



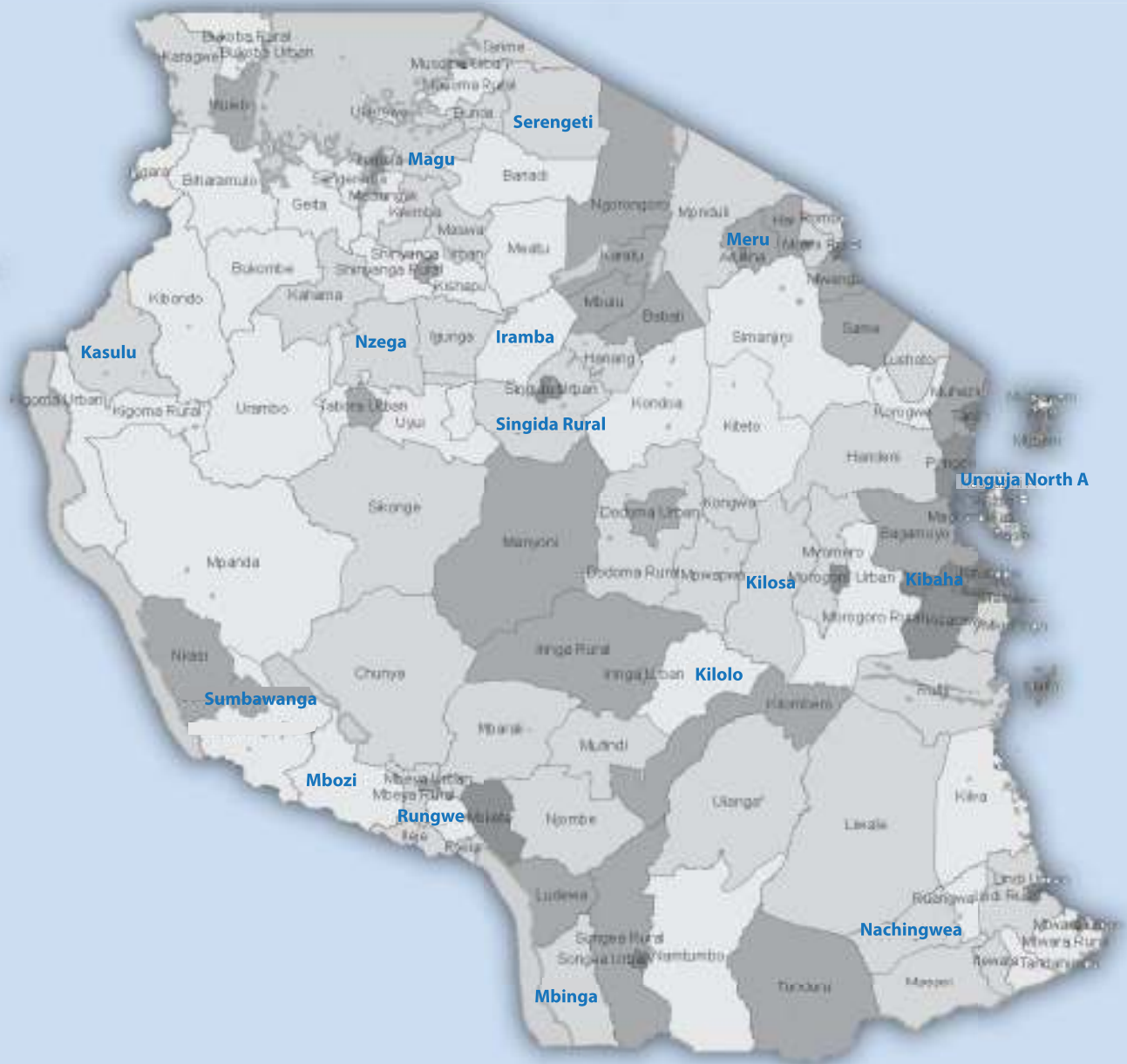
**World Health
Organization**



Experience from Peer Learning Districts on Health Systems Strengthening

Concept to practice

Tanzania



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Acronyms

CCHP	-	Comprehensive Council Health Plan
CHF	-	Community Health Fund
CHMT	-	Council Health Management Team
DHMT	-	District Health Management Team
EmOC	-	Emergency Obstetric Care
EPI	-	Expanded Programme for Immunization
HMIS	-	Health Management Information System
MOHCDGEC	-	Ministry of Health, Community Development, Gender, Elderly and Children
