THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL HEALTH AND SOCIAL WELFARE QUALITY IMPROVEMENT STRATEGIC PLAN 2013 - 2018

(NHSWQISP-I - 2013 - 2018)

NOVEMBER 2013

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Quality Improvement Series

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TABLE OF CONTENTS

CHAPTER 3: STRATEGIC QUALITY IMPROVEMENT PRIORITIES

FOREWORD

The Ministry of Health and Social Welfare (MoHSW) is committed to ensure that high-quality health care and social welfare services are provided to all citizens countrywide through implementation of evidence-based interventions. Development of the National Health and Social Welfare Quality Improvement Strategic Plan (NHSWQISP) is a major step towards responding to quality of care challenges in a comprehensive and systematic manner.

This Strategic Plan outlines evidence-based priorities necessary for achievement of high-quality health and social welfare services to the public; they include Conducive Working Environment, Safety, Care, Management of Quality Improvement and Evidence-driven Leadership

The National Health and Social Welfare Quality Improvement Strategic Plan, has been developed with a view to create enabling environment to improve the quality of health and social welfare system development and the delivery of health care and social services. In so doing, all methods of performance assessment and readjustment according to all available resources, thereby serving the health and welfare of the people will be applied.

This strategic plan will adequately address the following:

- Increase patient and staff safety;
- Improve client services practices through application of quality assured clinical and support services;
- Improve management systems and accountability;
- Enhance evidence for QI;
- Put in place a catalytic system for motivating applications of QI methods, tools on a wider scale countrywide; and
- Promote quality and equitable provision of social welfare services in the country.

Successful implementation of this Strategic Plan will depend greatly with collaboration among the various departments, sections, units, and programmes within the MoHSW, agencies, development partners and other stakeholders in the health sector. Capacity building at all levels and adequate funding is crucial. A number of challenges are anticipated, but with the commitment and sustained support from the Government, private sector, development partners, community and health and social welfare workers, they will be overcome.

In order to ensure that the Plan remains relevant at all times, it is intended that annual QI plans shall be submitted to MoHSW biannually to determine the level of performance. This strategic plan shall be subjected to a mid-term review (2.5 years down the line). Using a baseline status, changes at mid-term shall be measured and program adjustments be made accordingly. An end-term evaluation shall be undertaken during the last but one quarter of the final year.

Hence, the MoHSW recommends to all the stakeholders to use this strategic plan in the planning and implementation of all Quality Improvement Initiatives in Tanzania, as well as, to support the MoHSW through funding the costed activities as shown in chapter five..

Charles A. Pallangyo

PERMANENT SECRETARY

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Dr. Hobokela Stephen	-	URC/ASSIST
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Dr. Donan W. Mmbando

CHIEF MEDICAL OFFICER

LIST OF ACRONYMS

APHFTA	Association of Private Health Facilities in Tanzania
BEST	Basic Education Statistics
CMSS	Central Management Supportive Supervision
CHBS	Community and Home Based Services
CCHP	Comprehensive Council Health Plan
CDC	Centres for Disease Control
CHF	Community Health Fund
CHMT	Council Health Management Team
CHW	Community Health Worker
CJF	Community Justice Facilitation
CMP	Case Management Protocol
CMO	Chief Medical Officer
CPIMS	Child Protection Information Management System
CQI	Continuous Quality Improvement
CRC	Convention on the Rights of the Child
CSW	Commissioner for Social Welfare
CSSD	Central Sterile Supplies Department
CSS&M	Comprehensive Supportive Supervision and Mentoring
CTC	Care and Treatment Clinic
DHRD	Department of Human Resources Development
DHS	Demographic and Health Survey
DMS	Data Management System
DSW	Department of Social Welfare
ECD	Early Childhood Development
FEFO	First to Expire First Out
HAI	Health care Associated Infections
HBC	Home-Based Care
HMIS	Health Management Information System
HMT	Hospital Management Team
HQAD	Health Quality Assurance Department
HSIQAS	Health Services Inspectorate and Quality Assurance Section
HSWF	Health and Social Welfare Facilities
IC	Improvement Collaborative
IPC	Infection Prevention and Control
ITN	Insecticide Treated Net
JAHSR	Joint Annual Health Sector Review

LGAs	Local Government Authorities
MDGs	Millennium Development Goals
MMAM	Mpango wa Maendeleo ya Afya ya Msingi (Kiswahili words for Primary Health Services Development Program – PHSDP)
MMMAM	Malezi, Makuzi na Maendeleo ya Awali ya Mtoto (Kiswahili words for Early Childhood Development)
M&E	Monitoring and Evaluation
MTC	Medicines and Therapeutic Committee
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MVC	Most Vulnerable Children
MVCC	Most Vulnerable Children Committee
NACTE	National Council for Technical Education
NACP	National AIDS Control Program
NCPA-II	National Costed Plan of Action-II
NHBS	National Household Budget Survey
NHIF	National Health Insurance Fund
NHSWQISP	National Health and Social Welfare Quality Improvement Strategic Plan
NSAs	Non State Actors
PCs	Professional Councils
PDSA	Plan Do Study Act
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother To Child Transmission of HIV
PPM	Planned Preventive Maintenance
PPP	Public Private Partnership
PSW	Para Social Worker
PWD	Persons with Disabilities
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
RHMT	Regional Health Management Team
RMNCH	Reproductive Maternal Neonatal and Child Health
STI	Sexual Transmitted Disease
SOPs	Standard Operating Procedures
SOSPA	Sexual Offence Special Provision Act
SWAp	Sector Wide Approach
SWOC	Strengths Weaknesses Opportunities and Challenges

TAEC	Tanzania Atomic Energy Commission
TBS	Tanzania Bureau of Standards
TFDA	Tanzania Food and Drugs Authority
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TIIS	Training Institutions Information System
TQIF	Tanzania Quality Improvement Framework
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VAC	Violence Against Children
WHO	World Health Organization
WIT	Work Improvement Team

DEFINITION OF TERMS

Accreditation: In relation to quality of health care and social welfare services, this refers to official recognition that the care or health and social welfare institution has a guaranteed (acceptable) quality of service.

Biocontainment: Safe methods for managing infectious agents in a laboratory. The purpose is to reduce or eliminate exposure of laboratory workers and outside environment to potentially hazardous agents.

Biosafety vs. Biosecurity: Biosecurity is a part of Biosafety
Biosecurity and Biosafety are components of Good Laboratory Practice.

Biosafety aims at:

- Protecting people from dangerous pathogens
- Limiting lab access while work is in progress

Biosecurity:

- Protect pathogens from dangerous people

1. Limit access to Laboratories that contain certain biological agents

Certification: The issuance of a formal statement of fact or attestation of a fact in relation to a fulfillment of a requirement[1] (in case of health care facilities or services offered thereof, it is a formal statement recognizing the fulfillment of the relevant official requirements)

Community Health Workers (CHWs) Refers to all types of agents working on health matters at community and household level. Hence in this document the term CHBS denotes Community and Home Based Services.

Continuous Quality Improvement (CQI) emphasizes continuity of effort and active identification of weaknesses as opportunity for improving quality.

Indicator is a measurable variable or characteristic that can be used to determine the degree of adherence to a standard or achievement of quality goals.
Mentoring: Providing experienced and trusted advice (usually to subordinates). In the National Supportive Supervision Guidelines (2010) op cit, mentoring is described as a process conducted by a person [the mentor(s)] or team for another person or group [the mentee(s)] in order to help the other person or group to do a job more effectively.

Para Social Workers (PSWs) refers to people trained on basics of social welfare interventions and

who functions as a change agent in terms of problem assessment and assisting the individual, group and community to cope with problems.

Quality Improvement (QI) is a systematic effort to improve the quality of health and social welfare system development and the delivery of health care and social services, including all methods of performance assessment and readjustment according to all available resources, thereby serving the health and welfare of the people.

Standard is a statement of the "desired achievable (rather than observed) performance or value with regard to a given parameter".

Supportive supervision: This refers to "a process, which promotes quality outcomes by strengthening communication, identifying and solving problems, facilitating teamwork, and providing leadership and support to empower health and social welfare service providers to monitor and improve their own performance."

Total Quality Management (TQM) is an approach by which management and employees can become involved in the continuous improvement of the services aimed at embedding awareness of quality in all organizational processes.

Work Improvement Team (WIT) is essential employees based small group, which aims to provide staff with opportunities for meaningful involvement and contribution in solving problems and challenges.

VISION, MISSION, PURPOSE, PRINCIPLES AND GOALS OF QUALITY IMPROVEMENT

Vision

The vision of the Ministry of Health and Social Welfare:
Health and social welfare service of high quality, effective, accessible and affordable, delivered by a well performing and sustainable national health and welfare system that encourages responsiveness to the needs of the people

Mission

The strategy shall focus on comprehensive health care and social welfare services through instilling a philosophy of client and community centered among health and social welfare workers. The strategy shall ensure a strong and transparent leadership at all levels by promoting quality health care and social welfare services as part and parcel of daily activities among health staff and social welfare workforce across public and private sector.

Principles

The principles of health and social welfare services quality improvement are:

i. Client (Internal and external) focus
ii. Systems and processes focus
iii. Teamwork
iv. Effective communication
v. Use of data
vi. Confidentiality
vii. Respect of individual dignity
viii. Purposeful expression of feelings
ix. Non Judgemental
x. Self determination
xi. Social Justice
xii. Controlled emotional involvement

Core Values

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

- Safety of care (clients)
- Personal integrity and respect for professional ethics
- Equitable Access to health care and social welfare services by all with focus on community involvement and participation
- Dignity and worth of human person
- Human relationship that emphasizes on the importance of mutual relationship between the client and service provider
- Competency

Goals of the Quality Improvement strategy

G.1 Client and service provider rights and obligations are attained at optimal level with maximum use of available resources.

G.2 Safety of services, procedures and working environment is attained for the benefit of clients and care providers.

G.3 Optimal quality is achieved and sustained in medical and social welfare services.

G.4 An integrated QI program established that shall contribute to improved health and social welfare facility working processes and systems for the benefit of clients

G.5 Stepwise certification towards accreditation system functioning based on objective independent assessments

G.6 QI incorporated in all pre-service training programs for health and social welfare workers.

G.7 Enhance quality of life of vulnerable individuals, groups and families.

CHAPTER 1: INTRODUCTION

1.1 Background

The Tanzania National QI Framework (2011) second edition was launched in November 2011 at the occasion of the First National QI Forum, which brought together practitioners in QI across a majority of health programs around the country. In the course of the Forum, it transpired that there existed significant levels of effort in building QI capacities in the health and social welfare sector but the implementation is thinly spread with various uncoordinated approaches and sometimes duplicative. The National QI Framework was seen as appropriate response to the challenge as it provides a roadmap to maximize outcomes from these QI efforts. However, given the magnitude of the QI gap in health care and social welfare services, the MOHSW wished to select key QI priorities for the first five years of implementation. A situation analysis was conducted to map out achievements as well as priorities to aim for in the strategy.

Tanzania's overall development policy and health policy are supportive of quality focus in health and remarkable achievements in child survival have been captured in DHS 2010: Infant mortality has declined to 51 per 1000 live births from 96 during the period 1996-2000; under five mortality has declined to 74 per 1000. Under-5 mortality for births that occur four or more years apart is almost half the mortality that occurs for births two years apart (74 and 136 deaths per 1,000 live births) 4. The impressive gains in child health are diluted by sloth in attaining maternal mortality reduction goal, and sloth in attaining male involvement in some key programmatic areas.

