knowledge and skills at the workplace. It is easier for the trainees to focus on experiences and problems particular to them and therefore find solutions which will benefit them most. Training at the site also fosters team work among the staff. Since the trainers are also the supervisors, this assists them to see how they may support the facility or individual health worker. Also they may do follow up of problems identified to see if they have been implemented after the initial training.

Three or more nearby facilities may be trained at the same time for cost effectiveness and also as a way of forming support groups which will help each other even after the training.

TRAINING METHODOLOGY (APPROACHES)

Training for health workers will be done at the health facility using reference materials from their facility e.g. MTUHA data and other district data.

The use of various participatory teaching methods like small group discussions, brainstorming, case studies, role play, field visits, reflective learning and lecture - discussion are highly recommended in the facilitation of Quality Assurance.

EXPECTED TRAINING OUTCOMES

1. Health workers will be able to understand and apply the quality of care concept and standards in solving problems at their working areas.
2. Health workers will be able to have a quality assurance plan of work with standards and indicators, defined at their place of work for judging quality of care.
3. Health workers will be able to make supervision plans better for improving the quality of care. At the same time supervisors will be able to provide supportive or facilitative supervision to the facility health workers.
4. Health workers will have mechanisms for ensuring quality of care e.g. having integrated supervision teams and participation of community committees.
5. Participants will be able to organize integrated services in their health facilities for improved clients flow to minimize waiting time.
6. Participants will be able to design standards guidelines and checklists at their facility to improve quality of care. These will be used together with those prepared at the national level.
7. Participants will be able to work as a team recognizing each others role and supporting each other

UNIT I: CONCEPT OF QUALITY

TOPIC: QUALITY AND STANDARDS OF CARE

1. INTRODUCTION

Quality is a common word, which is used as a judgment of excellence in several situations. It can also be considered as doing the best with resources available or expressed as doing the right thing in the right way at the right time.

Contents of this unit will highlight quality in the health care context and how it can be measured and also the cost of poor quality. Similarly, they will learn on the use of standards.

2. OBJECTIVES

By the end of this unit trainees should be able to:

1. Define Quality and Standard
2. Describe the components of quality care
3. Describe categories of quality care
4. Describe the costs of poor quality
5. Describe characteristics and levels of standards
6. Use standards in their work

3. QUALITY

3.1 Definition of terms

Quality is a measure of how good something is. Something has quality if the object or the service meets or exceeds the expectations of the user. In health services there are various definitions of quality:

1. The quality of health service can be defined as the delivery of care following the standards which has been set. A standard is a statement of what is expected to happen or to be provided. For example the MOH has set guideline standards for health facilities. It is important that each facility should aim at reaching the standards at their level in terms of essential equipment, supplies, personnel, buildings and rooms where staff work etc.
2. Quality can also be defined in the way things are done i.e. "doing the right thing in the right way at the right time". For example if the correct diagnosis of malaria is made, the right thing has been done. If the treatment is given correctly, that is the right way, and if it is done early, before complications occur, then that is the right time. If the wrong diagnosis was made, or the wrong treatment given or the treatment was delayed, then that service lacks quality.

3. Quality can also be considered as doing the best with the resources available. Sometimes even with the resources we have -little as it may be, we don't achieve much. When the service being provided is less than what could be achieved with available resources, then a quality gap exists. For example, the drugs that we have could cure far more patients if they are properly used.

3.2 Components of Quality Care

Quality has some components or dimensions. These components of quality are interrelated and will singly or collectively promote quality.

Their lack will lead to quality gaps in service provided.

Components of quality

- 1 Policy
- 2 Technical competence
- 3 Efficiency
- 4 Interpersonal relationship
- 5 Effectiveness
- 6 Accessibility
- 7 Continuity
- 8 Safety
- 9 Acceptability
- 10 Equity

Policy

The government or state has the responsibility of protecting the public from poor-quality care. This role is necessary because the poor cannot afford health care. Thus it is important for the government to have sound policies to protect the poor, unprivileged and the at risk groups as one aspect of quality of care. The policy also provides a broader framework within which issues of quality services practice and control have to be closely addressed and monitored.

Technical competence

Technical competence is the knowledge and skills which a health worker needs to have in order to do a good job. These are obtained through formal training, experience, on job training and in continuing education.

Efficiency

Efficiency refers to using the minimum amount of effort or resources needed to achieve an intended result. This involves making the best use of the resources available. To ensure efficiency one has to eliminate the unnecessary steps and complexity in carrying out an activity. Efficiency minimizes wasted time, drugs and other supplies.

In an efficient system for example, a sick child with malaria, malnutrition and respiratory infection will be recognized and treated at a single visit. In an inefficient system several visits may be required before all conditions are recognized and treated.

Interpersonal relations

The working relations between health care workers, managers, patients, community and other sectors affect the quality of services provided. For example, in health facilities where patients are treated rudely, attendance is poor. On the other hand polite treatment of patients increases attendance. However there are barriers to good interpersonal relationship. These include low morale and work overload. Managers should try to increase morale by motivating workers. To reduce work overload, managing space, time and integration of services should be practiced at each facility.

The relationship between managers and health workers also affects the quality of service delivered. Good interpersonal relationships are essential in health services to build respect, confidentiality, trust, credibility, courtesy, responsiveness and empathy.

Effectiveness

Effectiveness is achieving the intended results. An effective district health service implements its annual health plans according to schedule and realizes its objectives. Since quality is measurable, methods for determining effectiveness are important as a way of monitoring performance.

One way of measuring performance is through the use of indicators. Indicators measure specific activities. For example an indicator to measure the effectiveness of a TB/L programme is the percentage of patients diagnosed with tuberculosis who complete the full treatment course.

Access to service

This refers to the proportion of the people in your catchment area who are able to utilize the services. Several factors influence access to health facilities.

Physical barriers - People may not reach health services because of long distances to that health facility or because of the presence of rivers, mountains or bad terrain.

Cultural barriers - Cultural beliefs and attitudes to health and diseases hinder some people to get health services.

Language barrier - The language or terminology used in communication at the health facility may also be a barrier. Staff at health facilities should give instructions in a simple language as possible. They should also repeat the messages to make sure they are understood and if possible they should ask the patient to repeat the messages.

Cost barriers - When people can not afford the health service this also affects their accessibility to health services.

Facility staff should put posters showing the fees at places where clients will see them. They should also inform clients on the procedures for exemptions.

Attitude of health workers - Access to health services may be deterred by negative attitudes of health workers who drive patients away. People will not utilize services where confidentiality is not observed.

Ignorance - Community should be educated on the health provided within the area.

Access to health services may be improved by community participation in planning and management of health service delivery, ready available health workers when needed, reduced waiting time for services and of course by removing the above barriers.

Continuity

This is the ability of the health service to initiate and complete a program of care to individuals and communities. It also means that services should continuously be available daily. Referring patients to a higher facility level is another form of continuity. The facility should be able to recognize those conditions above their capacity and refer them early to the next level where the services are available. Records are an important part of continuity, since this enables the health worker to follow the previous management of the patient and determine steps to follow. Continuity also involves keeping the patient well informed about their condition.

Safety

One of the definitions of quality is that activities should be both safe and efficacious. So health workers must consider the safety of clients, communities and themselves.

Examples of activities that might put the safety of patients at risk:

Incorrect diagnosis and treatment puts the safety of the patient at risk. Poor infection control may allow disease to spread through procedures.

Acceptability

Acceptance is interpersonal relationship. It shows client satisfaction which is determined by acceptance of services, time spent and attitudes of workers. If the users do not accept a service, it will not be utilized.

Equity

There are two dimensions to ensuring equity in health care. These are the issue of density and geographical distribution of health services and equitable funding of the national health system. This should be considered for all citizens irrespective of their gender orientation, colour, race, income and social status.

Examples of good quality services in a health facility

- 1. An immunization service is good quality if the cold chain is maintained the right way the correct antigens are given at the correct dates i.e. the right thing and time, and mothers are given appropriate counseling on side effects and told when to come back*
- 2. The Health Management Information System (H.M.I.S) will be of good quality when the relevant forms are filled- in correctly, data analyzed and utilizes at the health facilities where it is collected and appropriate feedback given at all levels.*

Examples of poor quality services at a health facility

When a health workers dispenses medications without making sure that the patient has understood clearly how the medicine will be taken, the such a service by the health workers is of poor quality.

3.3 Categories of quality of care

Quality of care may be grouped broadly into three main categories as follows:

- *Input quality (Structural quality)*

This refers to:

- Buildings with adequate space designed to allow smooth client flow and organization of all services. Buildings and environment should also be cleaned and maintained.
- Equipment adequate in good working condition for the provision of all services. Acceptable number and grades of staff in a facility required for the provision of the minimum package of essential health services.

- *Process quality.*

Is the delivery of a service or a performance of a procedure with available resources. It refers to knowledge and skills, which a health worker should have in order to perform quality care.

- *Outcome quality*

Refers to the end result of care such as reduction in dissatisfaction, discomfort, disability, disease (morbidity) and death (mortality).

3.4 The costs of Poor Quality

Poor quality has its costs both financially and in terms of the health of individuals and the community. If health services are not provided correctly the first time, the cost of the errors can be great, both to the health system and to the users.

The costs of poor quality are all the expenditures that would not have been incurred if the services had been provided right the first time. For example, treating an early respiratory infection immediately is less costly than treating a pneumonia which occurs if treatment is delayed. See more examples in the table below:-

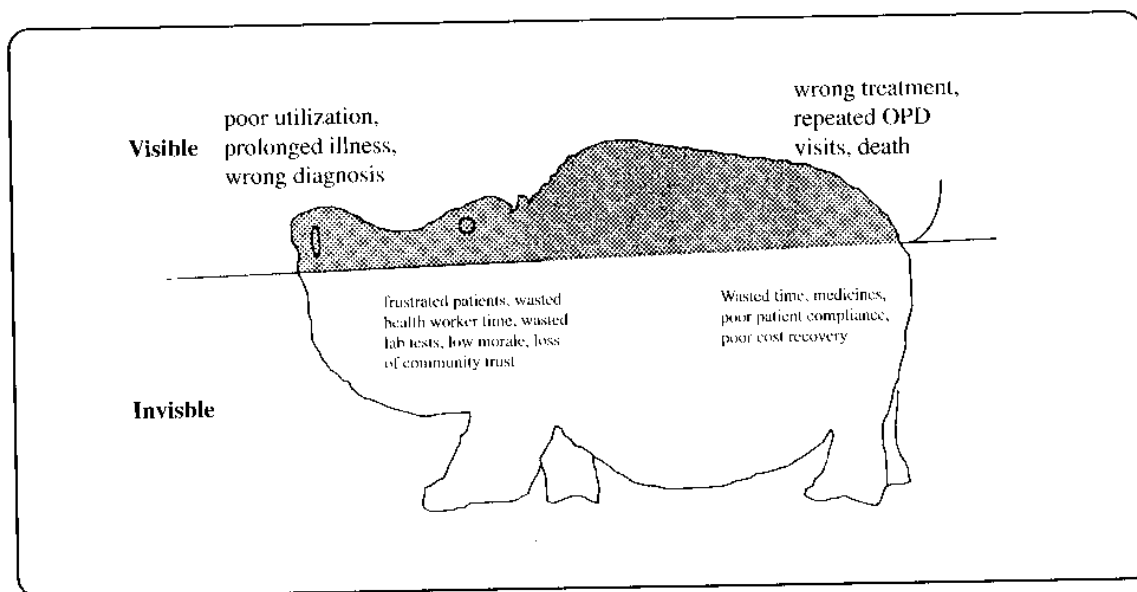
Examples of cost of poor quality

TOPIC	COSTS OF POOR QUALITY	COST SAVINGS OF GOOD QUALITY
Sterilization /processing of equipment	Incorrect processing increases the incidence of infections among clients, thus requiring treatment of complications (requiring additional staff time, medications, and other supplies	Correct processing decreases post procedure complications
	The reputation of the health facility suffers and clients begin to stay away from the services. Some clients may suffer permanently as a result of the infections they receive	Clients are satisfied with the services and recommend them to family and friends. The number of clients who go to the facility increases.
Performance of laboratory tests	Unsatisfactory tests waste time, money, and resources, causing clients and staff to repeat testing tests and needlessly waste supplies.	Clients and service providers do not spend considerable time redoing Fewer testing supplies are required.
Clinical training in the diagnosis and treatment of STDs	Staff misdiagnose infections and diseases and provide ineffective treatment. Clients suffer adverse health consequences and complications	Effective treatment promptly cures clients. Clients who understand how to protect their partners help contain the spread of infections. Fewer clients have serious

TOPIC	COSTS OF POOR QUALITY	COST SAVINGS OF GOOD QUALITY
	that require expensive treatment. Clients do not understand how to protect themselves and their partners against infections.	complications that require additional treatment
Ordering of drugs and other supplies	Haphazard system causes ordering of unnecessary drugs and supplies. These expire before they can be used. They can also run out before the next shipment arrives, causing services to be delayed or stopped.	Health facility does not order unnecessary drugs and other supplies. Appropriate quantities of supplies are ordered and used before they expire (first expired, first out (FEFO). Providers have adequate supplies for the provision of services.
Information on drugs	Clients who receive poor information use drugs incorrectly, do not use drugs. or discontinue use of the drug.	Clients who receive clear information know how to use drugs, Clients achieve their health intentions

Many components of quality cost are hidden and are hard to find - they are invisible.
Only a small proportion of quality costs are easy to find - visible.

Figure 1: The Hippo example



4. STANDARDS

4.1 Definition

Standards can simply be defined as a quality measure serving as a basis to judge the level of excellent performance. It is a statement of expected quality and makes clear the organization's expectation for quality.

Examples of types of standards

Performance standards e.g. immunization coverage

Clinical practice e.g. systematic history taking

Guidelines These describe in a general way how an activity should be undertaken. e.g. The primary health care supervision guidelines or the Standard Treatment Guidelines

Protocols These are description of steps in a strict order which should be followed in treating a disease (e.g. diarrhoea treatment protocol).

Standard operating procedures These are process standards. They are commonly used in operating theatres and infection control including sterilization .

Specifications These are standards used to describe infrastructure such as equipment and buildings e.g. Standard Guidelines for Health Facilities

Checklists These consist of a list of inputs, process and outcome standards and is used during inspection or supervision to ensure that a task is carried out properly and is complete e.g. supervision checklists

Standards indicate the level of quality desired for a specific service and provide a basis of measurement against which performance can be compared and assessed.

4.2. Development of Standards

Standards are developed in response to an identified need. The process for developing standards involve all stakeholders e.g. experts in the field and healthcare providers who will implement them. Developed standards should be clear, realistic and reliable. After standards have been developed they should be widely circulated and understood by implementers, supervisors and those who allocate resources e.g. managers.

Standards once set should be applied. It is very important for health workers to cultivate a work culture that routinely applies standards.

Standards may be changed from time to time from the minimal to the optimal and finally ideal level for continuous improvement of services.

Characteristics of standards:

- **Clear** - Should be clear and easy to follow by the user.
- **Realistic and applicable** - Set standards should be achievable within the available resources including staff, equipment, money etc.
- **Reliable** - They should be based on sound principles, scientifically, socially and culturally. When they are followed

Levels of standards

- **Minimal Standards** Describes the lowest acceptable standard of performance. Minimum standards are often used to distinguish between acceptable and unacceptable practice.
- **Ideal standard** Describes the care it should be possible to give under ideal conditions, when there are no constraints on the resources of any kind.
- **Optimal standards** This lies between the minimum and the ideal. This is the standard of care most likely to be achieved under normal conditions of practice.

4.3 Use of Standards

After developing standard of care they should be distributed to all levels of health care facilities and displayed where staff can see them all the time.

The uses of standards are:

- ***Improve health services delivery***

One definition of quality assurance is performance according to set standards. Health care providers should improve their performance by providing health services according to all set standards available to them.

- ***Help self assessment***

The use of standards enables the health workers to assess their performance continuously. By assessing their performance health workers can identify gaps in performance and take actions on their own to improve.