MSD	-	Medical Stores Department
NHIF	-	National Health Insurance Fund
PLD	-	Peer Learning Districts
PORALG	-	President's Officer, Regional authority and Local Government
PPP	-	Public Private Partnership
RHMT	-	Regional Health Management Team
RMNCAH	-	Reproductive, Maternal, Newborn, Child and Adolescent Health
WHO	-	World Health Organization

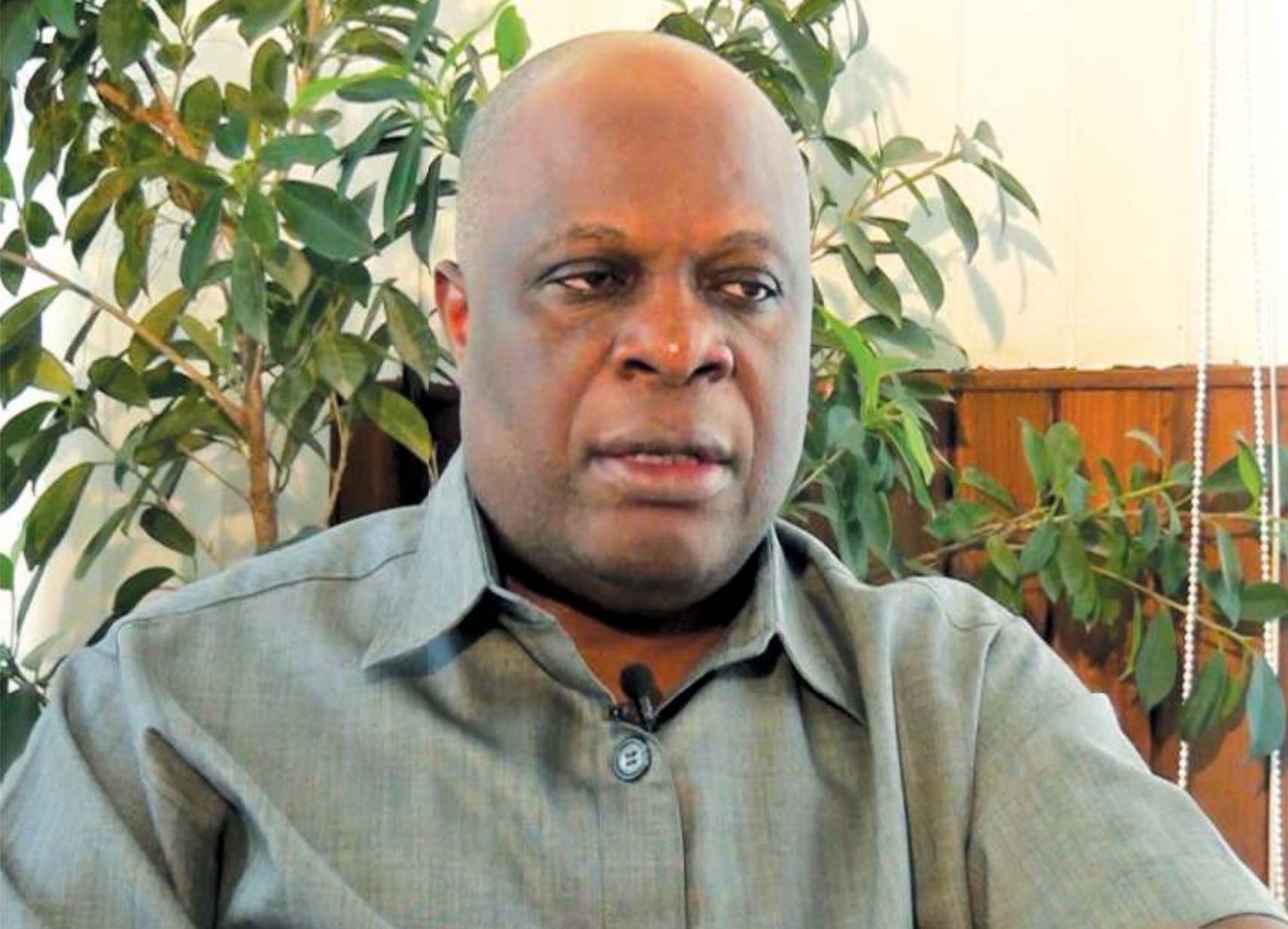
Acknowledgement

This report is a result of many efforts and contributions made by various individuals and partners committed to strengthen health system in Tanzania at district level.