To appreciate the momentous task to improve quality of health and social welfare services and make a contribution to the attainment of key health and social welfare indicators, the Health Services Inspectorate Unit of the Ministry, started from a humble beginning of health services inspection. It is noteworthy that the unit's work has been growing gradually over the past decade to the point that its scope has expanded and recently it has been upgraded to a Health Services Inspectorate and Quality Assurance Section (HSIQA) within a Health Quality Assurance Department. During the priming period of the past decade, the head of the unit assisted by two to three professionals managed to attract advocacy initiatives and specific thematic QI projects some with scale up after pilots [IPC, SBM-R, 5S-CQI (KAIZEN)-TQM, training of Tutors in Health Schools, development of tools, etc]. The unit also forged collaborative links with programs such as Improvement Collaborative (IC)

facilitation and support of HIV and AIDS; and working relations with Laboratory QI under the support of CDC.

Development Partners support for QI activities has been quite significant and instrumental in helping the MoHSW chart out the roadmap from early initiatives of QIRI and Quality Management Cycles to IPC, SBM-R, 5S-CQI-TQM, IC and Safe Care. Government has been supportive of these initiatives but with prevailing financial constraints (competing priorities in the health budget), local investment has been low posing a challenge of sustaining the ongoing projects after closure.

Advocacy and action for QI has been progressing, reaching systems such as human resources (QI for Training Institutions) and service delivery (IPC, 5S) and programs (HIV and AIDS, RCH).

1.2 Achievements in QI

The Ministry of Health and Social Welfare managed to establish a Health Services Inspectorate Unit with capacity to articulate and advocate for quality improvement in health care. The unit produced the key guide for Quality in 2004 that was reviewed in 2011 and titled "Tanzania Quality Improvement Framework 2011- 2016", second edition. An organization structure for QI has been outlined and is subject to review shortly; some aspects of this structure are already operational, such as Quality Improvement Teams (QITs) formed at health facilities.

The Ministry has initiated work on hospital standards and has already tested these. Further more, the Ministry through NACP has organized Care and Treatment, PMTCT services and records, and produced comprehensive supportive supervision and mentoring manual and tools for HIV and AIDS health services and its training package". Problem solving model capable of generating evidence-based solutions has been tested taking advantage of the PDSA cycle and shared learning approach, with positive results. As far as social welfare is concerned, the Ministry has put in place policies, legislations and guidelines that set the minimum standards for provision of social welfare services in the country.

The MoHSW has also managed to advocate for QI across stakeholders resulting into implementation of several QI initiatives by multiple actors countrywide. To facilitate sharing of information challenges and best practices, the MoHSW has since 2011 introduced annual QI Forum. These forums have been useful platforms to coordination and mainstreaming QI.

Training of trainers (all RHMTs and some CHMTs) on IPC and 5S-CQI has been done and assessment of hospitals was undertaken. Achievement in developing PSE CQI Tool could be harnessed in future to improve quality in pre-service education. Codes of conduct for professional councils and supportive supervision guidelines have been produced. Development Partners funding of QI initiatives was secured. Standards for QI assessment at District hospitals, Health Centers and Dispensaries are being tested, while programmatic guidelines (HIV/AIDS, TB, Malaria, RCH, etc) have been developed and are in use so as the nursing care standard operating procedures. Despite these achievements a lot still remains to be done to get QI work on a firm coordinated and harmonized footing.

The Ministry has established National Health Laboratory Quality Assurance and Training Centre since 2008. The Ministry has also established quality assurance teams at all levels (zonal, regional and district) to oversee implementation of quality management systems in laboratory to support implementation of health care interventions. The Ministry has also established Biomedical Engineering Unit under Diagnostic Services Section to strengthen quality of medical equipment procured and overseeing implementation of PPM of equipment in all health facilities.

The Ministry of Health and Social Welfare is mandated to provide health and social welfare services to people. Services provided are guided by policies, legislations, and guidelines namely: National Aging Policy (2003); National Policy on Disability (2004); Child Development Policy (2008); National Costed Plan of Action: 2013-2017; National Guidelines for Improving Quality of Care, Support and Protection for Most Vulnerable Children (2009); Law of the Child Act Na. 21 of 2009; Persons with Disability Act Na. 9 of 2010; The Anti Trafficking in Person Act Na 6 of 2008; Law of the Marriage Act Chapter 29; SOSPA Na. 4/ 1998; and Law of Inheritance and Succession of 1963. Currently, the Ministry of Health and Social Welfare operates seventeen (17) homes for the elderly and people with disabilities, seven (7) Vocational and Rehabilitation Centers for Persons with Disabilities, six (6) Retention Homes for Children in Conflict with the Law, one (1) Approved School, one (1) Approved Residential Home and Kisangara Early Childhood Training Institution.

The Ministry of Health and Social Welfare has conducted Social Welfare Workforce Assessment (2012), Institutional Care Assessment (2011), Assessment of the Situation of Children in Detention Facilities (2011), National Disability Survey (2008), and Rapid Assessment of Children Living and Working in the Street in Dar es salaam Region (2012) in order to determine the quality of services and measures to be taken to improve Quality of social welfare services provision in the country.

The findings revealed critical shortage of social welfare workers by (88%), 31 % of social welfare workforce lack understanding and awareness of the contents of the policies and legislations guiding social welfare provisions. Most of the social welfare institutions are not in good condition hence providing inadequate services to the inmates. Major finding of National Disability Survey (2008) shows that 24 million people (7.8%) of the total population have activity limitations. In the course of implementing NCPA-II, The Ministry has established the Data Management System and Child Protection Information Management System that keeps detailed information of MVC. Currently 894,519 children who have been identified in 110 districts out of 169 district councils are supported with necessary social services. However the department does not have a comprehensive database that carter for social welfare services provided in the community.

Table 1: Social Welfare Institutions in Tanzania

S/no	Type of institution	Government	Private	Total
1	Children Home	1	281	282
2	Homes for the elderly	17	24	41
3	Retention homes	6	-	6
4	Approved school	1	-	1
5	Training institution – for people with disability	7	-	7
6	Day-care centers training institutions	1	15	16
7	Day-care centers	114	2036	2150

There is also a general increased awareness about quality improvement (QI) in health services as evidenced by featuring of QI activities in Strategic Plans for various Sections of MoHSW: Oral Health Section; Non-Communicable Diseases (NCD) Section; Diagnostic Services Section, and HRH-Planning Section.

Human resources for Health Training (HRH) has registered impressive progress in terms of: number of health training institutions (table 1); enrollment and output (table 2); and deployment trends (table 3).

Table 2: Number of Health Training Institutions by ownership in Tanzania Mainland 2013 (Source: Human Resource for Health Country Profile July 2013)

Type of Training Institution	Type of ownership			Total
	Public	Private Not for profit, FBOs	Private for Profit	
Medicine	2	6	2	10
Clinical Officer	5	3	5	13
Clinical Assistant	6	0	0	6
Dentistry	2	1	0	3
Pharmacy	2	1	0	3
Nursing and Midwifery	31	35	2	68
Paramedical (Laboratory)	4	4	0	8
Paramedical (Radiology)	0	1	0	1
Paramedical (OT /PT)	4	0	0	4
Paramedical (Optometry)	1	0	0	1
Environmental and Public Health	6	0	0	6
Health Record	1	0	0	1
Assistant Medical Officer	5	1	0	6
Assisistant Dental Officer	1	0	0	1
Total Number of Courses	**70**	**52**	**9**	**131**

Table 3: Enrollment and Output (Source: Human Resource for Health Country Profile July 2013)

Nursing Courses								
Enrolment					Output			
Programme	2009/2010	2010/2011	2011/2012	2012/2013	2009/2010	2010/2011	2011/2012	2012/2013
Certificate	**1627**	**2354**	**1921**	**1915**	**1437**	**1136**	**1616**	**1560**
Diploma	**1547**	**1988**	**2148**	**1408**	**1168**	**1777**	**1207**	**1158**
Advanced Diploma	**81**	**53**	**0**	**0**	**74**	**58**	**20**	**72**
Bachelor	**99**	**200**	**263**	**275**	**114**	**122**	**144**	**154**
Sub Total	**3354**	**4595**	**4332**	**3598**	**2793**	**3093**	**2987**	**2944**
Allied Sciences					**Output**			
Programme	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**
Certificate	**758**	**696**	**830**	**703**	**644**	**790**	**647**	**833**
Diploma	**1121**	**1350**	**1398**	**1229**	**850**	**946**	**1018**	**844**
Advanced Diploma	**343**	**311**	**300**	**244**	**315**	**337**	**277**	**307**
Bachelor	**625**	**864**	**1074**	**921**	**490**	**671**	**433**	**952**
Sub Total	**2847**	**3494**	**3602**	**3148**	**2299**	**2744**	**2375**	**2936**

Table 4: Deployment trends (source: MoHSW Directorate of Administration and Personnel 2013).

Year	New Positions Granted by PO-PSM / Treasury	Number of Graduates Posted by MOHSW for Recruitment by Employment Authorities
2005/2006	1,677	983
2006/2007	3,890	3,669
2007/2008	6,437	4,812
2008/2009	5,241	3,010
2009/2010	6,257	4,090
2010/2011	7,471	5,687
2011/2012	9391	6400
2012/2013	6533	6533
Total	46,897	35,184

1.3 Rationale for the Strategic Plan

The Tanzania National QI Framework (2011-2016) second edition launched in November 2011 at the occasion of the First National QI Forum which brought together practitioners in QI across a majority of health programs made a case for development of an operational strategy for QI. The MoHSW has been advocating for the improvement of the Quality of Health and Social Welfare provision, therefore it transpired that there existed significant levels of effort in building QI capacities in the health sector but the implementation is thinly spread with various uncoordinated approaches and sometimes duplicative. The National QI Strategic Plan was seen an appropriate response to address the challenges as it provides a roadmap to maximize outcomes from these QI efforts. However, given the magnitude of the QI gaps in health care, the MoHSW wished to select key priorities for the First Five Years of implementation.

Health services are delivered under the conducive, pro-quality policy environment not matched by a corresponding resource envelope. Health systems weaknesses threaten the very essence of keeping the quality of services at an acceptable level, and thus undermining credibility of health services. Sector reforms have given attention to the quality dimension but practitioners have yet to internalize the culture and rigor of quality improvement process.

Due to HIV and AIDS pandemic, change of life style, increase of poverty and weakening of social bonds, social welfare services on the other hand have expanded, however coordination and adherence to standards has remained to be an all-time challenge to Department of Social Welfare (DSW) and provider of services particularly to vulnerable groups, hence the quality of services provided compromise with existing policies, laws and guidelines.

Therefore, the MoHSW is strongly convinced that putting in place a QI strategic plan could stand as a solution with regard to provision of quality health and social welfare services in Tanzania.

CHAPTER 2: SITUATION ANALYSIS

2.1 Introduction

The United Nations (UN) classifies Tanzania as one of the least developed countries. About 25 % of Tanzanians were living below the poverty line in 2007. At the macroeconomic level, Tanzania is doing well, yet at the household level, income poverty did not decline during the period 2001-2007. GDP growth during this period averaged about 7 percent, yet the headcount poverty index/income-poor proportion of the population declined marginally from 35.7 percent to 33.6 percent[10] (MKUKUTA-II growth debate).