- ***Support supervision***

The use of standards during supervision will assist in identification of gaps in performance needing improvement.

- ***Accreditation***

Where licenses are required to practice or to operate a health service or to provide training, set standards are needed to decide whether minimum requirements have been met before the license can be issued or withdrawn.

- ***Inspection***

Inspection implies an evaluation activity to find out if standards are being complied with and goes with power to impose a penalty if lack of compliance is identified. It is needed to confirm that self assessment and support supervision are effective and where standards are deliberately ignored, corrective action can be enforced.

Standards should

- *Be communicated adequately to those who are responsible for implementation .*
- *Be understood and accepted by users*
- *Displayed at service delivery point*

Activity 1

59. Give examples in your setting of services which you think are of good quality.
2. Give examples of poor quality in your setting. Why are they of poor quality?
Describe how you can improve them.

UNIT 2: QUALITY ASSURANCE IN HEALTH CARE

TOPIC: IMPROVING QUALITY IN HEALTH CARE

2.1 INTRODUCTION

The provision of quality care to clients should consider proper management of services in the health facility and entire population within the catchment area. Quality assurance is both a management philosophy and a management method. As a philosophy it stresses the continual improvement of performance and the constant revision upwards of standards. As a method it has principles which are used to improve quality.

2.2 OBJECTIVES

At end of this unit participants should be able to;

1. Define Quality assurance.
2. Describe the principles of improving the quality of health services.
3. Describe the quality assurance cycle.

2.3 QUALITY ASSURANCE

2.3.1 Definition

Quality assurance is a process of assessing care (against set standards), that has already been provided and taking action to improve it in the future. This is done after identifying problems in health services delivery, analyzing those problems and seeking ways to solve them.

It is the concerted effort to continuously do things better until they are done right the first time, every time.

2.3.2 Importance of Quality assurance in Health Care

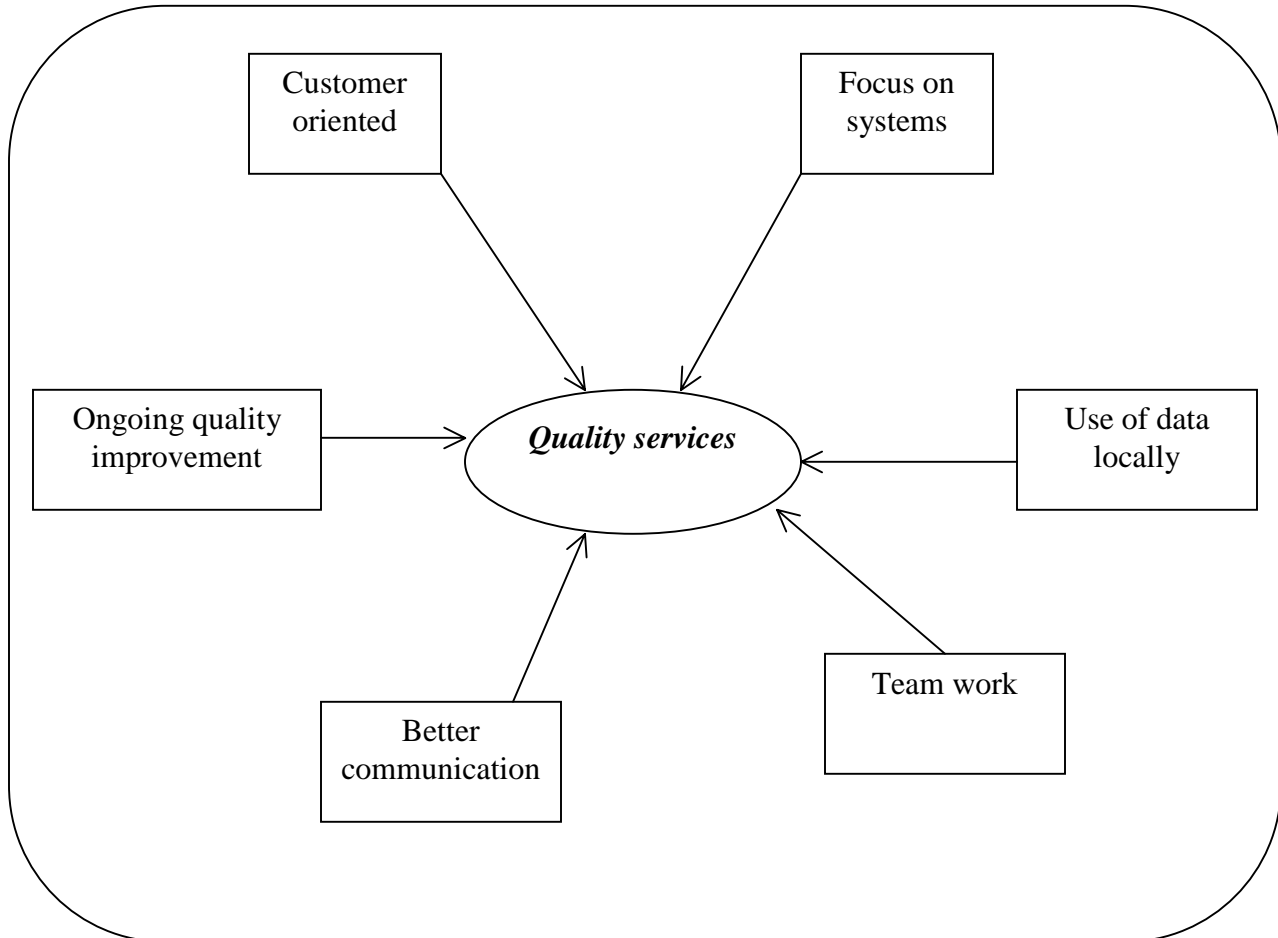
1. Helps everyone in the service to take responsibilities for controlling quality.
2. Enables health workers to use quality methods to improve the processes for delivering the services.
3. Changes manager and supervisors from the traditional role of inspection to facilitators who help health workers to solve their health facility problems.
4. It ensures that the health system sets standards according to the interests of all the key players in the health system so that consistent and continuous services are offered according to available resources.

2.4 PRINCIPLES OF IMPROVING THE QUALITY OF HEALTH SERVICES

Quality assurance management requires active and continuing support from top leadership at all levels. At the district level for example, the District Executive Director (DED), the District Health Board and the DHMT should be actively involved in efforts to improve the quality of district health services by supporting the application of quality improvement methods. Equally, at the ward and village levels, the political and administrative leaders play an important role in sustaining the culture of quality.

There are six principles of quality improvement in health care as summarized in figure 2 below:

Figure 2: Principles of improving the Quality of Health Services



Principle 1: Meeting The Needs Of Clients / Customers

For any service to be of value it must meet *the* needs of *the* users.

Any person who has an interest in the quality of services is a customer

Types of customers/clients

There are two types of customers:

- **External customers**
People who are outside the health services delivery system and receive services.
i.e. patients including their families, clients or the community through health committees and community leaders.
- **Internal customers**
Individuals and organizations which are part of the health service delivery system
e.g. health workers, donor agencies and the Government.

The role of the customer and provider

A customer may be defined as a person who receives a service while a provider is the one who gives the service. In health services, it is sometimes possible for the same individual to be a customer at one point and a provider at another point of the health delivery system. For example, a nurse in the hospital is a customer to the pharmacist when she goes to the hospital pharmacy to collect drugs, and when she gets back to the ward with the drugs she becomes a provider to her patients. In the community, health workers are providers of health services to the community, on the other hand, the community is the provider to the health workers with regard to incentives and a favourable working environment. If each party provides the services as expected, this will go a long way towards improving the quality of the services.

Relationship between customer and health care provider

The relationship between the client or customer, and the provider implies that the provider must seek to meet the needs of the customer in order to maintain their confidence. If these expectations or needs are not being met, the customer will be dissatisfied, and is likely to go away, and seek care from other providers e.g. private or traditional healers.

Needs of the customer

Needs are requirements of an individual or community. There are two types of needs, felt and unfelt needs:

- ***Felt needs*** are those which an individual or the community is already aware of. e.g. the need to relieve pain, or the need for maternity services within easy reach. Curative services usually answer to felt needs
- ***Unfelt needs*** are those of which the community is unaware of. Examples of this are the need for protected water sources, the need for well planned families or the need for continued feeding when a child has diarrhoea. Preventive and promotive services usually answer unfelt needs.

It is important for health workers to help communities to identify the unfelt needs and to understand why these needs can be as important as the felt needs for curative services.

Note: It is important to distinguish between health needs and wants. Sometimes communities or individuals want a service which is either unnecessary or harmful. e.g. patients requesting injections in every prescription etc.

Assessing the customer's needs

To distinguish between all the different types of needs, it is necessary to have information from the affected community. This can be done through simple surveys in which the community should be involved. Information obtained should be interpreted, explained to the community and translated into services.

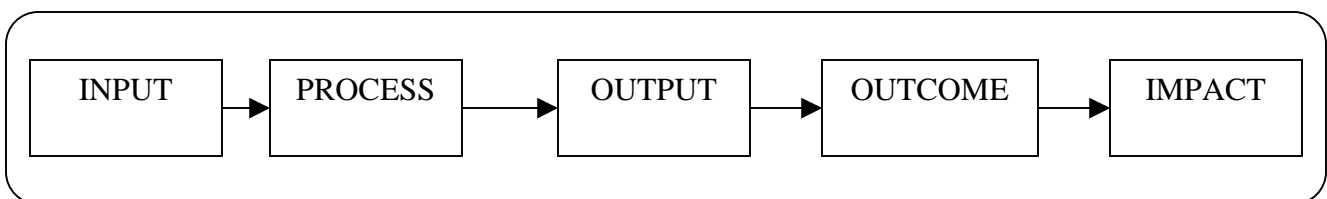
Principle 2:

Focusing on systems

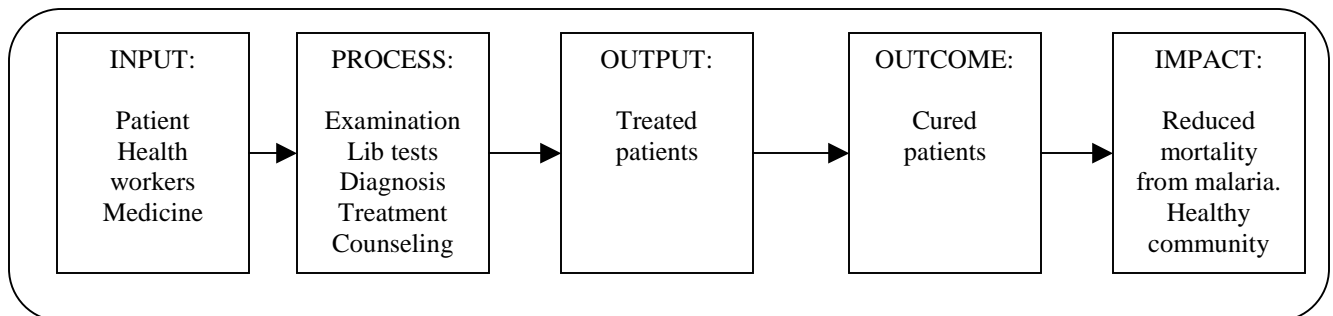
In order to do any activity it is important to understand what needs to be done, the individual steps which have to be taken, and in what order.

A system can be defined as a collection of related processes with a common objective. System analysis focuses on the *Inputs, Processes Outputs, Outcomes and Impact* of the health services provided. Analysis of the process looks at where strong and weak steps are in the provision of services.

The system model states that every activity can be broken down into related parts as follows:



An example of a system model for malaria treatment



The system model approach is different from the other management approaches which concentrate on outputs or results. This approach emphasizes the importance of focusing on the steps through which results are achieved. In this way the strengths and weaknesses of the process and the system can be identified. It indicates where choices and decisions must be made. It emphasizes identifying weak, missing or redundant steps in the processes and taking corrective actions.

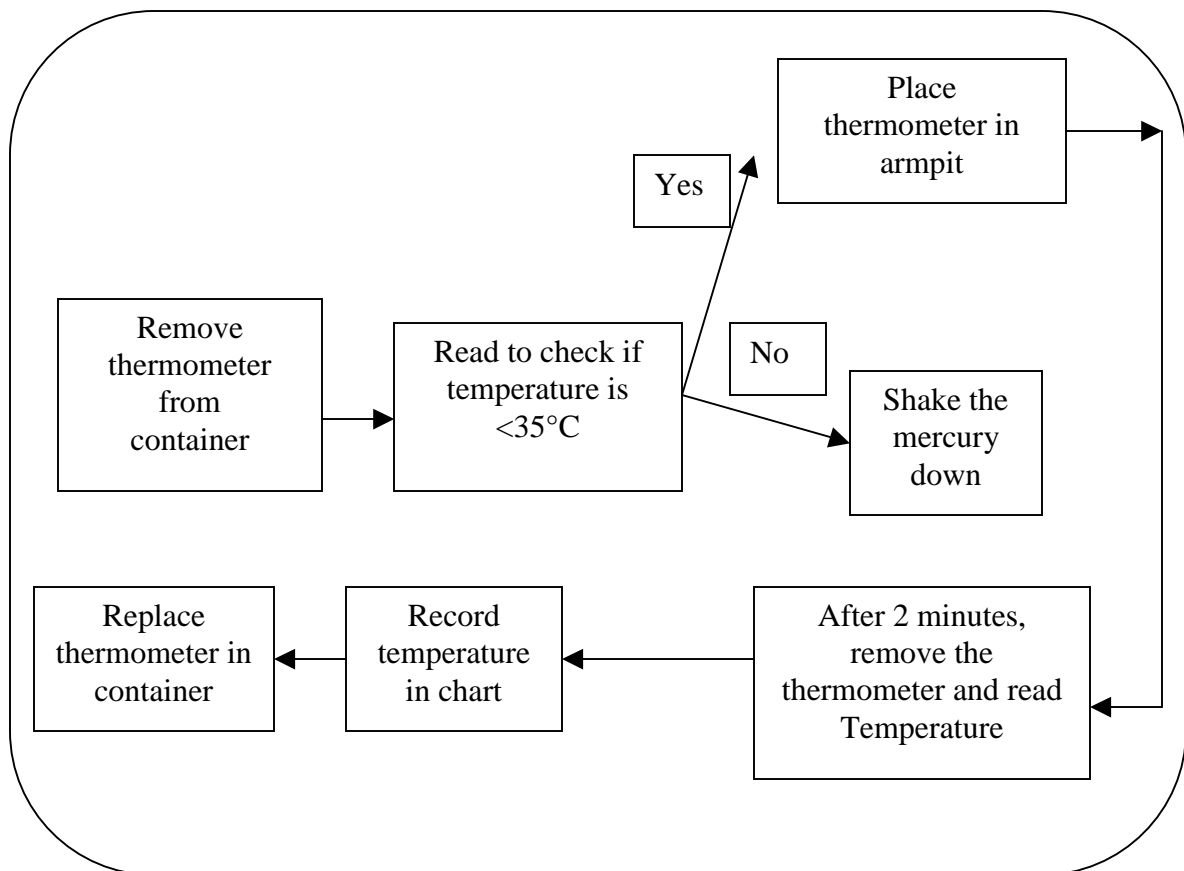
NOTE: In a system model the whole process of an activity is analyzed. Analysis of the process is done graphically for easy understanding. Flow charts may be used to analyze the process.

Using Flow Charts To Analyze Processes

Flow charts are graphic representations of how a process works, showing the sequence of steps. By writing down each step in a process a flow chart helps to clarify how things are currently working. By determining at which steps a process fails, where there are parallel processes, unnecessary steps and where there is no established sequence of steps, the root causes of poor performance can be determined.

For example, if a health centre in-charge is having a problem with excessive breakage of thermometers, he might construct the following flow chart to look for the weak steps resulting in the breakages.