WHO would like to acknowledge the following for making this initiative possible: District Executive Directors (DEDs), District Medical Officers (DMOs), Regional Health Management Teams (RHMTs), the District Health Management Teams (DHMTs), Council Health Management Teams (CHMTs), MOHCDGEC, PMORALG and MoH Zanzibar and health facility staff in all seventeen peer learning districts.

We would also like to thank all the contributors to the United Nations Development Assistance Plan I (UNDAP I) 2011-2016 in Tanzania as their contributions made this initiative possible.

Finally we wish to thank various development partners, NGOs, CSOs and private institutions.



“Our objective was to set up a programme which would enable the central level to visit the districts as well as the facilities to support them to do what is provided for in the national guidelines for health service delivery and also to check if policies are being followed”

Dr. Rufaro Chatora, WHO Representative, Tanzania.

Introduction

The Peer Learning District Initiative (PLD)

The peer learning district initiative involved seventeen (17) relatively well performing districts selected to serve as models to other districts on how health service delivery can be improved. This concept emanated from the 12th Joint Annual Health Sector Review (JAHSR) meeting held in 2011.

The goal of the initiative was to demonstrate how existing resources with a minimal addition of new resources can be effectively used to yield optimal results. Selected Regional and District Health Management Teams were to be assisted on strategic planning and budgeting to enable them strengthen their respective Comprehensive Council Health Plans (CCHP) in line with recommended national policies and guidelines.

Based on a set of performance criteria agreed upon by the government and development partners, seventeen districts were selected to participate in the peer learning district initiative. The selection criteria included: capacity of district leadership, availability of functional teams and structures, functional Community Health Funds (CHF), functional National Health Insurance Fund (NHIF), operational facility accounts, and districts' capacity to adhere to the national guidelines.

Sixteen districts were selected from Tanzania Mainland: these are Mbozi, Serengeti, Kibaha, Magu, Meru, Rungwe, Iramba, Singida Rural, Nzega, Kasulu, Bahi, Sumbawanga, Mbinga, Kilolo, Kilosa and Nachingwea, and the seventeenth was from Zanzibar, namely Unguja North A district. The initial duration of the peer learning initiative was four years from 2012-2015.



“In order to understand what the situation was like, we had to do the baseline assessment. So we went to Singida Rural, Iramba, and Meru and using what we called Six Building Blocks of Health Systems which WHO advocates, we tried to look at each block to see what is happening at that level.”

Dr Ritha Njau, WHO National Professional Officer.

WHO's Engagement in the Peer Learning Districts Initiative

WHO in collaboration with the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), Prime Minister's Office, Regional Administration and Local Governments (PMORALG) and Ministry of Health (MoH), Zanzibar conducted baseline assessments in all the 17 districts. The status of implementation of Comprehensive Council Health Plans was assessed in line with available resources. Other important areas assessed were the health services delivery infrastructure, human resources' skills and distribution and health information system, its use in planning and decision making. The level of community engagement in planning and managing of Community Health Fund (CHF) scheme was also assessed.

The key strengths noted included presence of Health Facility Governing committees in dispensaries and health centres. These committees among other things authorized expenditures from facility accounts. This demonstrated good level of transparency and accountability. The findings also noted that Health facility accounts were operational

and CHF money deposited and used at the point of collection. The team noted an increasing rate of community participation in CHF. Main challenges were: shortages of medical equipment, medicines and supplies generally observed in all the seventeen districts. There was a critical shortage and maldistribution of health workers. Health facilities which were off the national electricity grid reported difficulties in conducting deliveries at night. Supportive supervision was not regularly conducted due to delays of health basket funds disbursement and worn out vehicles.