The National Strategy for Growth and Reduction of Poverty-NSGRP-II was launched in 2010; subsequent to that, the Five Year Development Plan (2011/2012 – 2015/2016) re-align the country efforts towards attaining the Tanzania Vision 2025. Across in both of these documents the quality issue is emphasized

The health sector on the other hand aligns with the MKUKUTA-II and Vision 2025 through the National Health Policy (2007) which is translated and implemented through HSSP III. Similarly, the existing social welfare policies and guidelines have put quality as key issues in delivery of social welfare services in the country.

2.2 Health Services Situation

According to HSSP-III, life expectancy has increased from an average of 51 years in 2002 to 59 years in 2010[11], mainly due to declines in adult and child mortality. There has been an improvement in infant and under-five mortality rate, largely due to the coverage of child immunization, vitamin A supplementation, and gains in malaria control through improved diagnosis and treatment of malaria, as well as prevention through increased use of insecticide treated nets. HIV and AIDS continue to be a national challenge. According to the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) (2011- 2012), the national prevalence amongst the sexually active population (between 15 and 49 years of age) is 5.7 percent. The data also indicated that more women (6.6percent) are infected than men (4.6 percent).

Tanzania has continued to record progress in health outcomes, but some challenges still remain. The maternal mortality ratio has declined from 578 per 100,000 live births in 2004/05 to 454 per 100,000 live births in 2009/1. More than 50% of women aged 19 are either pregnant or are already mothers, increasing their vulnerability to sexual and reproductive

health complications. However, the benchmark for low middle-income countries is 260 per 100,000 live births, which shows that Tanzania's achievement is not satisfactory.

Similarly, improvements have also been recorded in child health according to TDHS 2009/2010. The infant mortality rate declined from 68 per 1,000 live births to 51 per 1,000 live births in 2009/10. The under-five mortality rate also declined from 112 per 1,000 live births in 2004/05 to 81 child deaths per 1,000 live births in 2009/10. The percentage of under-five children who were stunted declined from 44 percent in 1999 to 35 percent in 2009. The proportion of children facing wasting and/or severe malnutrition was 3.7 percent in 2004/05 compared to 3.8 percent in 2009/10. The number of health facilities offering PMTCT services increased from 5 in 2004 to 3,626 by December 2009, equivalent to 78.6 percent of all ANC facilities in the country.

2.3 The Situation of Social Welfare Services

The social welfare services in the country are coordinated by the Department of Social Welfare. The department has three areas of focus, namely, services to people with disabilities and the elderly, Juvenile Justice and correctional services, and, family, children's welfare and early childhood development. The provision of social welfare services are guided by the existing policies, legislations, regulations and guidelines.

Social economic and political changes which occurred in early 1980s have weakened traditional safety net that used to provide care, support and protection to individuals, groups and communities. Moreover, the increased pace of globalization, HIV/AIDS and the adoption of neo-liberal policies such as cost sharing and privatization have led to increased household income insecurity, breakdown of family relationship, retrenchment, poor health, rising rate of crime, alcoholism, drug abuse and suicide.

According to WHO, 10% of the world's population are disabled (URT 2004). Moreover, the world disability report (2011) indicates that children with disabilities have less access to formal education; the situation that hampers the ability to develop to their full potential compared to the children without disability. The Tanzania disability survey report (2008) revealed that there is an increased number of people with disabilities from1.3 million in 2002 to 2.4 million in 2008. Moreover, according to Basic Education Statistics in Tanzania (BEST) report of 2012, the enrolment of children with disabilities is only 1%.
On the other hand, Tanzania is estimated to have 2 million elderly, which is equivalent to 4.6% of the total population. However, weakening of the traditional ties has led to lack of support from the family and community members. The situation has caused majority

of the elderly to live in chronic poverty. According to National Household Budget Survey (NHBS) 2007 indicates that 22.4% of elderly live in chronic poverty compared to 33.4% of the national poverty line. To date there are 41 homes for the elderly whereas government runs 17 and 24 are run by private organizations.

The Tanzania Violence Against children study (VAC, 2009) indicates that violence against children is serious problem in Tanzania: nearly 3 in 10 females and approximately 1 in 7 males in Tanzania have experienced sexual violence prior to the age of 18. In addition, almost three- quarters of both females and males experienced physical violence prior to 18 by an adult or intimate partner and one quarter have experienced emotional violence during childhood. Early years of human life provide unique opportunities socially and cognitive investment but at the same time this is the most vulnerable period for all forms of stunting if holistic development id not nurtured.

UNICEF report on Early Child Development (ECD) 2007, documented that in Tanzania more than 95% of young children lack access to early childhood stimulation social protection program and early childhood care facilities. Systems to support early childhood programs like management, training, human resource and monitoring and evaluation are not in place. Currently, there are 680 registered day care centers and 18 childcare training institutions while more than 1520-Day Care Centers are not registered. In addition, the curriculum used by childcare training institutions is not accredited by NACTE.

Besides the existing challenges, the Department of Social Welfare (DSW) lacks comprehensive information system to inform and guide decision making at all levels.

2.4 Current status of Quality Improvement work

A situation analysis of Quality Improvement (QI) in Tanzania was undertaken to inform the process of developing this strategic plan[12].

2.5 Standards and Standards Operating Procedures

Standards and Standard Operating Procedures have been developed to guide technical implementation in every area of specialty and services delivery. Program guides serve as SOPs along with nursing SOPs and laboratory standards that are quite advanced and been put to application at tertiary hospitals and Regional Laboratories

2.6 QI Indicators

Among the national Health Sector strategy indicators elaborated in HSSP III, reference is

made to comply with TQIF standards in terms of a) proportion of health facilities accredited, b) hospitals with QA Units, c) blood safety, d) quality safety and efficacy of medicines (HSSP III op cit). At the first QI Forum in 2011 a concern was raised about the lack of appropriate indicators to measure agreed benchmarks on quality improvement. From a fully elaborated set of standards and their assessment criteria, it would be possible to choose a few sensitive indicators for each agreed quality domain. Indicators to monitor the pace and effective delivery of this strategic plan shall also be important; at health facility level QITs shall need to be capacitated to come up with sensitive process indicators.

2.7 Assessment of Hospitals Using IPC Standards

Findings for year 2012 assessment, 36 hospitals revealed significant improvement of average performance scores between September 2011 data score was 34% while the May 2012 scores was 46% (HSIQAS 2012).

2.8 Processes

Valuable experience and lessons constitute the first steps towards developing consensus and actualizing a national QI program run by the government through partnership.

Major QI impediments include poorly organized patient records and limited functionality of Health Management Information System (HMIS). The HMIS has been underperforming in terms of completeness, validation of data and other data quality criteria; in addition to that the data collected has limitation in collection and analysis of qualitative data. Moreover, the tendency for projects to protect their brands to fulfill specific reporting requirements cause development of running parallel data collection and reporting system different to HMIS.

Resource constraints (Human, financial, materials, supplies and equipment) present a weakness and threat to QI work if deliberate steps are not taken at planning and resource allocation. Optimizing what is currently available is a practical starting point. Nevertheless limited or non-inclusion of QI plans in annual plans of work at various levels of care is still a point of weakness that needs urgent address.

The upgraded status of the HSIU to become a section (HSIQAS) indicates a higher value attached to quality improvement in the MOHSW presenting an opportunity for organizing QI work on a more effective coordinated footing.

2.9 SWOC analysis

STRENGTHS	WEAKNESSES
Program development	***Program development issues***
▪ Guiding documents in place (Health Policy; HSSP-III; implementation guidelines for specific interventions; rules, regulations and guiding principles; SOPs; MMAM, LCA 2009, Persons with Disability Act 2010, People with Disability Policy 2004, National Aging Policy 2003, Child Development Policy 2008, NCPA II, MVC-QI, M &E plan for MVC(2011). ▪ Political stability, peace and harmony. ▪ National PPP policy, law and regulations in place ▪ Stakeholders supporting health and social welfare through SWAp ▪ Established a directorate providing oversight of QI ▪ TQIF provides guidance and signal to bring the various quality improvement initiatives and also guides in favor of coordination and harmonization. ▪ Readiness for integration of different QI approaches implemented amongst partners is already noted.	▪ Uncoordinated QI guidelines at all levels. ▪ Inadequate coordination of programs both at Ministry level and Partners ▪ Ineffective/inadequate supportive supervision, mentoring and coaching ▪ Lack of ownership on QI initiatives at facility level (need to put quality in the hands of providers). ▪ Poor cascading system of QI ▪ Low involvement of private sector ▪ Client service charter not used, not enforced ▪ Rural – Urban disparity ▪ Lack of comprehensive national standards and indicators for monitoring and evaluating quality of care ▪ Weak linkage between HMIS and Quality Improvement initiatives ▪ There is no clear comprehensive reporting mechanism on QI from district to region, region to central level ▪ Low hygiene and sanitation standards as a result of neglect to environmental health problems and public behavior such as hand washing, infectious solid waste disposal - witnessed by Cholera prevalence, other diarrheal diseases, protozoa illnesses and helminthes ▪ No mechanism of measuring performance of health professionals
Planning and Management ▪ Existence of well-defined health sector organizational structure from national to community level ▪ PPP Policy guideline and PPP Strategic Plan (in health). ▪ QITs are established at hospitals (level 1, 2 and tertiary) ▪ QI forum provides a platform for advocacy to stakeholders and policy makers and for shared learning and sensitization on coordination, harmonization and integration. ▪ Already done activities in QI e.g. IPC, HIV	***Managerial and planning issues*** ▪ Low pace of change (e.g., HWs not following IPC guidelines despite training). ▪ There is Know-Do gap on QI among HWs ▪ Weak information sharing. ▪ Weak management of funds especially cost