Figure 3: Flow chart showing the process of taking temperatures and avoiding breakage



which do you think are the weakest steps, where most of the breakage occurs ? Perhaps these would be the steps of shaking down the thermometer (when the bedside table could be struck) or in writing down the results (when the thermometer could be set down, and roll off the table)

Principle 3: Using data to improve health services

In order to improve quality, services offered have to be measured. Measurement of performance includes data collection and analysis. Analyzed data is used to identify problems. Solving problem identified will lead to improvement of service.
For more information on this see Unit 11

Principle 4: Improving quality through team work

Quality assurance emphasizes the use of teams to improve quality the delivery of health services will depend on good teamwork to share responsibilities.
For more information see unit 6

Team spirit improves quality while poor team work lowers quality of the health services

Principle 5: Improving quality through better communication

Effective communication is essential for ensuring the quality of health care delivery and satisfaction of users. Examples of communication patterns in the quality of health care:

1. Health workers with patients
2. Health system with health workers
3. Health system with community

Effective communications in health system, health worker and community leads to quality care

Further discussions on communication see unit 9

Principle 6: On going quality improvement:

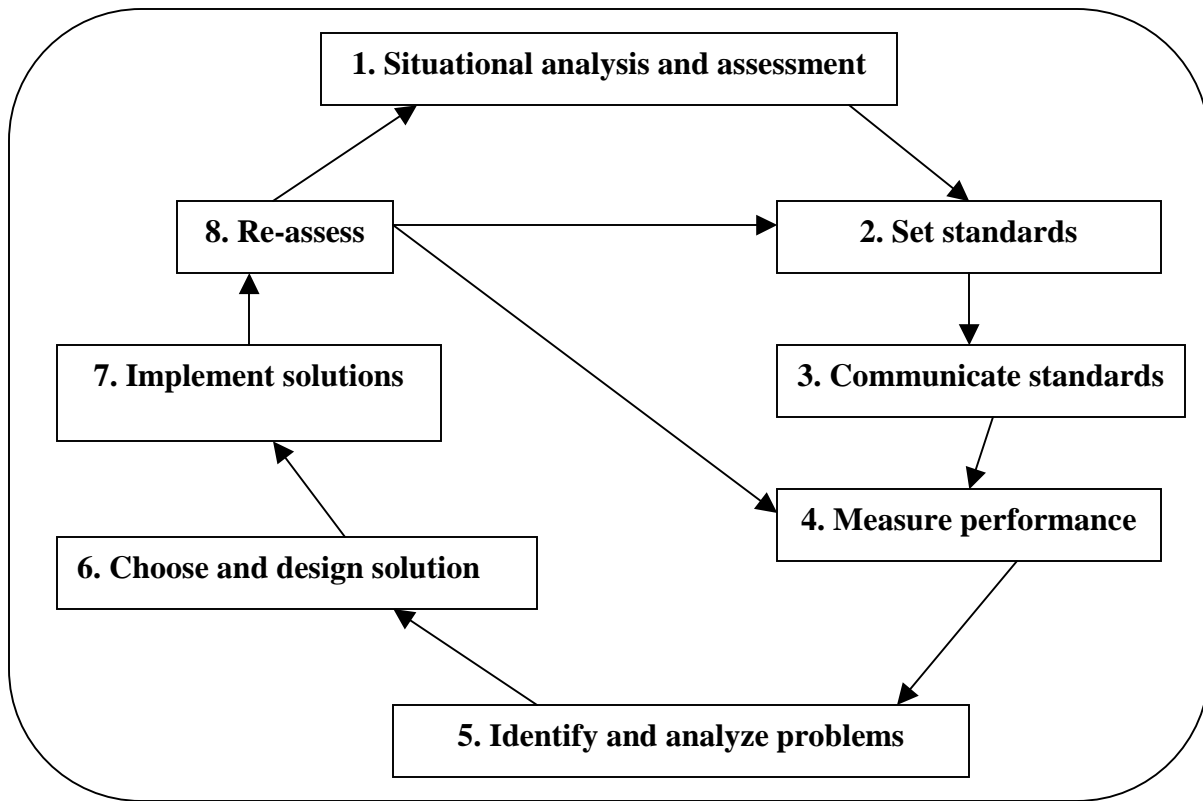
The use of quality -improvement tools that have ongoing or follow up components at health service delivery sites by supportive (facilitative) supervisors will foster and improve quality of health services. In this way, gains in quality improvement are regularly monitored and maintained, while problem areas are constantly identified and improved.

2.5 THE QUALITY ASSURANCE CYCLE

The aim of Quality assurance is to help everyone in the health services to take responsibility to improve quality of care offered. For Quality assurance to have maximum effect the quality assurance cycle should be used.

The following diagram summarizes the main parts of the cycle, details of each point are discussed next page:

Figure 4: The quality assurance cycle



1. Situational Analysis

In this step, needs and concerns of clients / community, health workers and health systems are determined. At this point therefore, it is important to involve clients / community, health workers and representatives of the health system as all of them have interest in improving quality of care.

2. Setting Standards

Taking into consideration the needs and concerns of all partners (client/community, health workers and health system), standards to be observed by the health facilities will be set.

Examples of standards include;

1. Immunization coverage targets

Measles 75 - 90%

BCG 90%

2. Outpatient / MCH work load

- each health worker to see between 20 - 50 clients per day.

3. Equipment and staff to be available in each health facility.

4. Treatment protocols.

3. Communicating Standards

Once the standards have been set, they have to be communicated to all interested partners. It is very important that standards are communicated because if not, health workers and clients will

not be able to measure and improve quality of care. At the facility level, agreed standards should be displayed so that all the staff are aware of them.

4. Measuring Performance

Once the services have standards, it is then possible to measure performance in relation to each standard. The aim of this measurement is to see whether what is happening was intended. All partners involved in formulating standards should also be involved in measuring actual performance.

5. Problem Identification And Analysis

Performance is measured by using and analyzing available records at a health facility. The result of this analysis will show if the standards have been met or not. If they have not been met then the identification of problems related to quality of care is done. These problems are further analyzed so as to find out the causes of the problems. The problems show the variations in performance as compared to standards.

6. Choose And Design Solution

After the major cause(s) have been found, clear objectives are set using the standards. Strategies and solutions to the problems are identified. Individual/teams which will implement the solutions will be identified and assigned.

7. Implementation

The solutions chosen and designed are implemented with the anticipation of improving the quality of care. The implementation plan should show who should implement, when it should start and finish and how it should be done.

8. Re-Assessment

After the implementation of the solutions is complete, services are re-assessed whether to modify the solutions, find other solutions or to increase the standards.

The purpose of the cycle is to ensure that the services have a process for continuously improving the quality.

Facilities are encouraged to meet at least twice a year and go through the cycle by setting standards and seeing that they are implemented. Facility health workers may set new standards or adapt those from the central level. Each health facility should be encouraged to have a work-plan for quality improvement.

Activity 2

Group work: 1. Identify standards you need to achieve in your facility then use the quality assurance cycle to make a quality improvement work plan which you will follow after the training.
2. Draw a flow chart for the cold chain of the EPI programme and identify weakest points where the cold chain could be broken. Suggest ways of preventing this from happening.

UNIT 3:QUALITY CONTROL

TOPIC: MEASURING QUALITY OF HEALTH CARE

3.1 INTRODUCTION

Quality Control is essentially the activities and techniques employed to achieve and maintain the quality of a product, process or service. It includes a monitory activity, but is also concerned with finding and eliminating causes of quality problems so that the requirements of the customer are continually met.

A health care service could be well performed through appropriate designed standards. To ensure consistency and maintenance in quality care it is vital that performance should be measured.

3.2 OBJECTIVES

By the end of the session, participants should be able to:

1. Describe methods of measuring quality health care.
2. Identify performance indicators, and means of verification.
3. Explain who should measure quality of health care.

3.3 MEASURING QUALITY OF HEALTH CARE

In unit one, quality of health care was defined in three main components;

- Input/Structural quality which refers to the structure of health facility buildings, equipment for services, appropriate number and grade of staff.
- Process quality which looks at performance issues.
- Outcome quality which refers to the results of the health services efforts on populations morbidity and mortality.

3.3.1 Measuring input/structural quality

Health facility buildings, available equipment for services, appropriate number and grade of staff are things which are quite easy to measure. Information obtained in these area can not sufficiently be used on their own unless they are related to performance outcomes.

For example, a well spaced designed health facility may still show problems of poor client flow and overcrowding if there is poor organization of services. Similarly, a big number of untrained staff may provide poor quality services.

Standards used to measure structural quality are described in the standards guidelines for health facilities.

3.3.2 Measuring process quality

This refers to the actual process of health care delivery. This includes the activities, productivity, use of services and better utilization of resources. The measurement of service provided is very useful because it tells us about the quality of services offered to clients.

For example to ensure high standard of Antenatal care services the following standard checklist must be observed:

Antenatal Services

- Is there a qualified antenatal/postnatal services provider?
- Is there privacy for the client during examination?
- Is the service provider to client relationship good? Check - if
 - the service provider welcomes the mothers
 - the service provider discuss her findings and management plan with the mothers
- Is the establishment of LNMP correct?
- Is the EDD calculated correctly?
- Is the Gestation period established correctly?
- Are the risk factors screened adequately?
- Is the correct fundal height established?
- Is the correct presentation established?
- Is the foetal heart established correctly?
- Does the service provider make correct decisions for mothers with risk factors?
- Are prophylactic drugs given to the clients with adequate instructions on use?
i.e.- Chloroquine, Iron tablets, Folic acid tablets
- Does the service provider record findings in the Antenatal card correctly?
- Does the health worker ask for the TT card and examine it?
- Is the Antenatal register filled in correctly?
- Are the monthly summations done? If yes, are they up-to-date?
- Are registers currently not in use kept in appropriate places?

Standards for prescribes are found in the Standard Treatment Guidelines. There are also standards for laboratory technicians and technologists, nurses, health/environmental officers and pharmacists.

3.3.3 Measuring outcomes

Outcome is the end result of health care or staff performance

Outcome measures would include:

- Morbidity and mortality figures e.g. decreased incidence of malaria, increased
- immunization coverage.
- Client and provider satisfaction
- Better organization of services with improved client flow and waiting times
- Increase in utilization of services
- Availability of a minimum package of services offered in every health facility.

3.4 PERFORMANCE INDICATORS AND MEANS OF VERIFICATION

Indicator is a measurable variable or characteristic that can be used to determine degree of adherence to a standard or achievement of quality goals e.g. Post operative infection rate is an indicator to aseptic surgical technique. An indicator can also be described as a variable which helps to measure change.

When are indicators to be used:

Baseline: these indicators are regarded to be essential for initial planning and for measuring change over time

Operational study: these are indicators for which complex data from different sources are needed, but which are very important to gain the necessary insight into the health problems of the area. They can be assessed only by carrying out an operational study

Monitoring: collecting the data for these indicators has to be part of the district's monitoring system. They are to be analyzed on a continuous basis and used for management decisions

Evaluation: these indicators are regarded to be essential for the systematic assessment of the relevance, adequacy, progress, efficiency, effectiveness and impact of the health programme

Examples of Indicators and means of Verification;

Measurable Variable	Standard		Indicator	Means of Verification
<i>Structure/ input</i>	Cadre	No. Required	Number available	
Staff Availability at a Dispensary	RMA MA NM PHNB MCHA Lab/Asst	1 1 1 1 1 1		Health Facility Data MTUHA Report F001
<i>Process</i> 1. New FP acceptors	Increase of 2% per year		Acceptance rate	Health Facility Data MTUHA Report F005
<i>Outcome</i> 1. Infant mortality	Decreasing IMR 105/1000 to reach 90/1000 by the year 2000		IMR	Census/Survey
2. Client and provider Satisfaction	Increasing Utilization		% of clients using health services	Health Facility Data Interviewing clients

For more Indicators see Annex 4

3.5 WHO MEASURES QUALITY OF HEALTH CARE

Quality care is a measure of how good health services are being provided. Quality of care is measured by all those interested in health service, these are;

- Clients - because they are direct beneficiaries.
- Service providers - because they would like to offer good services so as to get job satisfaction.
- Government and donors - because they want to ensure effective utilization of resources.

- Community- because they will benefit from the outcome of services. e.g. reduction of diseases and increased life expectancy.

The above mentioned partners in provision of health care, have equal status to be involved in the quality of care measurement.

How to measure quality of health care

1. Health worker self assessment
Each health worker should evaluate his/her work using available standard for each procedure. Also by going through health facility performance reports, health workers will be able to assess the performance of their health facilities.

2. Supportive supervision
A Quality assurance approach to supervision differs from traditional supervision in its focus on problem solving and on empowering supervisee to monitor their own performance and seek quality improvement.

During supervision supervisors and supervisees together go through available performance reports checking progress of planned activities, actual provision of services, utilization of resource, and problem areas identified.

Service providers and their supervisors should build a system for self assessment without waiting for outsiders to evaluate their performance. A self assessment shows maturity of character and also shows that people are genuinely interested in their jobs (Revisit unit 7.5.4).

3. Community assessment.;
Since communities are owners of the health facilities, administrative structures should be instituted, so as communities are directly involved in the provision and measurement of health services. Such structures are;

- District Health Boards
- Hospital Boards
- Health Facility Committees.

Assessment by communities is done through regular meeting where by health facility performance reports are reviewed and necessary actions for improvement are taken. In doing so public opinions are taken into consideration.

Assessment can also be done through interviews e.g. focus group discussions with the community leaders to see how they perceive the health services are offered in the facility within their area.

4. Measuring indicators:
This is done by looking at the indicators to see if the targets have been achieved and that the resources used have been well used to produce positive results. This can be a form of self assessment or external assessment by supervisors or donor agents.

5. Client exit interviews

Supervisors should do exit interviews of patients from time to time to find out how they perceive the quality of the service they are getting. Focus group discussions with the local leaders or target groups e.g. mothers for evaluation of MCH services can also be done.

An example of a questionnaire for exit interviews is shown in annex 3.

Activity 3

1. In groups, discuss how performance in immunization is measured in your health facilities.

UNIT 4: PROFESSIONAL STANDARDS

TOPIC: MAINTAINING PROFESSIONAL STANDARDS AND CONTINUOUS EDUCATION

4.1 INTRODUCTION

Professional Associations have a duty of ensuring that their professionals adhere to professional standards and quality care to the clients, community and the public. Both the Professional Associations and the National Health Policy, and in particular, the National Human Resources policy demand that health professionals take a responsibility of perpetually updating and upgrading the knowledge and skills for improved performance and competence in managing health services.

Health professionals are mostly involved in daily routine professional duties in the various health facilities. Thus they lack forums in which to discuss issues on dissemination of information pertaining to their professions. e.g. professional rights, professional advancement etc. In order to achieve this various profession cadre members had to form associations or councils, that would act as overseers of their professional cadres.

This unit will introduce you to ethics, code of conduct, standards, roles, client and providers, rights and legal issues pertaining to professional associations in relation to Quality assurance.

2.2 OBJECTIVES:

At the end of session participants should be able to:

1. Define a professional association
2. Identify roles of professional association in relation to Quality assurance
3. Explain the rights of clients/providers
4. Explain the importance of continuing education and professional advancement in relation to Quality assurance.

4.3 PROFESSIONAL ASSOCIATIONS

4.3.1 Definition

Professional Associations are legal bodies formed voluntarily by cadre members. They are bodies, with prescribed constitutions, registration and a license to practice. They are formed with the aim of improving their professional performance and hence their service delivery. The following are some examples of professional associations:

- MAT: Medical Association of Tanzania
- PST: Pharmaceutical Society of Tanzania
- TARENA: Tanganyika Registered Nurses Association
- TAMA: Tanzania Midwives Association
- TPHA: Tanzania Public Health Association

4.3.2 Roles of Professional Associations

Professional associations have important roles to play in ensuring that professional standards are attained and maintained. Such roles may include:

- To oversee and protect the rights and interests of the clients, public/community and providers.
- To safeguard the rights and interests of association members
- To publicize and portray the associations standing and image.
- To provide continuous professional advancement and staff development.
- To advise the MOH on technical and professional issues
- To inform and educate the public on issues pertaining to the association
- To carry out research relevant to the profession.