WHO selected Meru, Singida Rural and Iramba districts from Tanzania Mainland and Unguja North A in Zanzibar for additional support. Capacity was built on data management, supportive supervision, immunization, reproductive, maternal and child health services.

On quarterly basis, joint field visits were conducted in collaboration with MOHCDGEC, PMORALG and MOH Zanzibar to assess progress and provide further support.



"After the provision of medical equipment, the number of surgeries conducted has gone up from around 30 to 110 per month at Meru District Hospital."

Dr. Focus Maneno, Medical Officer in Charge, Meru District.

Maternal and Child Health Services

Given the challenges noted in the delivery of maternal and child health services, WHO provided maternal and child health equipment for the health facilities. These included autoclave machines, oxygen concentrators, portable ultrasound machines and pediatric resuscitation tables which were distributed to the seventeen districts. To strengthen emergency obstetric care, the organization also provided delivery beds, delivery kits, baby weighing scales, labour monitoring tools and theatre operating tables. Meru district also received an anaesthetic machine for one of its newly built operating theatre.

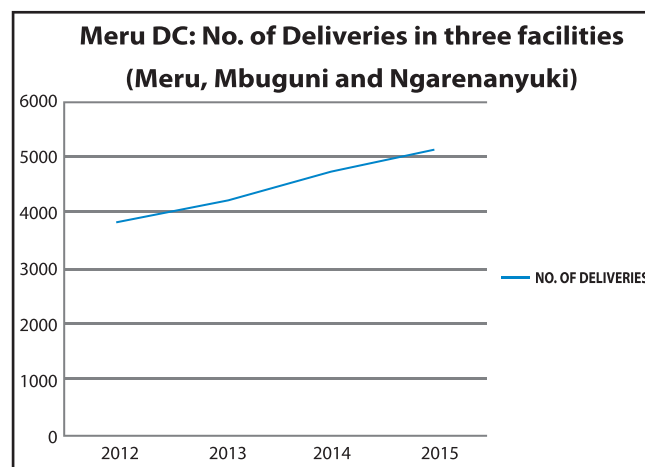
Twenty five (25) health facilities in Meru, Iramba and Singida Rural had solar power installed. Solar power was also installed in Rungwe, Nachingwea and Serengeti districts.

“The installation of solar power has helped in laboratory services for example; microscope uses power as well as other equipment. We used to send people to town for diagnosis, but now we don’t have to, we have what we need here.” Dr. Shuleka, Kinyamwenda Health Centre, Singida Rural district.

Orientation sessions were provided to Council Health Management Teams (CHMT) and District Reproductive and Child Health Coordinators (DRCHCOs) on RMNCAH. Health care providers from 25 health facilities were trained on Reach

Every Child Strategy for immunization.

Following the installation of solar power and equipment, the number of deliveries in the beneficiary health facilities increased. This is evidenced in Meru District whereby the three supported facilities: Meru district hospital, Ngarenanyuki and Mbuguni health centres reported increase in the number of facility based deliveries from 3825 in 2012 to 5141 in 2015 as shown in the below graph:



“Together with the districts, we identified equipment which brings the highest impact on lives of mothers and children.” Dr Theopista Kabuteni, WHO National Professional Officer.



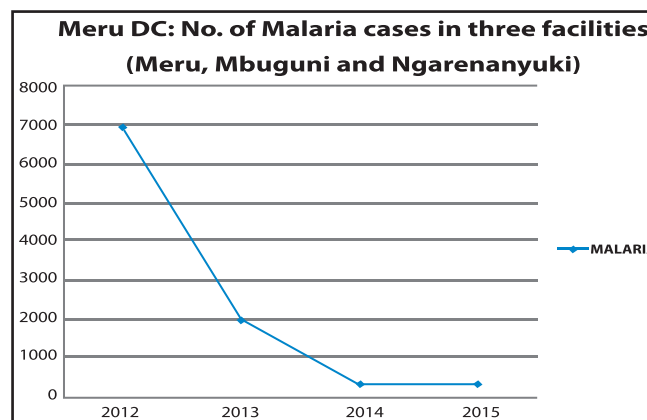
A vehicle provided by WHO for supportive supervision

Health Systems Strengthening

Supportive Supervision

A supportive supervision manual and checklist were revised and updated to facilitate supervision by the districts. Seed funds were provided to complement Health Basket Funds on operational costs of the visits. In addition WHO provided vehicles specifically for conducting supportive supervision. Prior to that the districts experienced difficulties in conducting regular supervision due to limited number of roadworthy vehicles.