AIDS, RCH and others have opened doors for expanding and consolidating ▪ Supportive community ▪ Deployment of social welfare services to local government authorities. ▪ Establishment of MVCC, CJF, Para Social Workers and child protection teams in Local Government Authorities. ***Capacity*** ▪ Training institutions for all cadres in place. ▪ Availability of Health and Social Welfare Workers of various cadres ▪ Awareness on QI has improved among health managers and workers	sharing, CHF and NHIF (poor compliance, record/receipt keeping) ▪ Weak dissemination of the developed policies and guidelines. ▪ Health facility performance below its scope and level ▪ Poor medicines and supplies store management (inventory, stock management) ▪ Lack/inadequate technical equipment; old, under standardized medical equipment and lack of maintenance and planned preventive maintenance; lack of adherence to health facility building and equipment standards ▪ Inadequate health infrastructure to support provision of quality health care (buildings, water supply, power supply, incinerators, equipment) ▪ Poor health care waste disposal (lack of standard incineration) ***Health systems issues*** ▪ Poor coordination in data collection, analysis, interpretation, dissemination and use (HMIS, Research): Parallel reporting systems, which is a burden to health workers. ▪ Unsystematic medical records storage and retrieval system at some health facilities ▪ Low coverage of social health protection schemes (Insurance, CHF, etc). ▪ Poor access to some services due to mal-distribution of health services ▪ Weak patients' referral system ▪ Weak Supply Chain Management System. ▪ Health Care Financing; inadequate national health accounts (limited government funding): Most activities are donor funded. Large pool of exempt categories accounting for a bulk of demanded care without clear compensation

	mechanisms for the costs incurred in service delivery (they are covered neither by CHF nor NHIF): under funded health plans for QI at all levels. Slow disbursement of basket fund to implementers ▪ **Human resources (shortage of skilled staff):** having right number and right skills mix; poorly motivated low morale health work force with high turnover due to lack of retention mechanism and succession plan. Also, recruitment of HR does not match the needs of the HFs. ▪ **Service delivery:** Ethical lapses, poor attention to mental health and other NCDs, assessment of patients, care of patients and access to and continuity of care have insufficient prominence in standards. ▪ **Logistics and supplies:** shortage of medicine and essential diagnostic equipment/reagents due to poor supply chain management and lack of emergency contingency planning. ▪ **Governance:** Poor feedback from professional bodies to policy makers. Insufficient link between professional development and licensing; slow movement to accreditation of all health facilities and specialized aspects of care; weak functionality of existing mechanisms. **Social Welfare Issues** ▪ The department has no permanent offices, in adequate working tool, no strategic plan, weak data collection systems, codification of strategies, unmapped vulnerable groups ▪ Unsystematic social welfare recording systems at some social welfare institution. ▪ Absence of comprehensive social protection framework to accommodate different

	categories of the population ▪ Weak client referral system ▪ Low morale among social welfare workers ▪ Inadequate budget for social welfare services ▪ Inadequate coordination between the Department of Social Welfare and Local Government Authorities (LGAs). ***Capacity issues*** ▪ Lack of QI commitment and accountability at different levels ▪ Sloth in nurture of quality culture amongst providers and managers of care: Low QI skills amongst health workers ▪ Inadequate staff particularly Social Welfare Officers ▪ Capacity gaps in Zonal Centers; absence of structured modules on QI in training schools /colleges curricula may be the explanation behind health workers lack of QI knowledge and skills ▪ Limited capacity to carry out operational research on QI ▪ There is limited competency-based internship programme / processes ▪ Capacity gaps in Training institutions and universities **Low or absent innovations for QI** ▪ No countrywide effective system for recognition and rewarding good performance at regions and districts let alone health facilities. ▪ Weak community focus; minimal community involvement; Community not aware of their rights

OPPORTUNITIES	CHALLENGES
Program development ▪ Presence of regulatory bodies. ▪ Existence of different guidelines, tools, IEC materials on QI, ▪ Availability of stakeholders to work on QI. ▪ Importance of integration of different QI approaches is appreciated by stakeholders ▪ Government commitment in QI. ▪ Health and social welfare service providers and supportive community in place. ▪ Ongoing health sector reforms. ***Planning and Management*** ▪ Sector reforms avail space to articulate management for quality (leadership) in addition to strengthening quality of management, patient and providers' safety, and client focus. ▪ Involvement of private sector ***Health and social welfare systems*** ▪ Health services beneficiaries (insurers, out of pocket bearer, cost sharing, exempted categories) demand quality services ▪ Capacity ▪ Existence of health and social welfare training institutions. ▪ Existence of mass media (TV, Radio) for raising awareness. ▪ Availability of staff that can be groomed to assume champion role. ▪ Training materials, guidelines and tools already available in HIV and AIDS and IPC can be optimized.	***Program development*** ▪ Inadequate financial resources. ▪ Inadequate HRH and Social Welfare. ▪ Lack of national strategy for information dissemination. ▪ Harmonization/ Integration of approaches ***Planning and Management*** ▪ Reaching every district and every health facility with an integrated package of QI know-how, mentoring and coaching, skills multiplication and sustenance ▪ Client education and orientation to their rights and obligations in health care and social welfare services ***Health and social welfare systems*** ▪ Inadequate governance (promotion not systematic). ▪ Ineffective supportive supervision ▪ Vertical and uncoordinated supportive supervision Linking and focusing health financing opportunities, e.g. Health insurance schemes to be drivers for QI and accreditation ▪ Inadequate adherence to professional ethical conduct. ▪ Human resource deployment and retention ▪ New emerging social problems such as drug abuse, commercial sex enchantment, STIs, MVCs, human trafficking ***Innovation*** ▪ Staff motivation and effective support for institutionalization of QI ▪ Low level of motivation among health and social welfare services providers. ▪ Budget allocation on QI at health facility

	level and social welfare institutions ▪ Negative Mind set / Attitude of HWs; "Quality of theirs" attitude ▪ Knowledge on hygiene and sanitation among clients/facility users (modified and moved from environment weakness) ▪ "Openness" in organization/institutions on knowledge and skills sharing among HWs at health facility level and social welfare institutions ▪ Everyone's involvement and participation on QI

2.10 Key issues and challenges for Quality Improvement

2.10.1 Key Issues

- Coordination of various QI approaches in the absence of a generic national QI program.
- Comprehensive standards (minimum requirements) for health services not established; absence of an independent baseline assessment and incomplete sets of SOPs in health facilities.
- Continuous QI capacity building requires substantial financial investment to design integrated training modules and discharge the training countrywide in a manner that does not disrupt service delivery yet providing more practical work for skill development.
- Gaps in supply chain management interrupting availability of drugs, medical supplies and equipment; substandard supplies and equipment is sometimes delivered. As a result even where gains in QI have begun to register, e.g. in laboratory standards, the system starts to lose out.
- Inventory/stock management at health facility level.
- Dysfunctional primary care facilities encouraging undesirable referrals (self or otherwise), resulting in congestion at secondary and tertiary facilities.
- Team weakening seminars and training events (absenteeism, same individuals repeating attendance and not giving others a chance).
- Gaps in coordination of social welfare activities between the Department of Social Welfare and Local Government Authorities (LGAs).
- Improved budget for social welfare services.
- Improved infrastructures for social welfare facilities.
- Integrated social welfare information into HMIS.
- Lack of comprehensive social protection framework to accommodate different categories of the population.

2.10.2 Challenges

- Resources pooling for QI
- Transforming traditional supervision to supportive supervision in combination with mentoring (reaching all health facilities).
- Boosting staff morale for QI under current resource constraints
- Putting clients rights at the forefront
- Health systems weakness in each building block
- Development of comprehensive social protection framework to accommodate different categories of the population
- Improved budget for social welfare services
- Integrated social welfare information into HMIS.

CHAPTER 3: STRATEGIC QUALITY IMPROVEMENT PRIORITIES

3.1: Priorities

From the situation analysis document (Section 6.1, table 5), the SWOC exercise output (Section 2.3 above), and reflection of strategic agenda in groups (section 6.2 of situation analysis document) a clear logic of core areas and core QI areas for benchmarking standards has emerged. These core QI areas for this strategic plan are:-

- **Client** responsiveness and **focus** is central
- **Safety** for clients (internal and external) is cardinal
- **Care** set the detailed agenda
- **Management** focuses on how the agenda will be implemented
- Evidence-driven **Leadership** as catalyst for scaling up
- **Conducive working environment**

Figure 3.1: Strategic Framework

While the core QI areas have equal importance, they have operational interconnections, applying to both public and private health and social welfare services. Therefore, they stand to benefit from PPP, with the ultimate goal of optimizing resources and processes to benefit clients as a deliberate strategic focus.

3.2 Strategic QI areas and main actions

3.2.1: Client focus

3.2.1.1: Clients communication and handling

- Introduce client help desks in all hospitals for client guidance and social support; Social Welfare Officers shall discharge this duty.
- Make it obligatory for health and social welfare facilities' management to provide name tags to the internal clients and for the name tags to be worn at all times while on duty.
- HF management to establish, strengthen and sustain triage services to fast track emergencies and care for those in critical conditions
- Search for client orientation, information, educational and communication materials from different sources and distribute to HFs.
- Organize peer learning on humane and compassionate handling of clients (developing drama, enter-educate songs, radio phone-ins, poetry etc).
- Strengthen client appointment system.
- Design and conduct behavioral change and communication strategies to:
    - Attain stakeholders' involvement
    - Positively influence change of internal and external clients
    - Meet internal and external client's expectations
    - Ensure social inclusion of most vulnerable groups

3.2.1.2: Client complaints' handling procedures

- Develop a guide on complaints' handling and response for health and social welfare institutions
- Orient health and social welfare management to systematic processing of complaints' records and follow up of responses
- Post appeal submission and handling procedure on public notice boards and websites

3.2.1.3: Develop and adopt a clients' charter that applies human rights-based approach in health and social welfare:

- Inform internal and external clients on clients' charter and code of ethics

- Collaborate with Health Promotion and Education (HE) Section to print and disseminate clients' charter to all health facilities and CHWs
- Collaborate with Professional Councils (PC) to review and establish functionality of respective ethics and code of conduct for each profession
- Collaborate with PCs on enforcement of professional ethics and code of conduct.
- Collaborate with the DHRD in reviewing curricula for health and social welfare professions' training

3.2.1.4: Informed-consent (both written and verbal) for medical and social services

- Update the tool in use for informed consent to make provision for alerting the internal and external clients on need for consent signing.
- Adapt the tool to clients' information needs: The information shall be made in client-friendly language for easy understanding.
- Oblige service providers to check that the client understands the given information before giving consent.

3.2.1.5: Accountability to clients and communities

- RHMTs, CHMTs and HMTs shall provide regular QI reports to the Regional Secretariat, Hospital Advisory Boards, Council Management Team (CMT), Council Social Services Committee and Health Facility Governing Committees
- QITs shall post QI progress reports on public notice boards.
- Best practices on QI shall be shared with stakeholders at Regional, Council, Community and central MOHSW levels.
- Management at all levels shall be proactive in recognizing excellent performance of individuals and teams, both internally and externally.
- MoHSW, RHMTs, HMTs and CHMTs shall organize QI information sharing events e.g. Health Days, PPP forums and during District Council meetings.
- Client satisfaction surveys' results shall be posted on public notice boards in addition to being shared in Regional Secritariat Council Management Team (CMT) Coulcil Socil Services Committee and Health Facility Governing Committees and Ward, Village Development meetings.

3.2.1.6 Strengthen QI procedures for Home Based Care services (HBC).

- Advocate the use of QI monitoring tools for Community and HBC in collaboration with partners.
- Consult existing CHBC guidelines in compiling QI procedures.
- Supportive supervisors shall ensure documentation of CHWs activities related to CHBC to facilitate monitoring and reporting on quality of care and challenges

encountered.

- Supportive supervision visits shall monitor RHMTs, CHMTs and HMTs support to HFs and social welfare in responding to challenges encountered during service delivery.
- Provide opportunity for updating knowledge and skills for the home based care services' providers.

3.2.2: To improve working environment and clients' safety[13]

3.2.2.1: Ensure availability of functional equipment, reagents, safe and potent medicines and supplies

- Accelerate disposal of expired, broken and worn out drugs, equipment and supplies
- Advocate for a change in law governing insurance of public property
- Strengthen collaboration with different regulatory authorities to address safety of medicines, reagents and supplies (reporting Adverse Reactions (ARs),and substandardness).
- Establish working relations with Tanzania Bureau of Standards (TBS) and TAEC to address equipment and supplies' standards.
- Strengthen the system to determine sub standard medicines, equipment and supplies and recommend appropriate compensation and litigations.
- Ensure supportive supervision is conducted to HF to strengthen equipment Planned Preventive Maintenance (PPM) and regular maintenance of buildings as well as attaining clearance of acquisitions and acceptance testing (incoming equipment inspections).
- Enhance PPP to strengthen the equipment PPM and regular maintenance of buildings
- Establish a national list of health service technology (equipment) that is safe, efficient and cost-effective.
- Advocate for the formation of health service technology advisory committee as per National Health Service Technology Guideline.