4.3.3 Rights, Ethics and Legal issues

Each profession has the code of conduct (ethics) with powers of litigation when the code is contravened.

The code of ethics is a legal document which protects the rights of both client and the service provider. The following are some clients' rights.

Clients have Rights to:

- Information
- Choice
- Privacy
- Dignity
- Comfort e.g. (toilet facilities, continuity of services)
- Opinion
- Health
- Access of services regardless of ethnic group, age, language, Social status etc.
- Need for supplies
- Need for guidance and encouragement
- Compensation
- Respect
- Self expression

The following are some providers rights:

- Need for information on issues related to their duties. This information should be channeled to service providers. A system has to be organized to ensure this
- Need for infrastructure: Service providers need physical facilities and organization necessary to provide services to required standard
- Need for supplies: Continuous and reliable supplies at appropriate standards of quality
- Need for guidance: Clear, objective and relevant to reinforce commitment and competence for providing high quality services
- Back-up: It is essential for service providers to be reassured that whatever the level of care they are working, (from the community level to the most comprehensive clinical service delivery site) they are members of a larger family in which individuals or units can provide support for each other.
- Respect: Service providers need recognition of their competence and potential as well as respect for their human needs.
- Encouragement: The need for stimulus in the development of the provider's potential and creativity.
- Advancement: Health workers have the right to promotion and professional development
- Feedback: It is necessary for service providers to have feedback concerning their competence and attitudes as others judge them
- Self expression: Service providers need to express their views concerning the quality and efficiency of the programme and to know that their opinion is taken into in management decision

4.4 CONTINUING EDUCATION AND PROFESSIONAL ADVANCEMENT

The Health sector reforms recognize the importance of an efficient updated and motivated work force for managing the reforms. Thus the need for elaborate Continuing education and professional advancement programmes of health workers in the comprehensive district plan. It is the responsibility of District Health Management Teams to ensure that plans for Continuing education for various health cadres are done both in the long-term and short-term, to this section we highlight below some important issues to consider when planning for continuing Education in the district as follows;

1. Continuing Education Needs

The District Health Management Team must conduct a surveyor situation analysis of continuing Education needs for various health care workers in the district. This implies that the DHMTs will find out the performance gaps or deficiencies for each cadre (How they perform and how they should perform) and priorities the needs in accordance to what actually they see or find out in the field. They then present the training needs for each cadre.

2. District Human Resources Profile/Inventory

The DHMT must maintain an updated, Human Resources profile or inventory for various cadres or health workers in the district. This becomes the basis for planning short/long term Continuing education and Professional advancement programmes in the district.

Such a profile/inventory may include some of the following;

- Total number of Health workers for each cadre in the whole district.
- Health workers experiences, qualifications, etc.
- Employment records e.g. Title, when last employed, current position and placement etc.
- Promotions (last promotion, next promotion, salary scale etc.).
- Professional Academic courses attended, seminars, workshops etc.
- Individual priority training areas of interest etc.

3. Planning and organizing Continuing Education

While developing comprehensive district health plan it is the duty of every DHMT to include continuing education plans for both short and long term. Such a plan may include some of the following:

- Priority training areas of need per cadre
- Specific training resources required
- The budget for training (short course, long course, seminar, workshop etc.).
- Date and Venue
- Source of funding e.g. District fund, Ministry of Health or Donor.
- Monitoring of the training.
- Inventory or availability of training institutions (Local/International).

4. Maintaining standards for continuing Education

The DHMT must ensure that minimum standards exist or are put in place and are readily made available to all management staff in the district as follows:

- There are orientation programmes to the facility and to the service. Orientation of especially new members ensures that there is adequate familiarization with management protocols and standards expected from them to address issues of quality care.
- There is a programme of Continuing Education available to all staff. A programme of Continuing Education ensures that each staff updates sufficiently himself/herself. This helps her/him to meet the challenges of changing technology and the ever expanding new literature on disease.
- There is a staff development - Programme. This addresses issues of developing people, facilitating their career development and competence in their work. A staff development programme includes elaborate supervision systems, appraisal systems and promotion plans to top management posts or positions. Again the aim is to ensure competence and quality care.
- There is evaluation for staff orientation, staff development and Continuing Education Programmes.

There is a need for the DHMTs to periodically monitor and evaluate their staff programmes to learn of their strengths and weaknesses according to the quality standards of care. Better planning can then be done on how to improve or correct the deficiencies.

5. Methods for Continuing Education

A variety of methods can be used in Continuing Education to update health workers such methods includes: clinical meetings, clinical audits, mortality morbidity meetings, scientific meetings, supportive supervision, open learning/distance education, self-directed learning etc.

The aim is to:

- Share and exchange of experiences with colleagues
- Avoid professional decay and continuing ignorance " The Kilimanjaro Syndrome"
- Motivate Health Workers
- Improve professional performance, efficiency and proficiency.

4.3.5 *The Re-certification/Re-Registration Concept and Quality Care*

The 1995/96 Human Resources for Health Development Policy of the Ministry of Health, makes it mandatory that it is the onus and responsibility of each health worker to continuously learn and search for knowledge (self- directed learning) for improved performance, competence and quality care. The Ministry of Health, Human Resources for Health Development department's policy on Continuing Education will soon or later introduce performance exams after registration and having practiced for a certain period to assess competencies. Certificates will then be re- issued and each worker required registering afresh after passing the examination in the respective profession. DHMT members must market this concept/approach to their staff in the context of quality of care. In turn health worker at every level should see these as professional obligations and challenges.

Activity 4.

- Discuss how professional associations assist health workers in their professional development.
- Discuss continuing education activities in your area by describing strengths and weakness, suggest methods for improvement.

UNIT 5: MINIMUM ESSENTIAL HEALTH INTERVENTIONS

TOPIC: THE PACKAGE OF MINIMUM ESSENTIAL INTERVENTIONS FOR TANZANIA

5.1 INTRODUCTION

The national package of health interventions is a way of assuring that the highest priority services are fully supported.

The services delivered in the package should:

- Address major health problems.
- Have a significant impact on health status.
- Address prevention as well as curative care.
- Be cost-effective.
- Respond to the demands of the population.

The services in the package are non-negotiable and should be provided at all facilities. The interventions in a package are clustered together so that they should be delivered together at a single visit of a patient/client to the health facility according to needs. The interventions in each component are usually related and are grouped together. This minimizes the total cost of the package by sharing use of inputs and reducing the cost to the patient obtaining individual services.

The implementation of the health package has a potential to contribute to Quality assurance through:

- The setting of clinical standards and guidelines.
- The improvement of health worker skills and knowledge and promotion of technical quality of care, through use of better procedures and improved communication with patients and other health workers.
- The improvement of the organisation of work at the health facility
- The improvement of supervision and monitoring in order to improve standards of care through quality control techniques.

In this unit participants will be introduced to the National Package of Essential Health Interventions.

The health workers will be equipped with skills required to implement the interventions in accordance with the National standards.

5.2 OBJECTIVES

At the end of the unit the participants should be able to:

1. Describe the package of minimum essential health intervention
2. Mention the elements/components of the Tanzania Essential package of Health interventions.
3. Describe the interventions of each element/component.

5.3 PACKAGE OF MINIMUM ESSENTIAL HEALTH INTERVENTIONS TANZANIA

5.3.1 Definition

The Package of Minimum Essential Health Interventions for Tanzania is a group of both public health measure and clinical services which are highly cost-effective and help to resolve major health problems.

5.3.2 Importance of the package

- The package guides the government in planning investments in buildings, equipment, and training of health personnel purchasing of drugs and other medical supplies.
- The service provided in the package have the greatest impact on the overall burden of diseases, this will lead to a significant impact on the overall health status of the Tanzanians i.e. reduce IMR, MMR, increase life expectancy and other outcome indicators.
- At the community level, since health education will be very much emphasized in this package, clients will be given health education both at the facility and in the community. This is hoped in the long run will lead to behaviour change and ultimately improved health conditions of the population and patient satisfaction to the provided health services.
- Helps the nation to estimate the need for external assistance and to use donor resources well by channeling more funds to interventions with high impact on health outcomes.

5.3.3 Components of the package

1. Treatment of other common disease/local priorities within the district e.g. Eye diseases, Oral Health,

2. Reproductive and Child Health

- Maternal conditions

ANC

Obstetric care

Post- Natal Care

Gynaecology, STD/HIV

- Family Planning
- IMCI (Malaria, ARI, DD etc)
- Perinatal
- Immunization
- Nutritional deficiencies

3. Communicable Disease Control

- Malaria
- TB/Leprosy
- HIV / AIDS/STD
- Epidemics (Cholera, Meningitis)

4. Non- Communicable Disease Control

- Cardiovascular diseases
- Diabetes
- Neoplasms
- Injuries/Trauma
- Mental Health
- Anaemia & Nutritional Deficiencies

5. Community Health Promotion/Disease Prevention

- IEC
- Water hygiene and sanitation
- School health promotion

5.3.4 Interventions of each component

Component 1: Treatment of common diseases/Local priorities within the district e.g. Eye diseases, Oral Health etc

The interventions of these components include:

- Rational prescription of drugs for treatment of the locally common diseases.
- Improving the supply of essential drugs, equipment and medical supplies.

Component 2: Reproductive and child Health

This component addresses the following:

- IMCI (Integrated Management of Childhood Illnesses). This addresses the following common diseases in children. Malaria, diarrhoea, malnutrition, anaemia and acute respiratory diseases.
- Immunization (mother and child)
- Provision of Family Planning
- Prenatal, child birth, postpartum and post-abortal care of women in their reproductive age.
- Information, education and communication provision of health education at the facility and in the community to:
 - create awareness demand for clinical and family planning services
 - alert women to danger signs and symptoms during pregnancy or delivery
 - mobilize communities for transport of women to the facilities and motivate women to use available services.
- Create awareness and provision of male family planning methods
- IEC

- Update knowledge on treatment of common diseases to prescribers. Provision and use of standard treatment guidelines.
- IEC

Component 3: Communicable Disease Control

This addresses the following diseases:

- Malaria
- TB/Leprosy
- HIV / AIDS/STD
- Epidemics (Cholera, Meningitis)
- IEC

a): Treatment and control of malaria:

The interventions include:

- Update knowledge on malaria treatment and control to health workers.
- Emphasize the use of standard treatment guidelines on proper first line and second line malaria case management
- Health promotion and education in the community and at the facility level on preventive measures as well as on the rational use of drugs to prevent drug resistance.
- Insect spraying in households.
- Promotion of use of impregnated bed-nets
- Community based malaria control e.g. environmental sanitation.
- Use of chemo-prophylaxis in pregnant women and sickle cell patients

b) Treatment and prevention of STDs/HIV/AIDs.

The interventions include;

- Health promotion and education
- Support for home based care.
- Provision of condoms.
- Counseling.
- Syndromic treatment of STDs.
- Standard treatment of opportunistic infections.
- Referral.

c) Treatment and prevention of TB and Leprosy

The interventions include:

- Education and advocacy to the community to facilitate case finding and reduce noncompliance including leprosy elimination campaigns.
- Supervision, monitoring and evaluation at the district, regional and National levels. Improvement of TB case findings and treatment (including maintenance of appropriate amount of drugs at all levels of health facilities)
- On the job training at the facility level to improve quality of treatment and proper record keeping.
- Improvement of referral system for laboratory diagnosis.

d) Prevention and control of epidemics

The interventions include:

- IEC on prevention measures of epidemic diseases
- Stocking of the required buffer drugs and other important supplies
- Case management
- Disease surveillance

Component 4: Non- Communicable Disease Control

This addresses the following conditions:

- Cardiovascular diseases
- Diabetes
- Neoplasms
- Injuries/Trauma
- Mental Health
- Anaemia & Nutritional Deficiencies
- IEC

The interventions include:

- Health promotion and education in prevention of diseases and accidents e.g. poisoning, motor accidents, burns, cardiovascular diseases, anaemia and nutritional deficiencies Standard case management
- Timely referral

Component 5: Community Health Promotion/Disease Prevention

- IEC
- Water hygiene and sanitation

This addresses health education on:

- The use of clean and safe water to avoid water borne infections.
- Proper refuse disposal
- Proper disposal of excreta
- Proper personal hygiene practice
- Hygiene practices on food handling, preparation, consumption and storage
- Safe disposal of waste and storm water.
- Revision and enforcement of regulations.
- Increased public investments.
- Buildings with adequate ventilation and light

Activity 5

- Describe components of package of minimum essential health interventions available in your health facility.

UNIT 6: TEAM WORK

TOPIC: WORKING AS A TEAM

1.1 INTRODUCTION

Services in health facilities are too many and complex for one person/staff to work individually. This may affect the quality of services provided. Collaboration and assisting each other is necessary. A team will achieve better results as opposed to individuals working on their own. Team work should start from the Central, Regional, District to the health facility levels.

6.2 OBJECTIVES

At the end of the unit participants should be able to:

- Define a team.
- Explain the importance of team work.
- Describe the qualities of an effective team.
- Explain the importance of integration in health care system.

6.3 WORKING AS A TEAM

6.3.1 Definition of a team

A team is a group of people working together for a common goal in providing quality services to clients and better health for people in their communities.

6.3.2 Importance of team work.

The main advantages for working as a team are:

- The knowledge and experiences of different persons are available and shared.
- Various ideas/options can be contributed
- Collective decision making is possible
- Responsibilities can be shared
- Tasks can be divided among members and therefore less time used.
- Members provide each other with support (moral, materials and emotional) to accomplish results
- Sharing of resources is enhanced
- Critique of each others' behaviour is for the purpose of improving team spirit and performance

6.3.3 The qualities of an effective team.

A well functioning health team should have the following qualities:

- It should have clear goals and objectives which everyone in the group understands and is committed to. The team should work together to achieve them.
- Each member should understand their roles and responsibilities and how they relate to the work of the others.
- The decision making procedures should be clearly defined. e.g. how will decisions be arrived at; Is it by consensus or majority vote?

- Each team member should understand the work and duties of others to be able to give assistance during a heavy work session or replace another in his/her absence. This means staff should be flexible.
- The team should have a leader who should assume a leadership role of organizing staff rosters, meetings, and on the job training to make sure the common goals are attained on time.
- The team leader should ask for assistance if in difficulties from other team members or supervisors.
- A good team should have a good relationship within the group and other related beneficiaries. Members should be open and understanding.
- An effective team has clear rules and norms and mechanisms for conflict resolution. Teams should disseminate information among team members and other beneficiaries through meetings, circulars, reports and feedback.
- An effective team is accountable for the responsibilities and resources assigned and conducts its work in a transparent manner.
- Delegation of authority and responsibilities motivates and develops team members and encourages initiative.

Training recognition, support and promotion helps effective team work.

6.3.4 Features of Teams

Features of Effective Team Work

- Regular and well attended meetings.
- Productive discussions leading to action.
- Members help one another.
- There are agreed goals.
- There is commitment from each member.
- Positive feelings and people like the group.
- Optimism.
- Success

Features of in-effective Team Work

- Frustrated members.
- Poor attendance
- Time wasted.
- Members rarely speak to one another.
- Collection of Individuals e.g. each person working alone.
- Negative feelings.
- Failure in achieving set objectives
- Different groups within a team.

Examples of team work

For treating patients the following are required to work as a team:

- *Someone to register the patients*
- *A person to examine the patient and prescribe treatment*
- *A person to dispense the treatment*

In the operating theatre the following have to work as a team:

- *A surgeon*
- *A scrub nurse*
- *An anaesthetist*
- *A runner*

A good immunization campaign at the district depends on the following team:

- *The cold chain coordinator*
- *Drivers*
- *Nurses*
- *The DHMT members*
- *The community and the leaders*

6.4 Integration

6.4.1 Definition of integration.

It is the provision of curative, preventive promotive and rehabilitative care by health staff working as a team and accepting responsibilities for all aspects of the care in one visit.