During supportive supervision, emphasis was put on ensuring health worker adherence to the technical guidelines. These visits helped narrow the gap between national policies and the actual practice on the ground. For example, the number of fevers attributed to malaria significantly reduced in the three supported facilities in Meru: Meru District hospital, Mbuguni and Ngarenanyuki health centres when laboratory confirmation of every suspected malaria case was conducted prior to treatment as per the new national malaria guidelines. See the graph below:



"...definitely we know we have challenges, we have many guidelines in place and sometimes dissemination is not adequate and we realize that we need to ensure that as we come up with various guidelines, that they are actually disseminated. And dissemination goes beyond just a one day workshop to orient people on the guidelines that are available. It is about working with the providers, bringing in mentorship, ensuring that they are assisted and supported to be able to implement these guidelines."

Dr. Neema Rusibamayila,
 Director of Preventive Services,
 Ministry of Health, Community
 Development, Gender, Elderly and Children
 (MOHCDGEC).



RMO Singida and DMO Iramba in a group photo with the former Hon. Minister for Health and Social Welfare, Dr. Hussein Mwinyi holding up certificates recognizing exemplary leadership in health care service provision in 2014.

Facility drug audits conducted during supervision visits helped improve drug management by the facility staff reducing frequencies of medicines stock outs. In Iramba for example, availability of medicines was seen as a key motivation factor for increased contributions to the Community Health Fund (CHF). In return, the upsurge in CHF funds enabled facilities to restock their pharmacies. The enrollment onto CHF in Ndago and Kyengege health centres and Kikonge dispensary in Iramba increased from 27% in 2012 to 61% in 2015. The enrolment in beneficiary facilities in Singida Rural: Kinyamwenda, Migori and Mang'onyi dispensaries increased from 10% in 2012 to 26% in 2015.

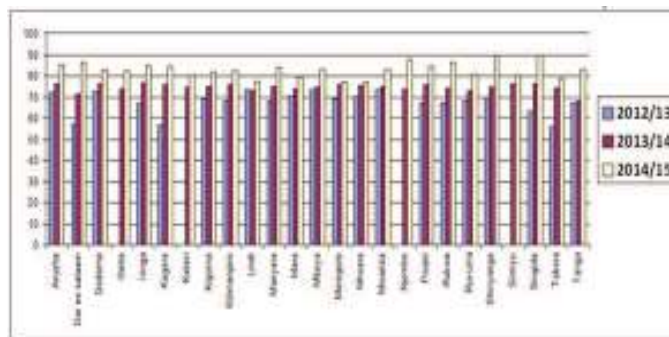
The peer learning districts planned and held review meetings amongst themselves annually to share experiences and best practices from the implementation of this initiative. The experience registered from Iramba on drug audits as part of supportive supervision rolled out to Meru and Bahi. WHO supported Regional and District Medical Officers (RMOs and DMOs) meetings which enabled effective coordination and sharing of the experiences in health services delivery. In this regard, Singida Regional Health Management Team (RHMT) and Iramba Council Health Management Team (CHMT) were recognized and awarded trophies as teams that have

demonstrated exemplary leadership in health care service provision.

Health Management Information Systems

All seventeen peer learning districts were provided with computers to improve data management and utilization. In addition, all districts in the country were trained on use of the Planning and Reporting (PlanRep) online tool for CCHP. This support enabled districts improve data collection, compilation, analysis and utilisation. This led to improved and well-informed Comprehensive Council Health Plans (CCHPs) as demonstrated by high scores yielded during the annual assessment of CCHPs.

CCHP planning performance by region:



For example, during the 2014 Joint Annual Health Sector Review (JAHSR) meeting, it was reported that 14% of the 162 councils had achieved a score of 90%+ for complying with CCHP guidelines, as per the graph above.