3.2.2.2: Consolidate gains made in Infection Prevention and Control (IPC)

- Orientation and mentoring of service providers
- Enforce use of PPEs (gloves, boots, aprons, goggles, uniform, appropriate masks) at all levels of health service delivery
- Introduce/revive Central Sterile Supply Department (CSSD)
- Promote hand hygiene practice
- Promote appropriate handling of sharps

- Strengthen applications of vaccination and Pre/ Post Exposure Prophylaxis (PEP) measures

3.2.2.3 Consolidate gains made in Health Services Waste Management

- Provide orientation and mentoring of HSPs.
- Enforce waste segregation and use of appropriate health waste color coded bin and bin liners.
- Liaise with responsible authorities to assure timely collection, storage, transport and disposal of segregated health waste.
- Encourage construction of high technology incinerators.

3.2.2.4: Consolidate and sustain gains made in improving working environment

- Orienting and mentoring newly recruited personnel on working environment improvement approach.
- Enforce maintenance of clean and organized work stations.
- Routinely conduct comprehensive supportive supervision on the state of cleanliness and organization of the health facility.
- Advocate for inclusion into comprehensive regional/ council comprehensive health plans of budgets for PPM of the equipment and buildings.
- Ensure infrastructure designs are pro-safe including:
  i. Access for the persons with disabilities and the elderly
  ii. Appropriate provisions for water supply, ventilation, lighting, safe flooring and fire hazard considerations.
  iii. Advocating for adherence to technical specifications of constructing health and social welfare facilities, procure and arrange furniture and technology that fit well into the infrastructure.

3.2.2.5: Establish a reporting system to the facility management on infrastructure availability and use at all HSWFs

- Ensure uninterrupted supply of oxygen, emergency drugs and medical supplies
- Ensure uninterrupted water supply
- Ensure uninterrupted functionality of incinerator
- Ensure uninterrupted functionality of power sources (generator)
- Ensure functionality of hospital sewage and other liquid waste system

3.3.1: To improve client service practices through application of quality assured clinical and support services

3.3.1.1: Standardize clinical management

- Ensure PB avail for Case Management Protocols (CMP) for use at different levels of service provision
- Vet the protocols for consistency, technical soundness and clinical correctness (MoHSW/ Professional bodies)
- Ensure HMTs introduce/ revive clinical meetings; make reference to CMP at clinical meetings.
- Ensure HMT conduct routine medical procedures audit and share reports with CHMT/ RHMT/ MOHSW.
- Strengthen Continuing Professional Development (CPD).

3.3.1.2: Ensure appropriate, safe and cost-effective use of medicines in health and social welfare facilities.

- Ensure presence of functioning Medicines and Therapeutics Committee (MTC) at all HFs.
- Ensure each HF adheres to the national standard treatment guidelines and essential medicines list.
- Print and distribute the institutional standard treatment guidelines and medicines list.
- Set standard operating procedures (SOP) for prescription writing, medicine dispensing and administration.
- Organize prescription review meetings with clinical service providers.
- Agree on periodicity and timing of clinical and prescription audit surveys.
- Undertake clinical audit surveys, analyze the findings and share results.

3.3.1.3: Transparent management reports of medical errors and professional ethics

- Establish incident reporting and investigating system for medical service errors.
- Strengthen the authority of HF Executive Committees in monitoring and addressing medical errors and ethics of practice in collaboration with QIT.
- Keep records of and evidence on practice errors.
- Hold investigative and correctional counseling sessions with individuals found to have committed errors.

3.3.1.4: Ensure availability of functional medical equipment.

- Liaise with diagnostic services section of the MoHSW in acquisition, testing and acceptance of medical equipment prior to using them.
- Address weaknesses of supply chain management.
- Strengthen PPM at all levels.

3.3.1.5: Ensure and maintain regular availability of medical supplies and consumables and their pricing for purpose of charges to patients and/or health insurance reimbursement.

- Arrange for regular stock taking.
- Check compliance to FEFO system.
- Establish re-order levels and timely placement of orders.
- Liaise with MSD to determine orders management and responsiveness
- Check for cold chain maintenance.
- Check for blood safety compliance – if procedures are followed strictly
- Agree pricing policy and regularly update the price list.

3.3.1.6: Maintain high standards of diagnostic services

- Oblige QITs to established laboratory quality control and quality assurance procedures and report accordingly.
- MOHSW, RHMTs and CHMTs to support verification measures on compliance to Laboratory Bio-risk (bio-safety and bio-security requirements).
- Ensure compliance to the level of bio-containment compliance by clinical and research laboratories.
- QITs and HF management shall receive reports on status of compliance to radiological imaging safety procedures.
- Establish working collaboration with Tanzania Atomic Energy Commission (TAEC) on quality assurance procedures.
- Liaise with MSD to ensure constant availability of essential diagnostic equipment, reagents and emergency contingency supplies.
- Sensitize managers and planners to maintain high standards of diagnostics in light of critical importance of scientific evidence in patient management.
- Establish working collaborations with private health service providers under PPP to benefit on diagnostic services.

3.3.4: To improve management systems and accountability

3.3.4.1: Promote innovative QI leadership

- Identify sites with evidenced QI leadership and capture documentaries of leadership scenes and sessions
- Organize leadership innovation sensitization and mentoring program.
- Apply recognition system for QI leadership
- Establish national QI TOTs, supervisors and train them on SS& M as well as external assessments and facilitation of QI training.
- Establish the QI Technical working group under SWAp

3.3.4.2: Build capacity of MOHSW, RHMTs, CHMTs, HMTs and HSW Institutions in comprehensive supportive supervision and mentoring

- Develop Comprehensive Support Supervision Mentoring (CSSM) training package
- Orient RHMTs, CHMTs, HMTs and HSWF and social welfare institutions on CSSM manual and tools
- Plan and budget for supportive supervision and mentoring in HSW institutions.
- RHMTs, CHMTs and HMTs shall monitor and report on implementation of the supportive supervision and mentoring of HSW institutions.

3.3.4.3 Develop and disseminate national QI guidelines and tools

- Disseminate the CSSM tools to RHMTs, CHMTs, HMTs, QITs, of HSW institutions.
- Monitor, evaluate and give feedback on the implementation of the QI action plans included in HSW institutional plans and CCHPs.

3.3.4.4: Collaborate with health systems experts to address QI in health and social welfare systems

- Advocate for introduction of universal health coverage through health insurance
- Ensure a robust system for the poor and marginalized groups to access health and social welfare services.
- Ensure posting and retention of qualified, competent and committed HRH at different levels of HSWF.
- Synthesize and put forward innovative proposals for optimizing HRH performance and productivity.
- Launch a national QI newsletter to recognize QI exemplary performers
- Share QI experiences to enhance motivation of HSPs as well as provide visibility for the QI program.

- Ensure HRH access further career development opportunities
- Guide RHMTs, CHMTs and HF management teams to undertake human resource induction for new appointees
- Ensure equity in health sector resource allocation.

3.4.1: To enhance evidence based QI

3.4.1.1: Research and assessments

- Develop prioritized QI research agenda.
- Provide capacity building on QI research at all levels
- Commission QI research.
- Advocate for development of Scientific QI Centers of Excellence for documentation, assessment, storage and sharing of results.
- Commission external assessments and effective feedback of results.
- Organize dissemination of research products and optimize utilization of the findings.

3.4.1.2: Learning from QI best practices

- CSS to identify and document best practices from the HSW institutions.
- Mapping of best health and social welfare service practices and posting on a dedicated web page for easy access and dissemination.
- Documenting best health and social welfare practices in public and private HSW institutions and sharing the reports widely.
- Facilitate adaptation of best health and social welfare service practices.

3.4.1.3: Clients records and HMIS

- Sensitize different levels of the HSW service provision on importance of documentation of clients' records.
- Strengthen/ revive client record keeping.
- Advocate for introduction of electronic medical records.
- MOHSW in collaboration with other stakeholders. strengthen data management systems.

3.4.1.4: Standards and indicators for assessments

- Advocate for utilization of the existing health service QI standards and indicators
    - Distribute the QI standards and indicators to the Ministerial departments, agencies and programs, RHMTs, CHMTs and HSWFs .
    - Develop a computerized system for feeding for internal and external assessment findings and proposed solutions into a database to be observable centrally.

3.4.1.5: Phase-based introduction of Stepwise Certification towards Accreditation system

- Advocate for a national system for stepwise certification towards accreditation of HSWFs.
- Scale up a national system for stepwise certification towards accreditation of HSWFs Establish an accreditation agency or Commission.

3.4.1.6: Putting in place a system for motivating different levels of service provision to apply QI methods and tools countrywide.

- Advocate for high-level support towards QI resource mobilization.
- Widen scope of and participation in QI forums.
- Identify potential high-level champions for QI and work with them in mapping out a strategic mutual action agenda.
- Advocate for budgeting of QI activities in the health plans at different levels
- Advocate for participation of private sector in recognizing and awards for QI
- Mobilize resources for QI operational research.

3.4.1.7: Integrate QI into Pre- and In-service training programs for health service and social welfare service providers.

- Develop integrated training modules on QI planning, implementation and evaluation for inclusion into health and social welfare training curricula.
- Orient QI modules to staff at ZHRCs and HSW training institutions.
- Organize distance learning on QI planning, implementation and evaluation for in-service personnel.

3.5.1: Promote quality and equitable provision of social welfare services in the country.

3.5.1.1: HSIQAS to incorporate data from Departments / Directorates within the MOHSW into Central Data Management System of the Ministry.

3.5.1.2 Social Welfare information and data shall be translated, transcribed and disseminated in a manner that children and persons with special needs can access, understand and utilize.

3.5.1.3 HSIQAS to ensure policies, guidelines, strategies and plans of the MoHSW are revised to incorporate social welfare issues.