Integration of care in time means that all services are available at the same time, so that at each contact with the services a patient can have access to any type of care.

Integration of care in space means that all services are provided by the same team but at different points in time, for example, a curative clinic in the morning and a preventive clinic in the afternoon. Another aspect of integration is the involvement of other sectors in the provision of health services.

6.4.2 Why integration in PHC

- It is cost effective in that resources are better utilized.
- It improves the organization and patient flow thereby reducing waiting time thus increasing patient satisfaction and utilization.
- It reduces workload to health workers and saves time so that health workers can do other things.
- It avoids missed Opportunities to clients for example a pregnant woman coming with a child will get treatment and immunizations for both instead of each coming on separate days.

6.4.3 Why integration with other beneficiaries i.e. Private hospitals and Non Governmental Organizations.

- Promotes sharing of resources and responsibilities through comprehensive district health planning.
- Enhances implementation of health activities in the community e.g. National Immunization Days.
- Promotes a conducive working environment between government health workers and other sectors.
- Combines efforts of different sectors for the achievements of the intended goals.

Activity 6

1. Describe the steps involved in building a team.
2. Do you work as a team? If yes explain how you work as a team. If no explain what have been the practical difficulties.
3. Mention mistakes of performance that have occurred as a result of lack team work. Suggest possible ways to improve team work in your health facilities.

NB: See Annex 2 for Team effectiveness self- assessment test.

UNIT 7: MANAGEMENT

TOPIC: MANAGING HEALTH SERVICES

7.1 INTRODUCTION

This Unit introduces managerial skills; it outlines the relevance of management in health care. All people no matter what they do in life must manage in order to accomplish activity or task; therefore management goes beyond meeting personal need.

7.2 OBJECTIVES

At the end of this session health workers should be able to:

1. Define management.
2. Describe management skills.
3. Describe management functions.
4. Explain the importance of management in health services.

7.3 DEFINITION

MANAGEMENT: is the process of designing and maintaining a working environment in which individuals work as a team efficiently and effectively to accomplish selected aims.

EFFICIENT: Is the possible use of resources e.g. time, material and human

EFFECTIVENESS: Is the extent to which a specific intervention or service achieves the intended results or goals.

7.4 MANAGERIAL SKILLS

The following skills are necessary in managing health services.

7.4.1 Technical Skills

Is the professional competence which is required in carrying out activities in health services e.g. The District cold chain operator should have the competence in maintaining cold chain system. i.e. storage of vaccines and provision of vaccines.

7.4.2 Human Skills

- It is the ability to work with people.
- It is necessary for team working.
- It is a creation of an environment in which people feel secure and free to express their opinions.
e.g. communication, leading, assisting innovative, initiative, creativity.

7.4.3 Conceptual Skills

It involves the ability to see an organization as a whole; to recognize how the various elements of the organization depend on one another and how changes in anyone element affect all the others. It also involves the ability to visualize the relationship to the individual organization to the environment. A manager with conceptual skills should be able to analyze situations and problems and formulate solutions.

7.4.4 Decision - making skills

It is the ability to solve problems in a way that will benefit health services.

7.5 MANAGERIAL FUNCTIONS

An effective manager should do the following

7.5.1 Planning

This is the process of trying to ensure that the resources available now and in future are used in the most efficient way to achieve objectives.

Why planning

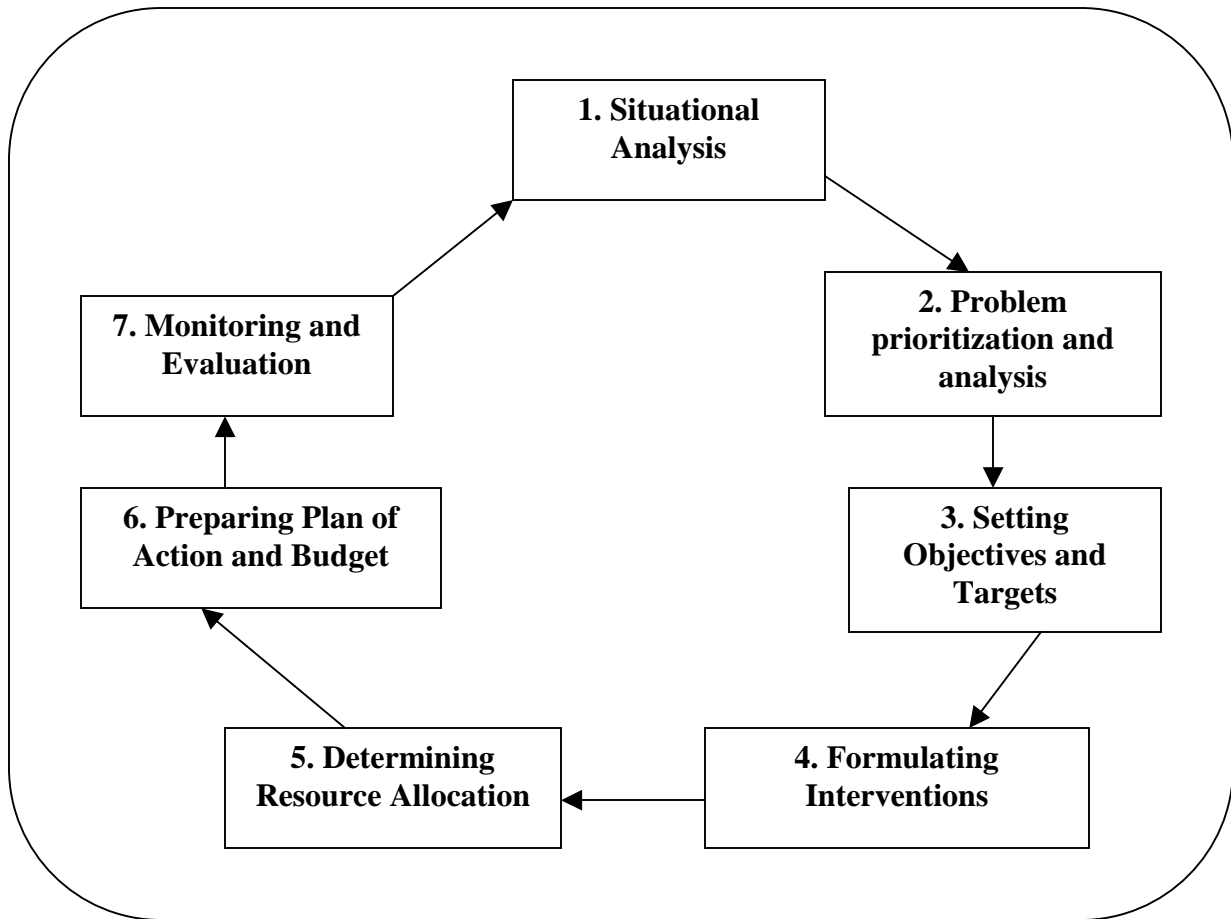
- For proper and rational use of available resources.
- To enable health workers to monitor and evaluate health activities.
- To make choices and think of real alternatives.

The planning process ensure quality care in health services by standards objectives and indicators.

Steps in planning (How to plan)

There are several steps in the planning process.
The following chart summaries the planning steps

Figure 5: Planning Steps



- 1. Situational analysis**
Answers the key questions "where are we now?" Which means assessment to identify needs and problems
- 2. Problem prioritization and analysis**
After identifying problems, prioritize them in order of importance and according to available resources.
- 3. Setting plan objectives and targets**
This stage involves the determination of the objectives and targets of the health organization. It is the stage that the following key questions should be addressed. "where do we want to go/ or what do we want to achieve?"
- 4. Formulate interventions**
In this stage the process of identifying, short listing and deciding between alternative approaches and measures to address identified and prioritized health problems and needs are done. This is the stage whereby the question. " How will we get there?" should be addressed.
- 5. Determining resource allocation**

This is the stage whereby resources are identified for the formulated interventions;

- Manpower (Human resource)
- money
- supplies
- machinery and equipment
- time
- space

6 Preparing plan of action and budget

It is usually prepared in a matrix format and contains the following items;

- Inputs
- Key responsible actors
- Implementation
- Assumptions and risks
- Activity indicator
- Planned out put
- Activity cost and Implementation time frame

An example of Plan of Action matrix is shown in table 2 next page.

Table 2:**Example of Plan of Action****Problem:**

High Maternal Rate (NMR) of 229/100,000 (National Rate is 400 – 600/100,000)

Objective:

To reduce MMR from 229 to 195/100,000 by the end of 1999

Intervention (How)	Activity (What)	Operational Target (What to be achieved)	Time frame (when)	Responsible (who)	Progress Indicators (what measurement)	Method of monitoring (What tool)	Resources needed (with what)	Funding Agency (who finances)	Estimated Cost (what cost) Tshs
1. Strengthen referral of high risk pregnant mothers	1. 1 Establish- ment of Maternity homes	To mobilize community construct the waiting home near the district hospital and 2 health centers	Jan – Jun	DMCHCo and DMO	Site identified and cleared. Mobilization of resources Physical construction in progress	Visit report	Human labour Local building materials Transport	Community contributions Cash/ material contribution by Local govt. Authority Centre Govt Donor contribution	
	1.2 Training of TBAs	Train 20 TBAs on emergency and obstructed labour care for 5 days	August	DMCHCo and DMO	TBAs Trained	Stationery Allowance Fuel Vehicle Classroom Refreshment	Local Gov't Authority	20 TBAs x 2,000 = 40,000 Fuel 20 Lx Ts 420 = 8400 Class hire = Ts 5,000 x 5 = 25,000 etc	

7.5.2 Organisation

This is a process of identifying the work to be done, dividing it into units and co-ordinating efforts to accomplish the goals.

Aspects of Organizing

The areas of emphasis in organization includes:

- The organization of work and the responsibilities included in each job.
- The structure of the organization itself which means integration of the jobs and organization of resources.

Organizing health services requires;

- Identification of activities (services to be offered)
- Identification resources in terms of human and materials
- Allocation of resources according to the activity

Organization of services should consider the following points.

- Basic principles for organizing services
- Work space available in the health facility
- Client flow
- Time for providing the health services
- Proper utilization of available resources in the health facility.

Good organization of health services decreases staff work load, waiting time for clients and improves staff relationship and client satisfaction

7.5.3 Monitoring and evaluation Monitoring

This means finding out what is going on. It is concerned with observation of activities or services ensuring their implementation. When monitoring you should pay attention of how people respond or perceive the action you take, the numbers of people responding in a certain way etc.

Tools for monitoring

Activity plans and schedules

Indicator of general activity (progress) or log frame work of activity. Checklist

How to monitor

The following are done in monitoring health activities to ensure quality care.

- Observe the performance of day to day activities
- Check various reports available e.g. MTUHA reports
- Do a community diagnosis by asking questions to leaders in the community or other representatives of the community
- Check various register used in the health facility.

Importance of monitoring

- Provides feedback
- Helps to identify immediate problems and deviations from the established plan.
- Highlights the difference between established norms/standards and actual performance.

Evaluation

This is the systematic assessment of action in order to improve planning or implementation of current and future activities. Evaluation includes areas both process and impact to assess whether the set out objectives have been achieved. This can be internal (by the implementers) and external (by outsiders) to evaluate the plan.

7.5.4 Supportive/facilitative Supervision

This is an approach to supervision that emphasizes mentoring, joint problem solving, and two way communication between supervisors and those being supervised.

What To Supervise

Supervision should look at **INPUTS, PROCESSES** and **OUTPUTS** of the health care services. For example in **EPI**, **INPUTS** are the availability of vaccines, staff and equipment, **PROCESSES** include storage and vaccination procedure and **OUTPUTS** are the number of children vaccinated.

How To Supervise

On the part of the supervisor, supportive supervision involves:

- Observing health workers doing the job
- Identifying positive factors and obstacles to performance
- Giving feedback through discussions, demonstrations, and supervised practice

Supportive supervision helps health workers improve the quality of health services through:

- On site problem solving
- On job training
- Motivating staff
- Team building
- Identifying and planning for training needs

Improving communication between the different levels of the service

Stages of Supervision:

It is important to know that supervision should be part of the annual work-plan of the district as well as the facility. This should be budgeted for annually by the district.

Preparation

- Study of documents
- Review previous supervision reports, and H.M.I.S. of the respective health facility to be visited. Priorities problems for supervision.
- Set supervision objectives.
- Prepare the checklist (supervision tool) to be used using the PHC supervision guidelines as reference .
- Prepare logistics, teams, supplies and other resources.
- Schedule and communicate to the supervisees

2. Conducting Supervision

- Get to the facility early
- Introduce yourselves to the supervisees and briefly explain the purpose of supervision and agree on how the supervision will proceed.
- the supervisor observes the health worker carrying out his/her tasks.
- The supervisor notes tasks done well and identifies gaps and needs for supportive supervision and follow up.
- During supervision some problems can be solved by dialogue between supervisor and supervisee.
- Give immediate feedback to the health team supervised; start with strong points following with weak points.

3. Immediate Feedback

The supervisors should point out areas which health workers have performed well, then mention areas of weaknesses. Discuss together on how improvements can be made. Demonstrate correct ways of performing problem tasks and ask for return demonstrations. Emphasis should be put on stimulating health workers to think on how to solve the problems themselves-instead of relying on the supervisors. Moreover, during feedback both supervisors and supervisees agree on an intervention plan or recommendation for follow-up issues in the next supervision cycle.

This commits everybody to ensuring a positive and desirable change and impact demanded by the supervision process. Lastly, the supervisors, leave a copy of the checklists to the management team for future reference.

Report writing of supervision

- start with introduction, name of supervisors, date of supervision
- objective of supervision
- observations noted
- Instructions given, the responsible person and the date expected for the activities to be accomplished. The following is an example of an implementation work plan.

Date of supervision	Problem and cause	Recommendations	To be done by whom	To be done by when
1/1/99	Essential drugs not available because HF is not following FEFO principles	- Order urgent supply of drugs - Arrange FEFO training for dispensing staff - Establish FEFO system	- Mr Maganga (HP In -charge) - Mrs Shayo District Pharmacist - Miss Ali Nurse I/C of dispensing	2/2/99 15/3/99 16/3/99

5. Late feedback

Send a copy of the supervision report to the supervised health facility

6. Filing of reports

The RHMT and the DHMT should have a file specific for supervision where all supervision reports are kept. This will help easy retrieval of previous reports for studying before a supervision visit. At the same time health facilities should have a similar file for all supervision reports and record in MTUHA book two.

7. Follow up action

The supervisor should take responsibility for ensuring actions are taken on identified problems; including informing other officers likely to address the problems.

Activity 7

- 1) Explain the importance of supervision.
- 2) Discuss stages of supervision.
- 3) Give your opinions on the supervisions done in health facilities.

UNIT 8: TOPIC:

MANAGING RESOURCES MANAGING TIME, SPACE, EQUIPMENT AND SUPPLIES

8.1 INTRODUCTION

The first level of health care in most communities is the dispensary. Staff are faced with a large population needing several services. This sometimes causes a heavy workload which makes staff unable to meet client needs. Also it leads to the shortage of equipment and supplies. Lack of proper service organization increases staff workload and client waiting time consequently the client attendance to Health facility drops.

The provision of quality care to client should not only consider proper organization of services in the health facility but also to the entire population in the service area. Organization of services should consider the following points so as to provide quality services:

- 1) Application of basic principles for organizing services
- 2) Client flow in the health facility
- 3) Management of work space and organization of client.
- 4) Management of time
- 5) Proper management of supplies and equipment.
- 6) Proper management of personnel and finance.

Essential equipment for different levels are described in the National Guideline Standard for Health Facilities.

8.2 OBJECTIVES

At the end of this unit the health workers should be able to:

- 1 Define management
- 2 Describe basic principles for organizing services to provide quality care
- 3 Organize services in the space available in the health facility while ensuring good client flow.
- 4 Manage working time efficiently.
- 5 Describe basic principles of managing personnel and finances.