"After the training, we were supplied with a computer from WHO and we use this computer to access eLMIS network for reporting and ordering of drugs or other medical equipment for the 35 health facilities in the District."

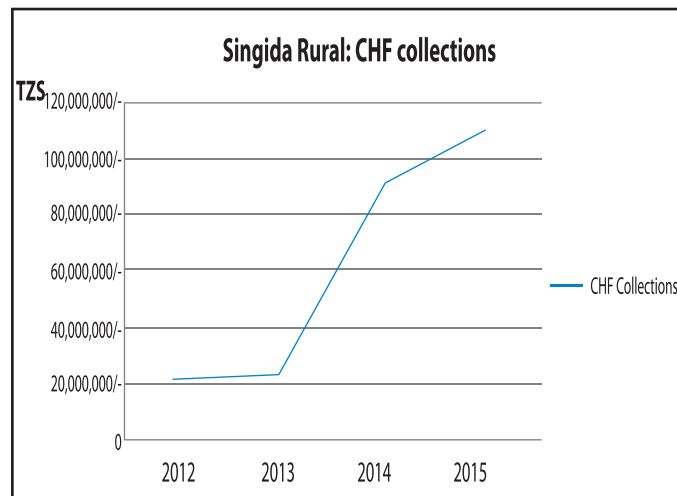
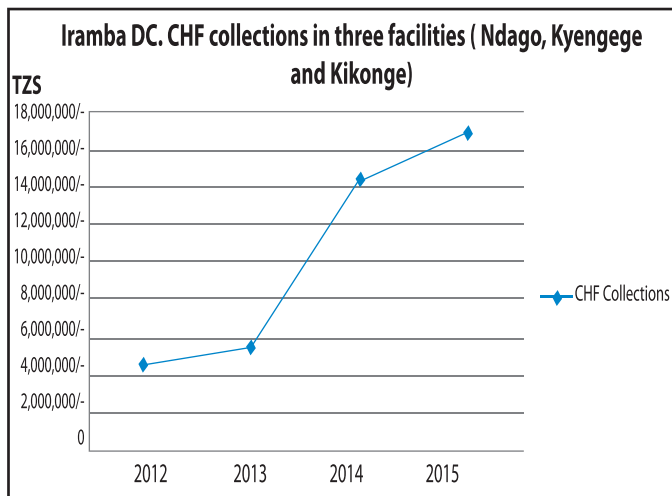
Mr. Abdi Mushi, District Pharmacist, Iramba

Supply Chain Management

District pharmacists and some of the CHMT members from seventeen peer learning districts were trained in the electronic Logistic Management Information System (eLMIS) to improve their skills in the management of health products at the district. eLMIS software was also installed in Meru, Iramba and Singida Rural districts to further address challenges of stock-outs and also facilitate faster collection, transmission and aggregation of data by the district pharmacists. Supported districts indicated increased compliance by the facilities in reporting in terms of timeliness and completeness; additionally this assisted in facilitating decision making and managing supply chain systems.

Health financing

The CHF and NHIF are potential sources of health care financing at primary health care level. The districts were supported to conduct awareness and sensitization campaigns with the communities for enrolment into the Community Health Fund. As a result the CHF collections increased both in Iramba and Singida Rural as shown in the below graphs:



Communities realized the importance of enrollment in CHF as they noticed that the collected money facilitated the availability of drugs and supplies. The experiences on CHF contributions attracted other districts to learn from Iramba. Among them included Mbinga, Serengeti, Manyoni, Nyasa, Rombo, Sumbawanga and Nachingwea District Councils.



Solar panel installed to support Kijini PHCU services

Zanzibar

Unguja North A was provided with a vehicle, two computers, solar power in two facilities and maternal health equipment. The latter was meant to improve quality of care for emergency obstetrics, newborn and child health services. The population of the district which is around 10,000 is served by the two health facilities.

The district acknowledged increased capacity to conduct supportive supervision following support of a vehicle which was specifically provided for the supervisions. Record keeping, data analysis and report writing including e-LMIS also improved.