3.5 Logical Framework Matrix

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
Strategic Area 1: Client focus					
1.1 Clients communication and handling	1.1.1 Introduce client help desks in all hospitals for client guidance and social support: Social Welfare Officers shall discharge this duty	Client help desk in place at all hospital with staff to discharge the service	Percentage of HSWF with client help desk	HSWF survey report, SS report	
	1.1.2 Make it obligatory for the health and social welfare facilities' management to provide name tags to the internal clients and for the name tags to be worn at all times while on duty.	All health staff provided with name tags and wear them at all times	Percentage of facilities providing name tags to staff	HF survey, SS report	
	1.1.3 HF management to establish, strengthen and sustain triage services to fast track emergencies and care for those in critical conditions	Triaging of patients practiced at all health facilities	Percentage of HF with functional triage system to track emergencies	HF survey, SS report	All HF will be provided with guidance on how to triage clients Facility QI teams will be regularly collecting data on triage
	1.1.4 Search for client orientation, information, educational and communication materials from different sources and distribute to HFs.	Increased accountability to clients and communities	Percent of clients admitting to have received/read QI Information, education and communication material/s from the HSWF (N: no of clients who read QI information, D: Total no attended at HF)	Client satisfaction survey report	Portable IEC material/s shall be provided to client while the fixed one shall be read at the health facility
	1.1.5 Organize peer learning on humane and compassionate handling of clients (developing drama, enter-educate songs, radio phone-ins, poetry etc). Strengthen client appointment system.	All HSWF have formed drama groups, and mass media is used for educating clients on human and compassionate handling of clients. Client appointment system in place	Percentage of HF, which has set up drama groups, initiated mass media use for educating clients. Percentage of facilities that have introduced client appointment system	HF survey reports, SS reports	SS checklist incorporates mass media education item

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	1.1.6 Advocate for the use of communication strategies: • Attain stakeholders' involvement • Positively influence change of internal and external clients • Meet internal and external client's expectations • Ensure social inclusion of most vulnerable groups	All HF employ communication strategy that involves stakeholders, positively influence change of internal and external clients	Percentage of facilities which apply effective communication strategies	SS reports	
1.2 Client complaints' handling procedures	1.2.1 Develop a guide on complaints' handling and response for health and social welfare institutions	Availability of guide on complaints' handling and response for health and social welfare institutions in all HSWF	Percentage of HSWF with guide so complaints' handling and response	SS reports	
	1.2.2 Orient health and social welfare management to systematic processing of complaints' records and follow up of responses	Systematic processing of complaints and follow up of response in place at all HSW facilities	Proportion of HFs that have processed client complaints and followed up responses	RHMT, CHMT HMT complaint processing report	QITs shall submit data on complaints to the management teams
	1.2.3 Post appeal submission and handling procedure on public notice boards and websites	Procedures for handling client complaints implemented at all HSWF	Proportion of HFs with appeal submission and handling procedures posted on public notice board	HSWF survey report, SS reports	
1.3. Develop and adopt a clients' charter that applies human rights based approach in health and social welfare	1.3.1 Inform internal and external clients on clients' charter and code of ethics	Clients are informed on Patient's Charter and Code of ethics at all HSWF	Percent of health service providers who are aware of Patient's Charter and code of ethics	HF survey report SS report	
	1.3.2 Collaborate with Health Promotion and Education (HE) Section to print and disseminate clients' charter to all health facilities and CHWs	Availability of sufficient copies of clients' charter for all HSWF	Percentage of facilities with copies of clients' charter	SS reports	

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	1.3.3 Collaborate with Professional Councils (PC) to review and establish functionality of respective ethics and code of conduct for each profession.	Functionality of respective ethics and code of conduct for each profession reviewed and established by professional Councils	Percentage of facilities with reviewed copies of ethics and code of conduct		
	1.3.4 Collaborate with the DHRD on reviewing the curricula of the health and social welfare profession' training	Quality Improvement incorporated in pre-service training programs for health workers.	QI modules incorporated in pre-service health training curricula	Health training curricula	
1.4. Informed-consent (both written and verbal) for medical and social services	1.4.1 Update the tool in use for informed consent to make provision for alerting the internal and external clients on need for consent signing.	Clients are thoroughly informed on medical procedures	Percent of patients who were informed on procedures, possible risk and alternative treatment option prior to surgical procedure	Client satisfaction survey report	
	1.4.2 Adapt the tool to clients' information needs: The information shall be made in client-friendly language for easy understanding.	Health facilities have adapted tools to clients needs	Percentage of health facilities with adapted tools	SS Reports	HMTs are fully accountable to ensure clients are satisfied with services provided
	1.4.3 Oblige service provider to check that the client understands the given information before giving consent.	Service providers check clients understanding before consent	Percentage of clients whose understanding was checked	SS Reports Health Facility Internal assessment reports	Health workers are fully aware of patients rights and code of conduct
1.5. accountability to clients and communities	1.5.1 RHMTs, CHMTs and HMTs shall provide regular QI reports to the Regional Secretariat, Hospital Advisory Boards, Council Management Team (CMT), Council Social Services Committee and Health Facility Governing Committees	RHMT, CHMT and HMT are accountable to clients and communities	Proportion of HF governing committees presented with a QI progress report	SS Reports	
	1.5.2 QITs shall post QI progress reports on public notice boards.	Progress reports posted on notice boards in all HF	Number of facilities posting progress reports on public notice boards	SS Reports	All Health Facilities have functional QIT

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	1.5.3 Best practices on QI shall be shared with stakeholders at Regional, Council, Community level and MOHSW.	System for sharing best practices with stakeholders at Regional, council, Community level and MoHSW in place	Number of facilities that have initiated a system of sharing best practices with stakeholders	SS Reports Best practices report	Health facilities have in place system for sharing best practices
	1.5.4 Management at all levels shall be proactive in recognizing excellent performance of individuals and teams, both internally and externally.	System for recognizing best performance in place at all HF. National level recognition system initiated	Number of facilities recognized for excellent performance	External verification and recognition visits reports	The system for external verification and recognition is fully functional
	1.5.5 MoHSW, RHMTs, HMTs and CHMTs shall organize QI information sharing events e.g. Health Days Client satisfaction surveys' results shall be posted on public notice boards in addition to being shared in different fora.	Fora for sharing information initiated at different levels Client satisfaction surveys' results posted in public boards at all HSWFs	Percentage of regions, districts/councils, hospitals with established for a for sharing QI information Percentage of HSWFs posting clients satisfaction results on public notice board	Forum Report Report of client satisfaction survey	There is commitment to organize for a information sharing
Strategic Area 2: Conducive working environment					
2.1. Ensure availability of functional equipment, reagents, safe and potent medicines and supplies	2.1.1 Accelerate disposal of expired, broken and worn out drugs, equipment and supplies	Expired, broken and worn out drugs, equipment and supplies are disposed appropriately	Number of HFs that dispose expired, broken and worn out drugs, equipment and supplies	Records for the dispose expired, broken and worn out drugs, equipment and supplies	Availability of funds for the disposal of expired, broken and worn out drugs, equipment and supplies
	2.1.2 Advocate for a change in law governing insurance of public property	Law governing insurance of public property is in place	Number of HFs that have insured their public property	Covering notes from Insurance company	Willingness of the stakeholders to change and implement the law
	2.1.3 Strengthen collaboration with different authorities to address safety of medicines, reagents and supplies (reporting Adverse Reactions (ARs), substandard).	Medicines, reagents and supplies are safe	Number of HFs that have reported the substandard medicines, reagents, supplies and ARs	Reports of the substandard medicines, reagents, supplies and ARs	HF are committed to report sub standardness

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	2.1.4 Establish working relations with Tanzania Bureau of Standards and TAEC to address equipment and supplies' standards.	TBS and TAEC relationship with MoHSW is improved	Number of Reports of the meeting amongst TBS, TAEC and MoHSW to discuss equipment and supplies' standards	Meeting reports	Commitment of the responsible parties
	2.1.5 Strengthen the system to determine sub standard medicines, equipment and supplies and recommend appropriate compensation and litigations.	The system to determine sub standard medicines, equipment and supplies and recommend appropriate compensation and litigations is in place.	The amount of sub standard medicines, equipment, supplies and ARs reported	Reports of the sub standard medicines, equipment, supplies and ARs	Commitment of the responsible stakeholders
	2.1.6 Ensure supportive supervision is conducted to HF to strengthen equipment Planned Preventive Maintenance (PPM) and regular maintenance of buildings as well as attaining clearance of acquisitions and acceptance testing (incoming equipment inspections).	PPM of equipment and regular maintenance of buildings is strengthens	The number of supervisions conducted to HF to strengthen equipment Planned Preventive Maintenance (PPM) and regular maintenance of buildings	SS reports	Funds are available for SS and PPM
	2.1.7 Enhance PPP to strengthen the equipment PPM and regular maintenance of buildings	PPP is strong enough to implement PPM and regular maintenance of building	Number of PPM and maintenance of building conducted from PPP initiatives	SS reports	Commitment of partners and presence of strong PPP
	2.1.8 Establish a national list of health service technology (equipment) that is safe, efficient and cost-effective.	National list of health service equipment is established	Number of HFs which follow the list of health service technology (equipment) that is safe, efficient and cost-effective.	National list of health equipment available	The list will be shared with the HFs and HF leadership will conform to specifications
	2.1.9 Advocate for the formation of health service technology advisory committee as per National Health Service Technology Guideline.	Health service technology advisory committee is in place	Number of reports of the meetings held by Health service technology advisory committee	Available report	Committed committee

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
2.2. Consolidate gains made in Infection Prevention and Control (IPC)	2.2.1 Orientation and mentoring of service providers on IPC	Service providers are oriented and mentored on IPC	Number of HCWs who are oriented and mentored on IPC	Orientation and mentoring report	Availability of funds to orient a big number of HCWs
	2.2.2 Enforce use of PPEs (gloves, boots, aprons, goggles, uniform, appropriate masks) at all levels of health service delivery	Use of PPEs is enforced in all levels	Number of HF who have enforced the use of PPEs	SS report	Availability of PPEs in all HFs
	2.2.3 Introduce/revive Central Sterile Supply Department (CSSD)	All hospitals are having standard CSSD	Number of HFs with standard CSSD	Standard CSSD available	Availability of resources
	2.2.4. Promote hand hygiene practice	Hand hygiene practice is adhered	Number of HFs with appropriate hand hygiene facilities	SS&M report	Commitment of stakeholders to adhere with the hand hygiene
	2.2.5 Promote appropriate handling of sharps Strengthen applications of vaccination and Pre/ Post Exposure prophylaxis measures	Handling of sharps is improved	Number of HFs which handle sharps according to the MoHSW standards	SS&M report	Commitment of stakeholders to adhere with the appropriate handling of sharps
2.3. Consolidate gains made in Health Care Waste Management (HCWM)	2.3.1 Provide orientation and mentoring of HSPs	Applications of vaccination and Pre/ Post Exposure prophylaxis measures is strengthened	Number of HFs which implement vaccination and Pre/ Post Exposure prophylaxis measures	Available reports	Availability of funds
	2.3.2 Enforce waste segregation and use of appropriate health waste color coded bin and bin liners	Orientation and mentoring of HSPs on HCWM is done	Number of the HCWs who have been orientated and mentored on HCWM	Orientation and mentoring report in place	Availability of funds
	2.3.3 Liaise with responsible authorities to assure timely collection, storage, transport and disposal of segregated health waste.	HCWM is improved	Number of HFs which have improved HCWM	SS&M reports	Positive attitude of HCWs
	2.3.4 Encourage construction of high technology incinerators as per national waste management guidelines	Timely collection, storage, transport and disposal of segregated health waste.	Number of HF which Timely collect, store, transport and dispose the segregated health waste.	HF reports	Commitment of responsible stakeholders

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
2.4. Consolidate and sustain gains made in improving working environment	2.4.1 Orienting and mentoring newly recruited personnel on working environment improvement approach	High technology incinerators are in place	Number of HFs with high technology incinerators	Available functional incinerator	Availability of funds
	2.4.2 Enforce maintenance of clean and organized work stations	Newly recruited personnel have knowledge and skills on working environment improvement approach	Number of the newly recruited personnel who are oriented and mentored on working environment improvement approach	Orientation and mentoring report in place	Availability of resources
	2.4.3 Routinely conduct comprehensive supportive supervision on the state of cleanliness and organization of the health facility	All HF are clean and organized	Number of clean and well organized HFs	SS reports	Commitment of the HMTs and HCWs
	2.4.5 Advocate for inclusion into comprehensive regional/ council comprehensive health plans of budgets for PPM of the equipment and buildings.	Routinely comprehensive supportive supervision is conducted	Number of Routinely comprehensive supportive supervision conducted	Comprehensive SS report	Availability of resources
	2.4.6 Ensure infrastructure designs are pro-safe including: i. Access for the persons with disabilities and the elderly ii. Appropriate provisions for water supply, ventilation, lighting, safe flooring and fire hazard considerations iii. Advocating for adherence to technical specifications of constructing health and social welfare facilities procure and arrange furniture and technology that fit well into the infrastructure.	Budgets for PPM of the equipment and buildings is in health plans of all HFs.	Number of HFs with Budgets for PPM of the equipment and buildings is in health plans of all HFs.	SS reports	Commitment of the responsible RHMT/CHMT