8.3 MANAGEMENT

8.3.1 Definition

Management has many definitions; for the purpose of this unit management is defined as getting things done through people. In order to have things done, it requires qualified personnel, minimum or essential equipment and supplies, available space and time allocation.

8.3.2 Basic requirement for organizing health services

The following requirements should be applied while organizing services for quality.

a) Rational Care

- This requires adequate number of staff, simple clear job descriptions on daily tasks to be performed by all staff. Also there should be a duty roster to ensure that all services are provided.
- The community should be involved in planning, implementation and evaluation of health services.
- The community should be made familiar with the concept of integrated service provision.

b) Continuous care

Organization of services should be done with a system of registration that allows follow-up in the community. E.g. registers, Index card system etc. Dropouts and defaulters of various services should be traced. The follow up system should involve the participation of community members such as TBAs, VHW s, CBDs etc. in planning out reach services. All services should be provided daily and if possible for 24 hours.

c) Integrated care

- Services are organized in a way that allows a client to receive all services required in one visit.
- The working schedule should ensure that a maximum package of services are provided daily for every client.

List of Health Services in Integrated Care

- Health Education
- Antenatal care
- Growth monitoring/immunisation
- Injection
- Dressing
- Dental
- Radiography
- Operations
- Counselling
- Other specialised health services
- Out Patient
- Family Planning
- Diarrhoea treatment
- Dispensing
- Delivery
- Laboratory
- Inpatient
- Referrals
- Environmental sanitation

d) Knowledge of the catchment and service area.

Organization requires a good knowledge of the number and location of villages, population size, influential groups and persons in the service area. This assists in efficient planning of health services and following-up activities.

8.3.3 Management of time

Time is an important resource, once wasted is not renewable.

Steps in time management:

1. Set your own goals and priorities them

List the actions needed to achieve the prioritized goal

Set target dates for completion. The dates should be realistic to avoid additional time pressures.

2. Organise your work

The advantage of organizing your work can reduce the amount of time spent doing things that are neither productive nor satisfying.

This can be achieved through the use of:-

a) Lists of things to be done e.g.

- A weekly time-table showing the time of the week when certain regular events occur e.g.
- Antenatal Care, Family Planning services, immunizations, outreach and meetings.
- Duty roster showing staff placement for appropriate section of work (e.g. night calls, OPD etc.)
- Schedules should give room for unplanned events e.g. emergency meetings, outbreaks etc.

3. *Set limits*

- Eliminating unnecessary work e.g. reducing social chatting
- Limiting activities to those which can be achieved
- Delegating some of the activities.

4. *Streamline your work.*

Keeping time log - recording all activities daily and the levels achieved.

8.3.4 Management of working space and Organization of client flow in the health facility.

The organization of services will differ at different levels according to availability of buildings and staff. Good organization ensures optimal use of space in a working area. There are no complex rules about space arrangements. The basic rules are:

- Think of services to be provided
- Ask yourself if the services could be arranged to suit both staff and clients. This will enhance efficiency and effectiveness of health services.
- Client flow. This is an arrangement of working station whereby client is required to go through one station to another. A good client flow can be achieved when each client can go to each station with minimum waiting time and if there are fewer stations he/she has to go through.

The following things could be done to avoid long waiting time:

- Proper registration and card filling system for quick sorting
- Label every door so that the client knows where to go
- Staff responsible for a particular service should be available in their work places at all times.
- Clear and friendly explanations telling the client where to go next.
- Patients with a daily course of treatment should be directed to a treatment room.
- Good arrangement of equipment and supplies.

8.3.5 Managing equipment and supplies

There are two types of material equipment:

1. Non consumable material (Equipment) which lasts for several years, needing care and maintenance e.g. weighing scales, microscopes, Bedpans, kidney dishes, vehicles etc.
2. Consumable material (supplies) which are used within a short time e.g. cotton wool, stationery, disposable syringes etc.

The following are the main procedures in the management of equipment and supplies.

1. *Ordering:*

This involves

- Listing requirement based on the past use and estimates of the present needs.
- Writing the requirement in the requisition form
- Forwarding the requisitions to the District/regional/MSD or pharmacy shops.

NOTE: There should be a lead time of at least 2-3 months when ordering. This means you should start the process of ordering while you have some stock which will last at least 3 months. Do not wait until stock is completely finished or about to be finished before you order.

2. *Storing:*

- Recording the receipts of new equipment/supplies and their issue note
- Keeping your equipment/supplies in the ledger balanced.

3. *Issuing:*

This is the process of giving out and balancing the remaining stock using signed issue voucher. When issuing observe the FIFO/FEFO system (First In First Out or First Expired First Out)

4. *Controlling and maintaining equipment supplies:*

Equipment and supplies must be controlled to avoid wastage and kept in good working condition. This should be done by:

- Keep the equipment clean
- Do frequent inspections
- Report defects immediately and actions to be taken by concerned authority (put in action plan immediately)
- Return equipment to their correct places after use
- Keep an up-dated inventory of everything. An inventory form of equipment in each room should be displayed at the back of the door or on the wall of each room.

8.3.6 Managing personnel

- Each health worker should have his/her job description .
- Understand the number of staff and their professional qualification.
- Allocate tasks according to experience/qualifications.
- Involve staff in the planning, implementation and evaluation of activities.
- Identify clear communication channels - with feedback mechanisms to be used.
- Involve staff in decision making.
- Develop and use staff appraisal tools e.g. filling of annual confidential forms.
- Regular supportive supervision.
- Motivate staff

8.3.7 Managing finances

Mobilizations of financial resources as indicated in the cost sharing guidelines of 1997 is done through;

- Admission inpatients/outpatients charges.
- Charges of various services e.g. opening files, drugs, medical examination, dental, x-rays, laboratories etc.
- Consultation fees
- Boarding of employees.
- Community funding e.g. packing-fees, community health funds and other sources.

Principles of managing funds;

There must be:

- A district or health facility health plan which has a budget.
- Compliance with appropriate disbursement procedures
- Adherence to appropriate procurement procedures
- Proper accounting records
- Documentation of receipts of fees, levies etc. including back records.

Rules and regulation in monitoring financial resources;

There should be:

- a strictly budgeting control system which is followed by everyone .
- Periodic financial reports and auditing (both internal and external)
- Transparency in cost accounting system

The financial resources and how they are used must be known to all members of the team e.g. all DHMT members or facility management committee.

Activity 8

1. Prepare your work plan for one week
2. Draw an MCH client flow indicating the activities each working station.
3. Identify problems according to the flow and suggest ways of improving client flow.

UNIT 9: COMMUNICATION

TOPIC: COMMUNICATION IN HEALTH CARE

9.1 INTRODUCTION

Effective communication is essential for ensuring the quality of health care delivery and the satisfaction of users.

In health facilities, communication occurs between the client and staff and among staff themselves.

9.2 OBJECTIVES

By the end of the unit, participants should be able to:

1. Define communication.
2. Describe methods and the process of communication
3. Describe skills for effective communication
4. Describe barriers to effective communication
5. Plan and carry out an effective health education session.

9.3 COMMUNICATION

9.3.1 Definition

Communication is the process of sharing or exchanging information between two or more persons. It also involves the transfer of ideas, emotions, knowledge and skills between people.

In a health care setting, communication would exist between:

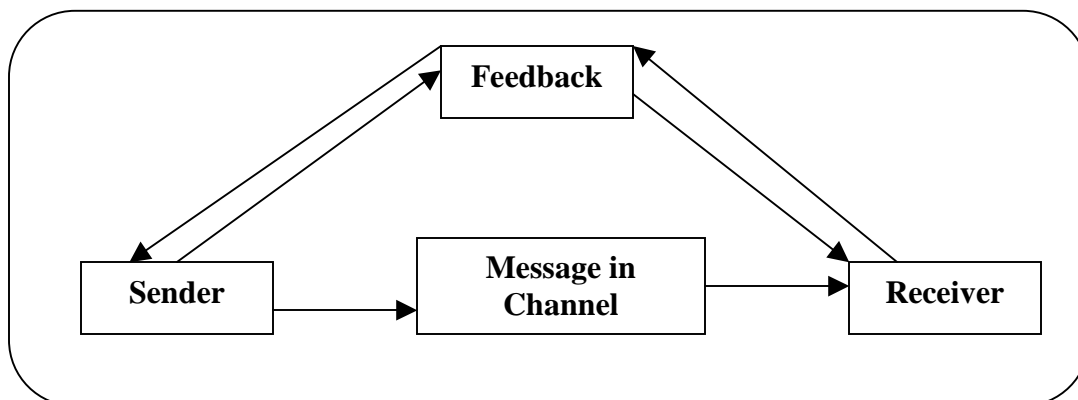
- Health workers with clients
- Health system with health workers
- Health system with community

9.3.2 Communication Process

In a communication process there is a sender, a message, the channel, the receiver and a feedback link to sender.

The figure below summarizes the communication process:

Figure 6:- Communication Process



1. Sender - Is the person who wants to communicate with another person
2. Message - Is the content which should be communicated
3. Channel - This is the method used to communicate the message e.g. Oral, written message or electronic media such as telephone, fax, computer.
4. Receiver - Is the person intended to receive a message
5. Feedback - Is a response sent back by receiver to the sender

Characteristics of communication

Sender	Message	Channel	Receiver	Feedback
Should be: - Knowledgeable - Credible - a good listener to receive feed back and good observer	should be: - Easily understood - In a simple language - Interesting - Relevant - Simple - Concise - Clear	Should be: - appropriate - accessible - familiar to both the sender and receiver	Should be: - Interested - Capable of understanding the message - Acceptable	For communication to be complete the sender should solicit feedback and the receiver should provide it
Expected outcome - Change in behaviour - Change in health care provision - Improved service quality				

9.4 LEVELS OF COMMUNICATION

9.4.1 Communication between health worker and patients

Good communication between health workers and patients increases the quality of care. For example, after a diagnosis is made the health workers should explain to the patient the nature of the illness, the treatment which is required, how to use the medicine, preventive measures against re-infection and any other necessary follow up.

9.4.2 Communication within the health system.

Examples among health workers

- A clinician should provide enough information to the laboratory personnel to ensure that the correct examination is done
- Prescribers should write legibly and completely to allow medicines to be dispensed promptly and correctly.

Examples within the health system

- Administrative circulars should be widely circulated and read Information concerning patients referred to hospitals should be complete.
- A feedback should be sent to the referring unit promptly.

9.4.3 Communication between the health system and the community

In Tanzania Primary Health care committees are present from the village to the national levels. At the dispensary and health centre level the village and ward PHC Committees should be mobilized to assist in day to day management of the local facilities.

9.5 SKILLS FOR EFFECTIVE COMMUNICATION

The following skills are required for effective communication.

9.5.1 Telling or lecturing

This is used in situations where NEW information is given to clients (as in a health education session). Lecturing can be boring. To avoid boredom, information should be *clear; short, concise, complete and convincing* to get the attention of clients.

9.5.2 Asking

Asking questions during a communication process (health education session/counseling) is a skill which is vital to find out if the message has been understood. Asking questions will assist in correcting misconceived ideas. Questioning gets the client involved in the process of communication and helps staff understand client needs better.

9.5.3 Listening

A good educator should be a good listener. Listening helps the educator to understand the client. When a health worker listens and gives correct answers to questions asked by clients, clients feel they are being cared for. This motivates clients, puts away shyness and encourages effective dialogue. The client will like to return to the health facility for more information if she feels that staff listen to her.

9.5.4 Observing

During communication with a client or at group health education sessions, client(s) should be observed for the following reactions: *smiling, frowning, yawning, sleeping, or whispering to neighbors*.

These reactions should be noted and identified because they tell how the client(s) receive information being delivered.

Some shy clients react by smiling or frowning while bored or uninterested clients would yawn or sleep off. When a client does not understand or does not accept information he/she might react by whispering to a neighbour.

It is therefore necessary for effective and quality communication process, the above negative reactions should be observed to improve the quality of health education sessions.

9.6 BARRIERS OF EFFECTIVE COMMUNICATION

9.6.1 *Problems related to sender*

- Poor planning of the message;
 - Message should have an objective and an appropriate channel and proper time to deliver it.
 - Consider Cultural issues.
 - Age difference
 - Gender
 - Social - economic status

9.6.2 *Problems related to the Message*

- Difficult language
- Too many messages and wrong timing of delivering a message
- Unclear and unattractive message.

9.6.3 *Problems related to the Channel*

- Inappropriate channel e.g. using radio while receiver is not having a Radio
- Bad handwriting.

9.6.4 *Problems related to the Receiver*

- Negative Attitude
- Ability to understand the message.

OVERCOMING COMMUNICATION BARRIERS

The sender must know the background, interest and language of the receiver. The message presented must be timely, meaningful and applicable to the situation. Use appropriate channel in presenting the message.

9.7 ORGANIZING A HEALTH EDUCATION SESSION

All health workers at one time or another are involved in giving health education at the facility or in the community. Effective health education session in health facilities involve good planning. Planning activities should include:

- Selection of relevant topics according to target of people you want to give health education (e.g. a session on proper breast-feeding will be more relevant to lactating mothers while a session on diarrhoea can be given to everyone).
- Preparation of a conducive environment
- Adequate timing and duration
- Organization of learning materials.
- Allocation of staff responsible for each session.
- Evaluation of the outcome of the client education in short and long term.

9.7.1 *Selection of topics*

Selected topics for health education sessions should meet client needs. This encourages return visits to health facilities, client satisfaction and improves staff -client relationships.

Selection of topics for Health Education Sessions

- Questions from previous sessions
- Current environmental problems e.g. epidemics
- Issues from PHC Committee meetings
- New health care approaches adopted after training sessions
- Special request from clients
- New health care issues from top managers

9.7.2 *Environment*

The environment should be conducive to encourage learning. Sitting on mats, Khangas or benches in an open area should be encouraged instead of standing. A very large group may be noisy with poor listening and participation. Usually smaller groups are better for demonstration and promote client participation.

It would therefore be appropriate to divide large groups into small groups for effective listening and client participation.

9.7.3 *Timing and duration*

Timing and duration should be convenient to the clients. Two or more short sessions could be organized than one long session. One session organized too early in the morning or too late might lead to missed opportunities or long waiting times for clients.

A duration of fifteen to twenty minutes is appropriate to avoid boredom and long waiting hours before the start of other activities.

9.7.4 *Use of learning materials*

Appropriate selection of learning materials will promote active learning. Posters and flip-charts relevant to a selected topic should be identified before sessions. The display of posters in health facilities should be done in the areas where services are being delivered.

9.7.5 *Allocation of responsible staff*

It is important that the health worker responsible for giving a health education session should know before time. This will allow for adequate preparation of content, organization of materials and appropriate teaching methods. Monthly or quarterly time-tables of health education sessions and responsible people should be displayed on prominent places where everyone can see.

Staff attitude affect staff/ clients relationship during counseling and health education sessions. Staff need to be friendly, respectful and show interest in client problems.

Key issues for organizing health education sessions

- Select relevant topics
- Organize contents: clear, complete, understandable
- Organize appropriate learning materials
- Timing
- Duration
- Environment
- Involve participants

Activity 9

In groups prepare a role- play to demonstrate effective and ineffective communication process to clients or patients.

UNIT 10: POPULATION ESTIMATES IN HEALTH SERVICES

TOPIC: HEALTH SERVICE AREAS AND TARGET POPULATION ESTIMATES

10.1 INTRODUCTION

Health workers need to understand, their service/catchment areas, in relation to this they need to identify target groups and the importance of continuous care. This will enable them to assess their performance in their working areas.

10.2 OBJECTIVES

At the end of the unit the health worker should be able to:

1. Define the following terms:
 - Service area
 - Catchment area
2. Describe the criteria for demarcation of service area
3. Explain the importance of demarcation
4. Identify the target groups
5. Explain the importance of population estimates in relation to health service delivery.
 1. Explain the importance of continuous care in relation to the management and follow-up of patients in their service area.

10.3 THE SERVICE AND CATCHMENT AREAS

10.3.1 Definitions

Service area

This is a specific administrative area assigned to a health facility.