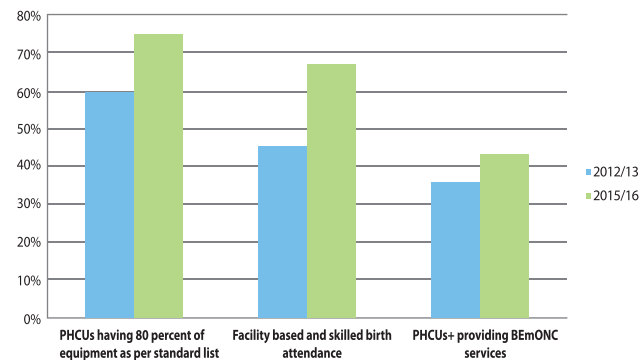
With regard to maternal health services, North A district performance report showed an increase in the proportion of pregnant women delivered at the beneficiary health facilities from 44.6% in 2012 to 67% in 2015. The number of Primary Health Care Units (PHCUs) having 80 percent of required equipment according to standard list increased from 60% to 75%.

Support of solar power installation in Matemwe and Kijini health facilities had an impact on immunization services as well. Prior to this, maintain vaccine cold chain was not possible due to

frequent electricity blackouts. Staff also acknowledged improved working environment as they could now provide health services at all times.

In the spirit of enhancing peer learning approach, Unguja North A successfully conducted Village Health Days to enhance community awareness and participation in health services. This has been conducted monthly using locally district funding and funds from development partners. Activities include health promotion on maternal and child health services, non-communicable diseases, tuberculosis, dental and eye health services. District Health Management Team (DHMT) members in North A were eager to share this good practice for other districts to learn.

Comparison of performance indicators between 2012/13 and 2015/16 in North A District





WHO Tanzania Staff, 2014

"It is possible to bring change in the health sector and it is possible to bring change in health services delivery. But the change requires commitment from different sectors, from different people, from different professionals."

Dr. Alphoncina Nanai, WHO National Professional Officer.

Conclusion

The frequency of CHMT supportive supervision and the joint field visits from the national level allowed time for mentorship and on spot problem solving. It gave an opportunity of clarifying national policies and technical guidelines at the implementation level. CHMT members acknowledged that support from the central motivated them to raise their performance indicators on which they could share experiences and the creativity with other districts.

“We are grateful for the support we receive from WHO as it reminds us that, as CHMTs we have a task to raise our performance indicators and share this experience and creativity with CHMTs in other Districts, probably those who need to improve their performance.” Dr. Focus Maneno, Medical Officer in Charge, Meru District Hospital.

The initiative also helped district teams to realize that they could maximize impact of the services with the available resources. For example, implementation of drug audits enabled monitoring of the medicine stocks, utilization and forecasting which ultimately improved medicines availability as evidenced in Iramba district. Funds intended to cover on the shortage of medicines could now be used to support other important services.

Installation of solar power in the health facilities prompted some of the districts on their own to extend solar electricity to staff houses and other health facilities as was the case in Singida Rural and Meru districts.

Solar power utility at the facility and staff houses complimented by regular mentorship and availability of working tools, served as motivation for the staff but also facilitated retention of health workers in the rural facilities. Solar power also improved the accessibility of diagnostic services through use of electrical microscopy at dispensary and health centers level. The number of patients to be referred to the district hospitals for laboratory investigation reduced.

Community participation improved in areas where service provision was improved. This was evident in Unguja North A district where the number of health promotion activities increased following increase of village health days undertaken. Meru and Iramba experienced significant increment in the community contributions to the local health insurance schemes.

Overall the lessons from the peer learning initiative show that ongoing mentoring and availability of the health workforce, working tools including medicines and supplies and good working environment are key areas for successful health services delivery. Narrowing the knowledge gap both in providers and those served, is vital. Better planning of available resources supported by community contribution, access and accountability stand a better chance in achieving the desired health outcomes.

“The new management in the Districts needs to support the health department, they need to understand the policies, guidelines; they need to be trained. We need to communicate this information to the District Executive Officers (DEDs). Those are the decision makers but they don't have information on the policies and guidelines.”



Dr. Anna Nswilla, Assistant Director-Health, President's Office, Regional Authority and Local Government (PORALG).



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