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
2.5. Establish a reporting system to the facility management on infrastructure availability and use at all HSWFs	2.5.1 Ensure uninterrupted supply of oxygen, emergency drugs' and medical supplies	Infrastructure of HF are User friendly: 1. For the persons with disabilities and the elderly 2. Water supply, ventilation, lighting, safe flooring and fire hazard considerations are in place 3. Improved adherence to technical specifications of constructing health and social welfare facilities	Number of HFS with user friendly infrastructure for the persons with disabilities and the elderly, water supply, ventilation, lighting, safe flooring and fire hazard considerations, improved adherence to technical specifications of constructing health and social welfare facilities	HF report	Availability of the resources and commitment of the stakeholders
	2.5.2 Ensure uninterrupted water supply	All HF have constant supply of oxygen, emergency drugs' and medical supplies	Number of HFs which have constant supply of oxygen, emergency drugs' and medical supplies	HF report	Commitment of the HMT
	2.5.3 Ensure uninterrupted functionality of incinerator	All HF have constant water supply	Number HF which have constant water supply	HF report	Commitment of stakeholders
	2.5.4 Ensure uninterrupted functionality of power sources (generator)	Incinerator is functional in all Hospital	Number of HFs with functional Incinerator	HF report	Commitment of stakeholders
	2.5.5 Ensure functionality of hospital sewage and other liquid waste system	All HF have constant power supply	Number HF with constant power supply	HF report	Commitment of stakeholders
Strategic Area 3: Care set the detailed agenda					
3.1. Standardize clinical management	3.1.1 Ensure PB avail for case management protocols (CMP) for use at different levels of service provision	CMPs availed to HSW services providers	Proportion of PB that avail CMPs	SS & M visits	Each profession has an active PB
	3.1.2 Vet the protocols for consistency, technical soundness and clinical correctness (MoHSW/ Professional bodies)	CMPs vetted	Percentage of CMPs that are vetted	SS&M visits, PB reports	

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	3.1.3 Ensure HMTs introduce/ revive Clinical Meetings; make reference to CMP at clinical meetings.	HSWFs conducts clinical meetings	Percentage of hospital conducting clinical meetings	SS reports, hospital reports	
	3.1.4 Ensure HMT conduct routine medical procedures audit and share reports with CHMT/ RHMT/ MOHSW	Routine medical procedures are audited	Percentage of HMTs conducting routine medical procedures auditing	HSWF reports, SS visits	
	3.1.5 Strengthen Continuing Professional Development (CPD).	Continuing professional development strengthened	Percentage of hospitals with CPD plans	HSWF reports, SS reports	
3.2. Ensure appropriate, safe and cost-effective use of medicines in health and social welfare facilities	3.2.1 Ensure presence of functioning Medicines and Therapeutics Committee (MTC) at all HFs.	MTC are available and functional	Percentage of HSWFs with functional MTCs	HSWF reports, SS reports	
	3.2.2 Ensure each HF adheres to the national standard treatment guidelines and essential medicines list.	National standard treatment guidelines and essential medicines list adhered	Percentage of HSWFs adhering to NSTG and ETL	HSWF reports, SS reports	
	3.2.3 Print and distribute the institutional standard treatment guidelines and medicines list.	Institutional standard treatment guidelines and medicines list are distributed	Percentage of HSWF with institutions standard treatment guidelines and medicines list	SS reports, HSWFs reports	
	3.2.4 Set standard operating procedures (SOP) for prescription writing, medicine dispensing and administration	SOPs are available for prescription writing, medicine dispensing and administration	Percentage of HSWFs with SOPs for prescribing, dispensing and administration	SS reports, HSWFs reports	
	3.2.5 Organize prescription review meetings with clinical service providers	Review meetings organized	Percentage of HSWFs conducting review meetings	SS reports, HSWFs reports	

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	3.2.6 Agree on periodicity and timing of clinical and prescription audit surveys				
	3.2.7 Undertake clinical audit surveys, analyze the findings and share the results	Clinical audit surveys conducted and reports shared	Percentage of clinic audit surveys conducted and reports shared	SS reports	
3.3. Transparent management reports of medical errors and professional ethics	3.3.1 Establish incident reporting and investigating system for medical service errors.	System for incident reporting and investigating system established	System for incident reporting and investigating system available	SS reports	
	3.3.2 Strengthen the authority of HF Executive Committee in monitoring and addressing medical errors and ethics of practice in collaboration with QIT	Authority of HF EC strengthened	Percentage of HF ECs monitoring and addressing medical errors	SS reports	
	3.3.3 Keep records of and evidence on practice errors	Records and evidence of practice errors kept	Percentage of HSWFs keeping records of practice errors	SS & M reports	
	3.3.4 Hold investigative and correctional counseling sessions with individuals found to have committed errors.	Counseling sessions held	Percentage of HSWFs conducting counseling sessions	SS and M reports	
3.4. Ensure availability of functional medical equipment	3.4.1 Liaise with diagnostic services section of the MoHSW in acquisition, testing and acceptance of medical equipment prior to using them.	Medical equipment acquisition testing conducted	Percentage of HSWFs with equipment tested before acquisition	HSWFs reports	
	3.4.2 Address weaknesses of supply chain management	Weaknesses of SCM addressed	Percentage of O/S days for essential medicines and supplies reduced	MSD reports, SS reports	
	3.4.3 Strengthen PPM at all levels	Functionality of medical technology improved	Percentage reduction of the DT of medical technology		

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
3.5. Ensure and maintain regular availability of medical supplies and consumables and their pricing for purpose of charges to patients and/or health insurance reimbursement	3.5.1 Arrange for regular stock taking	Regular stock taking conducted	Percentage of HFs conducting stock taking regularly	SS and M reports	All HFs conduct stock taking as prescribed
	3.5.2 Check compliance to FEFO system	FEFO system adhered to	Percentage reduction of the expired medicines and supplies	SS and M reports	FEFO system is in place in all HFs
	3.5.3 Establish re-order levels and timely placement of orders	Re-ordering and timely submission of orders is adhered to	Percentage of HFs with late re-ordering of medical supplies and consumables	MSD reports	MSD guidance on re-ordering and submission deadlines are clear to all HFs
	3.5.4 Liaise with MSD to determine orders management and responsiveness	Medical and Supplies ordering guidelines are communicated to all HFs	Percentage of HFs without MSD order management guidelines	SS and M reports MSD reports	MSD will disseminate order management guidelines
	3.5.5 Check for cold chain maintenance	Cold Chain is Maintained as per set standards	Percentage of HFs whose cold chain systems have malfunctioned	Cold chain reports SS reports	Cold chain management supplies and systems are available
	3.5.6 Check for blood safety compliance – if procedures are followed strictly.	Blood safety strictly complies to set standards	% HSWFs complying with blood safety standards	SS reports, Service auditing reports	Blood safety compliance supplies and systems are in place in all HFs
	3.5.7 Agree pricing policy and regularly update the price list.	Standardized price list available	Percentage of HFs with outdated price lists	MSD reports	Standardized price list in place in all HFs
	3.5.8 Arrange for regular stock taking	Stock taking conducted regularly	Percentage of HFs failing to conduct stock taking regularly	SS reports MSD reports	All HFs conduct stock taking within set/ agreed schedules
3.6. Maintain high standards of diagnostic services	3.6.1 Oblige QITs to established laboratory quality control and quality assurance procedures and report accordingly.	Lab QC and QA procedures in place	Percentage of HSWFs adhering to la QC and QA process	SS reports, services auditing reports	Lab QC and QA supplies and protocols are available in all Labs

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
	3.6.2 MOHSW, RHMTs and CHMTs to support verification measures on compliance to Laboratory Bio-risk (biosafety and biosecurity - requirements.	Budgets available for supporting compliance to lab bio risk requirements	Percentage of R/CHMTs with budget to support compliance of lab bio risk requirements	SS reports, services audit reports	Funds availability
	3.6.3 Ensure compliance to the level of bio-containment compliance by clinical and research laboratories.	Clinical and research labs complying to bio containment	Percentage of clinical and research lab complying to bio containment	SS reports	Bio-containment supplies and protocols are available in clinical and research labs
	3.6.4 QITs and HF management shall receive reports on status of compliance to radiological imaging safety procedures.				
	3.6.5 Establish working collaboration with Tanzania Atomic Energy Commission (TAEC) on quality assurance procedures.				
	3.6.6 Liaise with MSD to ensure constant availability of essential diagnostic equipment, reagents and emergency contingency supplies.	No S/O of equipment, reagents and supplies	Percentage reduction of S/O days in a year	Annual MSD reports	
	3.6.7 Sensitize managers and planners to maintain high standards of diagnostics in light of critical importance of scientific evidence in patient management.				
	3.6.8 Establish working collaborations with private health service providers under PPP to benefit on diagnostic services.	PPP contracts in place	Proportion of private HF signed contracts with public CHMTs on service provision	SS reports	

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
Strategic Area 4: Management focuses on how the agenda will be implemented					
4.1. Promote innovative QI leadership	4.1.1 Identify sites with evidenced QI leadership and capture documentaries of leadership scenes and sessions	Effective functional structure between HSIQAS and Health Systems focal points	Functional QI structure available at all levels	QI reports at all levels, CSS reports	Availability of funds for dissemination and implementation of TQIF at all levels. Inclusion of HS Focal persons in QITs shall be accepted. Setting up a QI Secretariat that includes HS Focal persons at MOHSW shall be added to approve structures.
	4.1.2 Organize leadership innovation sensitization and mentoring program.	Exemplary leadership documentatio ns	Availability of documentaries on exemplary leadership	Health facility records/ library	
	4.1.3 Apply recognition system for QI leadership				
	4.1.4 Establish national QI TOTs, supervisors and train them on SS& M as well as external assessments and facilitation of QI training.				
	4.1.5 Establish the QI Technical working group under SWAP	Establish a QI Technical working group under SWAP	A functional QI Technical working group in place		
4.2. Build capacity of MOHSW, RHMTs, CHMTs, HMTs and HSW Institutions in comprehensive	4.2.1 Develop CSS& M training package	A CSS&M training package developed	A CSS&M training package in place and being used for training		Resource for developing training package available