Catchment area

This is a geographical area where the majority of patients and clients going to the health facility reside.

10.3.2 Criteria for Demarcation of Service area

For good quality care the demarcation of service area is based on the following criteria:

- Population i.e. dispensary to serve 6,000- 10,000 and health centre should serve population of 50,000
- Distance between the health facility and the furthest village should not exceed a walking distance of 5 kilometres
- Geographical accessibility - consider big rivers, thick forest, mountains etc.

2.2.2 Importance of Demarcation

The demarcation of service area provides the following advantages:

- Provides the information of population under care
- Provides the basis for calculation of target population under the catchment area.
- Allows better planning of outreach, mobile services and home visiting.
- Accessibility to health facility by the population is assured.
- Community involvement will be planned to cover all parts of the population.

10.4 ESTIMATION OF TARGET POPULATION

Target population

Target population is a specified group of people in the population aimed to be given special attention/service.

Examples of target groups:

- Under 1 year (4% of the population)
- Under 5 years (20% of the population)
- Women of child bearing age (20% of the population)
- Under 15 years. (47% of the population)

How to calculate target population

Under 1 year = $\frac{4 \times \text{total population of a given area}}{100}$

Under 5 years = $\frac{20 \times \text{total population of a given area}}{100}$

Women of child bearing age = $\frac{20 \times \text{total population of given area}}{100}$

Under 15 years = $\frac{47 \times \text{total population of a given area}}{100}$

Importance of Target Population:

- Provides the information needed for planning and evaluation of health activities.
- Target population is used to assess coverage of health services.
- The information of population under care will enable health facility and the community to assess basic priority needs of the population.

Coverage

Coverage is the proportion of people with a need for health services who actually receive such services within a given time.

Or

Coverage is a measure of the extent to which a population entitled to a particular service such as antenatal care or immunization actually gets it

Examples of coverage measurements

Vaccination coverage = $\frac{\text{Number of vaccinated children}}{\text{Number of targeted children}} \times 100$
Number of targeted children < 1 year

Antenatal care coverage = $\frac{\text{Number of women with antenatal care}}{\text{Number of targeted women of child bearing age}} \times 100$

Coverage of birth attended by = $\frac{\text{Number of attended births}}{\text{Number of expected births}} \times 100$
Professionals and trained TBAs.

10.5 CONTINUOUS CARE

This is the provision of health services in the health facility and further into the community. Importance of continuous care is:

- To ensure compliance
- To ascertain continuity of services e.g. immunization, referrals, defaulters.
- To assess progress of the client.

Clients who need continuous care include the following:

- ***MCH/Family Planning services.***
 - Antenatal mothers
 - Under-five children
 - Post-natal mothers.
 - Family planning clients

Clients with chronic illness

- Tuberculosis and leprosy patients
- Hypertensive patients
- Mentally ill patients etc.

Clients with diseases of public interest

- STD/AIDS, Infections diseases.

10.5.1 Types of Continuous Care

1. *Outreach/mobile services*

Health workers also work with the community to improve their environmental sanitation and knowledge.

Health facility staff visit to the community in their service areas to provide immunization/ family planning or care of chronically ill patients.

Definition

- Outreach services are those activities of a health facility extended to service area, where staff provide service in the community.
 - Mobile services are those activities of a health facility extended to inaccessible communities.
- The services are usually offered by the DHMT.

2. *Home visiting*

Health facility workers follow-up clients in their homes; these could be family planning clients, tuberculosis defaulters and chronically ill patients, e.g. Aids and the mentally ill patients.

3. *Contact tracing*

It is a method used to trace and identify people who have been exposed to the originally diagnosed patient with a disease, hence at risk of being infected e.g. cholera or STD. In contact tracing health workers make a follow-up to the patients house.

4. *Referrals*

Clients with risk/serious conditions identified, should be referred to high levels for immediate and advanced care.

The first referral facility for a dispensary will be a well equipped health centre. For a health centre will be an appropriately equipped district hospital.

The following are the contents of referral letter:

Referral Letter

From: **Referral to:**
.....
.....
.....

Name of patient: **Age:** **Sex:** **Marital Status:** ...
Nationality: **Tribe:** **Religion:** **Address:**
Occupation: **Date of arrival:** **Time:**

History of present illness:
Past medical/obstetric history:
Physical examination:
Investigation results:
Diagnosis:
Reason for referral:
Treatment given before referral: ..

Name of referring health worker: **Signature:** ..
Qualifications: **Date of referral:** **Time:**

Referral point feedback to referring health facility:

1. Was referral diagnosis correct :
2. Was treatment given before referral appropriate:
3. Confirmed diagnosis at the referral centre ...
1. Follow up needed:
2. General comments for improvement in future referrals:..
.....
Name and signature of officer: **Date:**

NOTE

- It is worth noting that when a client is referred to a higher level, information should remain at the referral point.
- Feedback from the referral point should be communicated to the source of referral which in turn will communicate with the relatives.
- Treatment at the referral level will also be continued at the Primary level which is the dispensary and even at home.

Activity 10

1. a) Draw a map of your area indicating

- Population

-Distance and

Geographical features

b) Identify problems which hindered delivery of outreach activities in your services area.

c) Identify target population in your area and use them to calculate basic coverage for immunization

2. What types of Continuous care is practiced in your area?

3. Write a referral letter of child with severe anaemia from dispensary/ Health center to the district hospital.

UNIT 11: UTILISATION OF DATA IN HEALTH FACILITIES

TOPIC: DATA ANALYSIS AND UTILISATION FOR IMPROVEMENT OF QUALITY

11.1 INTRODUCTION

In order to ensure continuous quality care, measurement of the progress of service delivery is essential. One way of measuring quality care is by collecting data about activities carried out in the health facilities. This is already being done by all health facilities in the country through MTUHA. When this data is analyzed, it will indicate the quality of services provided.

The use of this data cannot be possible without the process of analysis. This will enable gaps in service delivery to be identified for appropriate action to improve the quality of care.

11.2 OBJECTIVES

By the end of the lesson participants should be able to:

1. Mention type of data
2. Identify sources of data available in the health facility.
3. Explain the importance of data utilization.
4. Utilize basic Quality assurance tools.

11.3 TYPES OF DATA

There are two main types of data available in health facilities. These are:

- Health facility data:
This is all information available in the health facility on services delivered.
- Community based data:
This is information collected about health and health related issues from the service area.

11.4 SOURCES OF DATA

The following are the main sources of collecting both health and community based data.

11.4.1 Health records

In health facilities, data is collected routinely as part of the HMIS (MTUHA). These include data from clinic records and registers. Other sources include supervision reports and health facility staff meetings.

11.4.2 Health and development committee reports

These are reports from health related groups in the community e.g. PHC Committees at all levels, village development committees and other health related sectors e.g. agriculture, water

11.4.3 Reports from Community Health actors

These are reports from community health actors such as VHW s, TBAs, and CBDs.

11.4.4 Census and Survey reports

Periodically, census surveys and programme reviews are conducted as planned activities. Community census of target populations such as children below 5 years and women of child bearing age are often conducted by health staff, VHW s, or CED agents.

Broad and specific programme survey reports include project programme review, demographic surveys or EPI/MCH review reports.

11.5 Data Analysis

When data is analyzed it becomes information which helps to visualize differences, trends, shortages and excesses. Simple mathematical comparisons using averages, totals, proportions and percentages can be done at all levels of the health system. These are compared to the set national standards.

For example one may want to find out:

- How successful the immunization activity has been in reducing cases of measles.
- What percentage of district health facilities are sending their quarterly reports this year compared to last year.
- What proportion of supervisory visits were carried out on time compared with your target in the supervision matrix.

11.5.1 Data Presentation

Data collected can be summarized and presented using simple tools which make it easier to understand e.g.

- frequency distribution table
- bar and Pie charts
- line graphs
- histograms etc.

1. *Frequency distribution table*

This is a table which shows variables and their frequencies. The three examples below show various types of tables. (These frequency tables will be used as examples in the charts below to visualize the trends)

Example 1. Immunization Coverage For Miono District – 1997

	Q1	Q2	Q3
Measles	85%	65%	68%
DPT 3	90%	85%	87%

Example 2: Under five Target Population For Makonde Dispensary - 1998

Village	Number	Percentage
Makonde	2,500	19%
Nyang oro	4,000	31%
Mbuyuni	6,500	50%
Total	13,000	100%

Example 3 Number Of Cholera Cases In Muheza District 1997

JAN	FEB	MARCH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
0	0	0	0	0	1	3	7	15	18	6	2

2. Bar charts and pie charts

These use pictures to compare the sizes, amounts, quantities or proportions of items or groups of items.

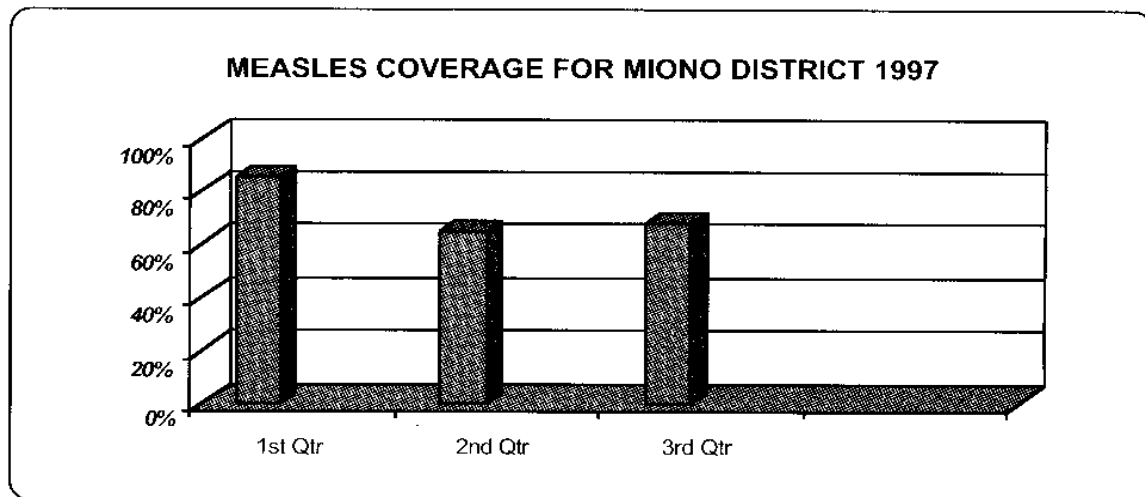
a) Bar Chart

Health staff teams may choose between three types of bar charts, depending on the type of data they have and what they want to stress

- Simple bar charts

This sorts data into simple categories

Example:

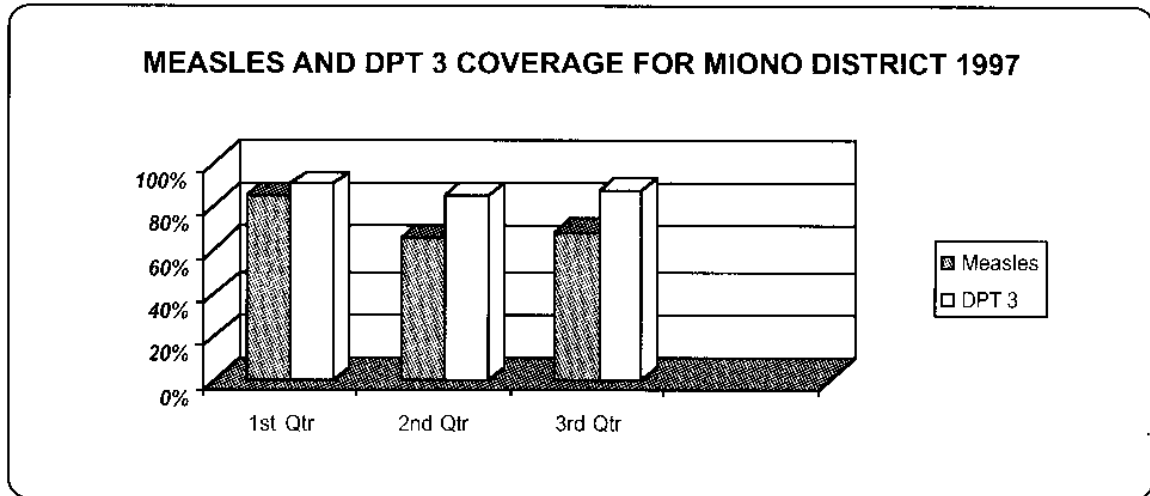


- Grouped bar charts:

The data is divided into groups within each category. It shows comparisons between individual groups as well as between categories.

This gives more useful information than a simple total of all the components.

Example:



- Stacked bar charts:

It is like a grouped bar chart but here the categories are put one on top of the other

Example:

STEPS IN CONSTRUCTING THE BAR CHART:

- Choose the type of bar chart that stresses the results to be focused on:
- Draw the vertical axis to represent the number
- Determine the scale for the vertical axis and label the axis with scale and units of measure
- Determine the scale for the horizontal axis and label the axis with scale and units of measure.
- Make sure number of bars needed should be equal to the number of categories. Draw bars of equal width for each item and label the Categories, and the group.
- Provide a title for the chart.

b) Pie Chart

This is a diagram which shows the relationship between different parts of a group. It shows how each part contribute to the group. The example of a pie chart representing data in table 2 above is shown below:

HOW TO CONSTRUCT A PIE CHART

- Select the data be charted
- Calculate the percentage contribution for each category by dividing the value of each category by the total and multiply by 100.
i.e. $\frac{\text{Value of each category} \times 100}{\text{total values}} = \text{percentage contribution each category}$
- Draw a circle
- Using these percentages determine what portion of the circle will be represented by each category ($\% \times 360$ degrees)
- Calculate the number of degrees using a compass to draw the portions.

Important

For all types of charts above ensure the following:

- Scales must be in regular intervals
- Charts for comparison must use the same scale or symbols
- Charts should be easy to read

c. Line Graphs

These usually shown trend of an event.

For example the graph below shows trend of Cholera cases in Muheza district for 1997

Utilization of Data

For data to be useful, it should be **analyzed and used locally** and also disseminated to the district, regional and national levels to improve services. If health data is adequately collected, analyzed and utilized, this will ensure quality of care is improved and sustained.

Data can be used for the following reasons:

- Identification of problems
- Improve planning
- Identification of resources required for better organization of services
- Monitoring and evaluation of services
- Make day to day decisions
- For supervision

a) Identification of problems

It is not only important to collect data for the purpose of doing it but to identify problems which affect services delivery. This leads to identification of possible solutions which are needed for improving the quality of services.

The following problems can be identified from records

- Poor utilization of services in health facility e.g. poor client attendance to specific services
- Epidemics e.g. Measles, cholera
- Poor organization of services (space, time, equipment, activities)
- Low Immunization coverage

- Increased morbidity and mortality
- Missing services e.g. dental services in dispensaries
- Poor staff performance
- Shortage of resources

From health and development committee reports, problems identified would include

- Inactive or in-existent health committees in some areas of the community.
- Poor membership of committees e.g. the absence of women. Poor representation of different population groups may influence activeness in that problems and decisions on health issues of this group will not be adequately addressed.
- Poor relationship between the health facility staff and members of the community
- Issues on agenda for health committee may not be related to community health problems.

Community health actors' reports may present problems of non-commitment, poor performance and poor relationship with community members and common health problem in community.

b) Improve Planning

Planning is an important aspect of management in order to improve the quality of health care delivery. This can only happen if data is collected and used for:

Planning health care activities

How to use resources e.g. equipment, supplies, time, space

c) Identification of resources required for better organization of health services

Identification of gaps in terms of:

- Staff number and cadres
- Equipment
- Supplies
- Time and space
- Infrastructure.

d) Monitoring and evaluation of services

Monitoring and evaluation measures the performance of health services. Monitoring continuously measures the carrying out of health activities, while evaluation assesses performance at a specific time period. All these need data.

The following can be monitored and evaluated:

- Health care delivery package performance
- time allocated for activities
- Utilized Materials and supplies

Activity 11

1. Mentioned the source of data available in a facility and community
2. What kind of data is collected from Health facility and Village Health committees?
3. Using data from health facilities draw Bar. Pie and /or time line graphs .

ANNEX 1 :

INTERPERSONAL RELATIONSHIP AND ROLE PLAY /CASE STUDY

OBJECTIVE: Identify skills in interpersonal relationship for improving quality care in health services.

CHARACTERS:

Health service providers:

- Mary - Public Health nurse
- Rhoda - Nurse Midwife
- Jean - Laboratory Assistant and friend of Mary

Clients

- Mrs. Said - Pregnant Mother fourth visit.
Mrs. John - Pregnant Mother first visit.
Ms. Joyce - Family Planning client

PLACE: MCH Clinic at Uchira Health Centre.

SCENE I: Clients are in the waiting area.

Clients are chatting among themselves;

Mrs. John - "We have been sitting here for a long time".

Mrs. Saidi - "This happens when Mary is on duty. I am Sure we are going to be here until 12 noon".

At 11.00 am Mary starts to call in the clients.

SCENE 2: Family Planning examination room.

The first client Joyce is going to be examined by Mary.

Mary - "What is your problem"

Joyce - "I have lower abdominal pain and vaginal discharge".

Jean walks in the room and starts talking to Mary on their personal issues.

Jean - " I have come to take you for tea"

Mary - " Okay, let us go"

Mary and Jean walk out and leave the client in the room. On the way they discuss the client;

Jean - "What's is wrong with Mrs. John".

Mary - "She has gonorrhoea".

Jean - "Oh! That's terrible. I am going to tell her husband, I know him".

Joyce waits for half an hour then decides to leave the examination room. On her way out she meets Rhoda.

Rhoda - "Why are you unhappy".

Joyce doesn't answer immediately; Rhoda encourages Joyce to come with her one of the rooms to talk. She offers her a sit. Joyce tells Rhoda the whole story about her problem and the bad handling from Mary and her friends. Rhoda examines Joyce and treats her according to standard treatment guidelines. Joyce is happy, thanks Rhoda and promises to come back for check up.

SCENE 3: At the waiting room.

Mary comes back and talks to the other clients

Mary "Do you have time to come tomorrow ? . While looking at her watch.

Clients "No we don't have time.

Mary "Okay then come when you have time".

Facilitation discussion:

Actors

- How did they feel when they were acting as clients and services providers.
- De-role actors.

Group discussion:

What suggestions do you have in improving quality of health services.

ANNEXE 2: TEAM EFFECTIVENESS SELF -ASSESSMENT

A 'team effectiveness assessment' is a simple chart which can be used to gain insight into the workings of your team. All the members of the team are asked to give their views on each of the nine variables and one can see where the low and the high ratings occur. Low ratings may indicate the need for change; high ratings may indicate features to be built on and strengthened

EXERCISE:

TEAM EFFECTIVENESS ASSESSMENT Analyze your team by rating it on a scale from one to seven (seven being what you consider to be the ideal) with respect to each of these variables:

STAGE 1:

Go through the chart yourself and rate your own team with a score of any number between 1 and 7 on each of the variables. Thus on I(a), if you think the team's objectives are well understood, you could score 6 or 7. If you think they are not understood, score for 2. If you think objectives are only partly understood you might score 3,4 or 5.

STAGE II:

Ask each member of your team to complete the chart.

STAGE III:

Collect and summarize the result of all your team members, to give a total score for each of the variables.

STAGE IV:

Discuss the results with your team. High scores indicate your team's strengths; low scores indicate where your team working might be improved. Discuss with your team how this might be done. Finally, when thinking about how your team works, think about its methods and procedures.

(1) *Group objectives*

- (a) Not understood by group. (1) (7)
(b) Group is negative towards objective (1) (7)

(2) *Utilization of member resources*

Our abilities, knowledge and experience are not fully utilized
as a group. (1) (7)

(3) *Degree of mutual support*

High suspicion (1) (7)

(4) *Control methods*

Control is imposed on us. (1) (7)

(5) *Handling conflicts within group*

We deny, avoid or suppress conflicts. (1) (7)

(6) *Experimental learning*

We ignore and do not learn from our group experiences. (1) (7)

(7) *Organizational environment*

Restrictive; pressure for conformity. (1) (7)

(8) *Communications*

- (a) Guarded, cautious. (1) (7)
(b) We don't listen to each others (1) (7)

(9) *Sense of belonging*

No cohesiveness We have no sense of belonging. (1) (7)

ANNEX 3: EXAMPLES OF QUESTIONS FOR an EXIT INTERVIEW
QUESTIONNAIRE FOR CLIENT

1. REASON FOR SEEKING CARE

- What made your came to this health facility
- Did you get what you came for?

2. PHYSICAL ACCESABILITY

- How much time did it take you to travel to this health facility?

3. SOCIAL A CCEPTABILITY

- Are you satisfied with the care of the Health Workers in the treatment of your illness?
- Did you get all the information that you expected about your illness?
- Did the Health Worker(s) spend enough time with you during consultation and treatment.
- Give your views on the overall cleanliness and comfort of the waiting room, examination room, availability of instruments and equipment and medicine of the centre.

4. SERVICE AFORDABILITY

- Did you feel that the cost for the services you received is reasonable?
- Is it a problem for you to pay that amount?

5. PROPOSAL FROM THE USERS FOR IMPROVEMENT OF SERVICES IN THE HEALTH FACILITY

- What do you think should be done to improve the services/provided in this facility.

ANNEX 4: EXAMPLES OF INDICATORS

INDICATOR	MEANS OF VERIFICATION	TO BE USED FOR	VALUE AND LIMITATIONS INDICATOR	COMMENTS
STRUCTURE				
Geographical accessibility X percent population living within x km of health facility _____x 100 total population in a defined area	-census data and geographical map -analysis of health service registers -interviews of users (questionnaire) -interviews of users (questionnaire) -interviews of resource persons	baseline evaluation	-gives an overview on which proportion of population lives in a specified distance to health services -Indirect measure to estimate how easily the service can be used -closely linked to factors of acceptance	The “population living within a specified distance from a health facility” is often called “catchment population”; i.e. the empirically refined potential user population. Distance to other public institutions (market, etc) has to be considered as well; especially for preventive services (e.g.: a mother might accept a longer distance to take her child for immunization, if she can combine this with going to the market). This is called “centrality” of the health care delivery point.

<div>Social, cultural accessibility No. of users from a specific subgroups (ethnical, social) _____ x 100 Total subgroup population)</div>	Interviews with subgroups participatory survey/observation	Operational study baseline study	Important for identification of discriminated groups difficult to quantify/interpret	<p>Social and cultural factors are important influences on the acceptability of health services. Examples: male nurses in family planning service may prevent women from attending.</p> <p>It data on specific subgroups are registered in the health services, a survey and /or qualitative investigation (such as group discussions, participant observation) has to be carried out to gain more insight into the structure of users/ non – users.</p> <p>Determinants for social subgroups (having an influence on acceptability) are: age, sex, religion, economic class educational level, profession</p>
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<p>Availability of standars forms, charts, papers</p> <p>No. of health facilities with specified items available $\frac{\text{_____}}{\text{total no of health facilities}} \times 1000$</p>	<p>Presence of papers(on the spot checks) Examples: clinic registers, working schedule, lists of standard equipment available</p>	Monitoring	Easy to assess important basic requirement for efficient management	<p>The importance of the availability of the standard forms, charts, paper etc. at the level it is meant for should be stressed, i.e. at the level it is meant for should have a copy of his or her job description, standardize therapeutic schemes should be with the staff they were written for, etc.</p> <p>The mere presence of these papers at management level is not sufficient.</p>
<p>Availability of standard Equipment</p> <p>No of health facilities with more than x% of Equipment $\frac{\text{_____}}{\text{Total health}} \times 100$</p>	Supervisory reports	Monitoring	Easy to assess if regular supervision (with checklist) is carried out	<p>Precondition is there should a standard lists for each type of health facility and are the level they are meant for. Primarily, this indicator is a measure for the management's capability to ensure the necessary continuous supply of standard equipment at the level. Since the</p>

				<p>availability of standard equipment is a precondition to offer adequate services for the population, it may be used as an indirect measure for the quality of services. If being used for this and completeness of equipment should be measured as Yes/no for each unit separately. With disposable goods (drugs, vaccines, etc) it will be useful to measure in addition for which time of the year it is available (e.g. essential drugs in stock at health center x months/ year</p>
<p>Manpower productivity</p> <p>Staff- Client contacts (per day or month or year) _____ scheduled working time of staff (per day or month or year)</p>	Routine Data	<ul style="list-style-type: none"> - Baseline - Monitoring - Evaluation 	<ul style="list-style-type: none"> -Useful for manpower planning -Comparison of performance between people or kinds of workers possible (identifying problems) -Note additional information is necessary to get a realistic. 	<p>Staff-client contactes are only of the number of activities expected to be carried out by each category of health workers. Because the staff-client contacts are usually reported in a health system, they form a good basis for</p>

				<p>manpower productivity indicator. If other activities (e.g. health talks given, health-team meetings attended, etc) are reported as well, they can be used in a similar way. If one allocates to each specific activity an expected average time, it is possible to calculate the productivity of a health worker by adding the time used for specific activities and dividing it by the scheduled working time. Working hours (per day/month/year) can be estimated e.g. 6th / day or 300 working days/year. As long as the figures are kept constant throughout the study, their absolute value has only a small influence on the results.</p>
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INDICATOR	MEANS OF VERIFICATION	TO BE USED FOR	VALUE AND LIMITATIONS INDICATOR	COMMENTS
PROCESS INDICATORS.				
Funtioning of reporting system <div> No of reports available at a given time _____ x 100 expected no of reports </div>	Report	Monitoring	Easy to assess no indication of quality of reporting system	Report can be either report sent to the central level by the peripheral level or reports produced by the management (i.e. yearly operational plans) There is a risk of producing reports lacking in content just to fulfill the requirement. Therefore it is highly recommended to use this indicator together with a qualitative measures
Appropriateness of Referrals hospital survey <div> No of justified referral cases _____ x 100 Total no of referral cases </div>	Routine Hospital data	Baseline Evaluation	-important to assess the functioning of the referral system -provides information as to the extent the hospital functions as a referral center -does not include those patients referred who do not actually attend the hospital	Care: Demand by patients to be referred to the hospital may distort the figures Can only be measured at hospital level Information on the appropriateness of referrals is important for supervising referring activities at the different levels. N.B. this

				indicator does not measure the number of cases needing referral who are in fact not referred
Regularity of Supervision <div> No of facilities visited by supervisors in past N months with standardized supervisory report _____ x 100 Total no health </div>	Supervisory report	Monitoring	Easy to assess no information on quality of supervision indirect measure for the functioning of the management	Precondition for this indicator are: -a clear definition, who is responsible for the supervision in a defined geographical area fixed regulation on the time interval of supervision -standardized report (checklists) for supervision -The properly (completely_ filled supervisory reports may be used as an indirect indicator for the quality of supervision (no of completely filled reports/total no of reports)

<p>Staff workload</p> <div> <p>No of hours actually worked (real working hours)</p> <p>_____ x</p> <p>100</p> <p>No of working hours theoretically available scheduled)</p> </div>	<p>Observation over a given period of time</p>	<p>-operational study</p>	<p>-very valuable as additional information for productivity measurements</p> <p>-very time consuming</p> <p>-personnel often reluctant to be “controlled by external person difficult to gain realistic figures (by your presence you are influencing the behavior)</p>	<p>A small qualitative study could be a useful proxy for this indicators. Such a study could include</p> <p>Group interviews of (potential) users if they find it difficult to meet the staff (because not there, because too busy)</p> <p>-Interview with staff on their working and obligations apart from official work</p> <p>-Random checks of the presence of health workers A simple version of this indicator would be to document whether staff are actually present at their posts (e.g. at time of supervision)</p>
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INDICATOR	MEANS OF VERIFICATION	TO BE USED FOR	VALUE AND LIMITATIONS INDICATOR	COMMENTS
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<p>Capacity of service</p> <div> <p>Total no of minutes available</p> <hr/> <p>No of minutes per for example: Total no minute available of ANC staff for consultation</p> <hr/> <p>No of minutes for one ANC consultation (eg 15 mins) 2 (nurses) x 180 (min. per day) x 5 (days a week)</p> <hr/> <p>_____15 (min. foe one ANC consultation)</p> </div>	<p>Routine service data (number of staff) Work schedule observation (survey)</p>	<p>Baseline Monitoring Evaluation</p>	<p>Gives estimate if available resources are sufficient in view of expected or planned services indicates the possible need of rationalizing the use of resources no of information on quality of service</p>	<p>To get a realistic estimate on time per consultation (e.g. ANC) the minimum of necessary tasks per consultation must be determined. A distinction between “new cases” and “re-at tenders” is necessarily mean higher quality of service- the actual tasks being carried out have to be measured and valued</p>
<p>Intensity of use</p> <div> <p>Total no of attendees _____ x 100</p> <p>No of first attendees</p> </div>	<p>Routine data of service (if differentiated in first attendees and re-attendees) survey (if no routine data available</p>	<p>Baseline Monitoring (if specific measures are planned) evaluation</p>	<p>Provides important information on compliance of users gives indirect information on quality of service (acceptability) gives no information on non- users exactly</p>	<p>The definition if a person is a “first attendee” difficult and often not (or incorrectly) reported. To be used as indicator targets for the intensity of use have to be set: for some preventive services (antenatal care, immunization schedule) and for chronic diseases,</p>

				<p>where patients have to be seen regular, time period can be defined Example 3 visit for antenatal care per pregnancy (first contact in third month of pregnancy) Year 0: 40% Year 2: 70% Year 3: 90%</p> <p>However for acute disease, it is difficult to define the number of necessary re-attendance, as this is dependent on a wide range of variables. Note: the intensity of the use refers only to the part of the population actually using the service (for at least one time)</p>
OUTCOME INDICATORS				

<p>Maternal Mortality Rate (MMR)</p> <div> <p>No of maternal deaths _____ per year 100,000 live birth</p> </div>	<p>Health service statistics census- data and vital statistics (demography dept) survey (if no data available)</p>	<p>Baseline Evaluation Operational study</p>	<p>Often used to measure achievement of project goal often used at national level very complex indicator difficult to assess (depending on quality of data)</p>	<p>Maternal deaths are the deaths arising during pregnancy or from puerperal causes i.e. deaths occurring during and/ or due to deliveries, complications of pregnancy, childbirth, and the puerperium, Women exposed to the risk of dying from puerperal causes are those as the being unknown, the number of live births is used as the conventional denominator for number of live births is used as the conventional denominator for maternal mortality rates. According to WHO, maternal death is defined as a death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy of its management but no from accidental or incidental causes In areas, where the majority of deliveries goes unattended (by trained personnel), the MMR can only be assessed by special population based studies (prospective or indirect</p>
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				techniques)
Low birth weight rate <div style="border: 1px solid black; border-radius: 15px; padding: 10px; margin: 10px 0;"> <p>No of life born babies with birth weight below 2,500 gm _____ x 100</p> <p>No of total life born babies with recorded birth weigh</p> </div>	Resisters of MCH service	Monitoring Baseline Evaluation	Easy to assess important information care: self selected group (see comments) influenced by many factors beyond the scope of MCH service	<p>Reliability depends on what proportion of pregnant women use the MCH-service for delivery i.e. if only a small proportion of births (from a self selected group of users) is recorded, the figure is title reliable. In this case a prospective population based study will be necessary.</p> <p>A high percentage of low birth weight points to deficient health status of pregnancy women, too close a spacing of births, inadequate prenatal care, and the need for improved care of the newborn (2)</p> <p>Like MMR and IMR, this indicator is only partially influenced by the health sector.</p>

Extracted from: Indicators for district Health system – a joint working group document of GTZ and Institute of tropical hygiene and public health of the University of Heidelberg.

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