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
supportive supervision and mentoring	4.2.2 Orient CMSS, RHMTs, CHMTs, HMTs and HSWF and social welfare institutions on CSS& M manual and tools	No. of MOHSW staff, RHMTs, CHMTs, HMTs and HSW Institutions trained in comprehensive supportive supervision and mentoring	Proportion of MOHSW staff, RHMTs, CHMTs, HMTs and HSW Institutions trained in comprehensive supportive supervision and mentoring	Training reports	Availability of training resources
	4.2.3 Plan and budget for supportive supervision and mentoring in HSW institutions.	Plan and budget for supportive supervision and mentoring in HSW institutions in place	Plan and budget for supportive supervision and mentoring in HSW institutions in place	Plan and budget for supportive supervision and mentoring in HSW institutions is used	Availability of committed staff
	4.2.4 RHMTs, CHMTs and HMTs shall monitor and report on implementation of the supportive supervision and mentoring of HSW institutions.	RHMTs, CHMTs and HMTs monitoring and reporting on implementation of supportive supervision and mentoring of HSW institutions.	No of monitoring visits by R/CHMT &HMTs per quarter	Monitoring reports	Resources available
4.3. Develop and disseminate national QI guidelines and tools	4.3.1 Disseminate the CSS& M materials to RHMTs, CHMTs, HMTs, QITs, of HSW institutions.	No. of dissemination events No of copies disseminates	Proportion of RHMTs, CHMTs, HMTs, QITs, of HSW institutions with CSS& M materials	Availability of CSS&M at the facilities	*Resource available*
	4.3.2 Monitor, evaluate and give feedback on the implementation of the QI action plans included in HSW institutional plans and CCHPs.	Monitoring activities done continuously	No. of Monitoring events per quarter	Monitoring reports	
4.4. Collaborate with health systems experts to address QI in health and social	4.4.1 Advocate for introduction of universal health coverage through health insurance	Advocacy events done	No. of Advocacy events done per quarter	Advocacy reports	Advocacy events done

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
welfare systems	4.4.2 Ensure a robust system for the poor and marginal groups to access health service	Increased service points for the marginalized groups	Proportion of service delivery points targeting marginalized groups	Activity reports	Increased service points for the marginalized groups
	4.4.3 Advocate for posting and retention of qualified, competent and committed HRH at different levels of HF	Advocacy Meetings	No of Advocacy meetings per quarter	Reports on Advocacy meetings	Advocacy Meetings
	4.4.4 Synthesize and put forward innovative proposals for optimizing HRH performance and productivity.				
	4.4.5 Launch a national QI newsletter to recognize QI exemplary performers	News letter developed	No. of publication of news letters per quarter.	Reports of dissemination of newsletter	News letter developed
	4.4.6 Share QI experiences to enhance motivation of HSPs as well as provide visibility for the QI program.	Sharing meetings and newsletter among stakeholders	No. of information sharing meetings and people receiving newsletter	Reports	Sharing meetings and newsletter among stakeholders
	4.4.7 Ensure HRH access further career development opportunities	Training of HRH in various areas.	Proportion of HRH trained	Training reports	Training of HRH in various areas.
	4.4.8 Guide RHMTs, CHMTs and HF management teams to undertake human resource induction for new appointees	Induction courses for new employees	Proportion of new employees taken through an induction courses	Training reports	Induction courses for new employees
	4.4.9 Advocate for equity in health sector resource allocation				
	4.4.10 Advocate for introduction of universal health coverage through health insurance				
	4.4.11 Ensure a robust system for the poor and marginal groups to access health service				

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
Strategic Areas 5: Evidence driven leadership and catalysts for scaling up					
5.1. Research and assessments	5.1.1 Develop prioritized QI research agenda	QI research agenda	Availability of QI research agenda		
	5.1.2 Provide capacity building on QI research at all levels	Skilled staff on QI research	Number of trained HSW service providers	Training reports	Availability of resources
	5.1.3 Commission QI research.	QI researches	Number of research commissioned	Inventory	Researches
	5.1.4 Advocate for development of Scientific QI Centers of Excellence for documentation, assessment, storage and sharing of results.				
	5.1.5 Commission external assessments and effective feedback of results	External assessments conducted	Number of institutions received external assessment	External assessment report	
	5.1.6 Organize dissemination of research products and optimize utilization of the findings.	Dissemination workshop on research	Number of dissemination workshop organized	Dissemination workshop report	
5.2. Learning from QI best practices	5.2.1 Comprehensive SS to identify and document best practices from the HSW institutions	Identification of best practice	Number of cases reported as best practices	SS report	
	5.2.2 Mapping of best health and social welfare service practices and posting on a dedicated web page for easy access and dissemination	Map of best health and social welfare service practices	Availability of Mapping of best health and social welfare service practices	Map of best health and social welfare service practices	
	5.2.3 Documenting best health and social welfare practices in public and private HSW institutions and sharing the reports widely	Inventory for best health and social welfare practices	Number of best practices documented annually (disaggregate by level)	Awards selection records	
	5.2.4 Facilitate adaptation of best health and social welfare service practices		Number of best practices adopted	SS report Inventory of institution	

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
5.3. Clients records and HMIS	5.3.1 Sensitize different levels of the HSW service provision on importance of documentation of clients' records		Number of HSW institutions sensitized	SS report	
	5.3.2 Strengthen/ revive client record keeping	Functional, well organized client records	Number of HSW institutions trained	Training report SS report	
	5.3.3 Advocate for introduction of electronic medical records	Electronic medical records introduced	Number of HSW institutions introduced electronic medical records	SS report	Electronic medical records is available
	5.3.4 MOHSW in collaboration with other stakeholders strengthen data management systems		Data coverage of HMIS, DHIS, HRHIS	SS report	
5.4. Standards and indicators for assessments	5.4.1 Advocate for utilization of the existing health service QI standards and indicators		Number of HSW institutions	Workshop report	
	5.4.2 Distribute the QI standards and indicators to the Ministerial departments, agencies and programs, , RHMTs, CHMTs and HSWFs		Number of HSW institutions	Inventory	
	5.4.3 Develop a computerized system for feeding for internal and external assessment findings and proposed solutions into a database to be observable centrally.	Computerized internal and external assessment system	Availability of computerized system		
5.5. Phase-based introduction of Stepwise Certification Towards Accreditation system	5.5.1 Advocate for a national system for stepwise certification towards accreditation of HSWFs	National system for stepwise certification towards accreditation is recognized by HSW facilities	Number of HSW institutions	Workshop report	
	5.5.2 Scale up a national system for stepwise certification towards accreditation of HSWFs Advocate for creation of a semi-autonomous (to autonomous) accreditation agency or Commission.	National system for stepwise certification towards accreditation is scaled up nation wide	Number of HSW institutions	Training report	

Objective	Strategy	Expected output	Verifiable indicators	Means of verification	Important assumption
5.6. Putting in place a system for motivating different levels of service provision to apply QI methods and tools country wide	5.6.1 Widen scope of participation in different QI Fora		Number of HSW workers participated QI fora	Various Reports	
	5.6.2 Identify potential high-level champions for QI and work with them in mapping out a strategic mutual action agenda.	high-level champions identified			
	5.6.3 Advocate for budgeting of QI activities in the health plans at different levels	Sufficient budget allocated for QI activities at all levels	Number of RHMTs/CHMTs allocate budget for QI activities	Annual plan at all levels	
	5.6.4 Advocate for participation of private sector in recognizing and awards for QI	Private sector participated	Number of private company	Inventory	
	5.6.5 Mobilize resources for QI operational research		Number of RHMTs/CHMTs allocate budget for QI activities	Annual plan at all levels	
5.7. Integrate QI into pre- and in-service training programs for health service and social welfare service providers	5.7.1 Develop integrated training modules on QI planning, implementation and evaluation for inclusion into health and social welfare training curricula.	Integrated training modules on QI planning, implementation and evaluation	Availability of integrated training module on QI		
	5.7.2 Orient QI modules to staff at ZHRCs and HSW training institutions	QI modules are oriented	Number of Training institutions oriented to QI modules	Training Report	
	5.7.3 Organize distance learning on QI planning, implementation and evaluation for in-service personnel.	Distance learning on QI planning, implementation and evaluation organized	Availability of distance learning program	Report on implementation of Distance Learning	

OUTPUTS	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Strategic area C: To improve client service practices through application of quality assured clinical and support services			
3.1 Standard case management protocols adapted and printed for system wide use	Proportion of tertiary hospitals with case management protocols Proportion of Regional Referral Hospitals having in place Standard case management protocols. Proportion District Hospitals with Standard case management protocols Proportion of HCs and Dispensaries with case management protocols	SS reports	Availability of funds for development, printing and dissemination
3.2 Medication management procedures audit	Availability and use of Medication management procedure audit tool.	Supportive Supervision reports	Availability of funds for development, printing and dissemination
3.3 Periodic prescriptions audit surveys		Prescriptions Audit reports	The mandated teams are capacitated
3.4 Records and evidence of practice errors in place	Number of sessions conducted for practical errors problem solving	Session reports	The mandated teams are capacitated
3.5 (i) Assurance of regular availability of basic health service delivery equipment	Percentage of HF with basic health service delivery equipment	SS reports	CSS tool covers the items; A list showing a basic set of essential equipment is made available nationally.
(ii)Assurance of regular availability of basic drugs and supplies stocks	Percentage of facilities reporting stock outs of drugs and supplies	Supportive supervision report	Comprehensive supportive supervision tool covers the items
3.6 Standards of diagnostic services compliance	Proportion of laboratories meeting approved laboratory standards	Supportive supervision reports	Availability of funds for development, printing and dissemination

OUTPUTS	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Strategic area D: To improve management systems and accountability			
4.1 Effective functional structure between HSIQAS and Health Systems focal points	Functional QI structure available at all levels	QI reports at all levels, SS reports	Availability of funds for dissemination and implementation of TQIF at all levels. Inclusion of HS Focal persons in QITs shall be accepted. Setting up a QI Secretariat that includes HS Focal persons at MOHSW shall be added to approve structures.
4.2 Exemplary leadership documentaries	Availability of documentaries on exemplary leadership	Health facility records/ library	
4.3 Integrated comprehensive supportive supervision and mentoring guidelines and tools	Availability and use of a comprehensive supportive supervision and mentoring guideline	Observation at field visit with supervision team	
4.4 Integrated QI implementation guidelines and harmonized tools	Percentage of HF with integrated QI implementation guidelines Percentage of HFs with harmonized QI tools	Supportive supervision reports	
Strategic area E: To enhance evidence for QI			
5.1 Health service standards and indicators (measurement criteria) guide	Percentage of HFs with basic health service delivery SOPs	SS reports	The work on standards shall be completed soon.
Strengthen stepwise certification to accreditation system	Proportion of facilities (disaggregated by level) awarded accreditation	A functional stepwise certification towards accreditation system in place, SS reports	Available funding for QI
5.2. Prioritizing QI research agenda at all levels	Number of prioritized QI researches	Annual QI progress report	Availability of funds
Orienting HSPs and social workers on QI research	Proportion of eligible HSPs trained on QI research (N: Health researchers trained in QI, D: Total no of Health researchers)	Orientation reports	Availability of resources

OUTPUTS	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Commission QI research	Number of QI researches commissioned	HSIQAS studies inventory	Funds are available for QI researches
E2. Learning from best practices of QI			
Documenting best practices in public and private HF and sharing widely in policy forums, annual reviews and dedicated media	Number of best practices documented annually (disaggregate by level)	Awards selection records	
E3. Retrievable patient records	Percent of HF (disaggregate by levels) with computerized patient information system	SS reports	
Strategic area F: To put in place a catalytic system for motivating applications of QI methods, tools on a wider scale country wide			
6.1 Integrated QI training modules	Proportion of health training Curricula with QI modules integrated	Health Training curricula	
6.2 Distance learning on QI course curriculum			
6.3 Pooled fund for innovation support (Establish funding to support QI Operation Research, capacity development and innovation).	Fund established for QI OR, capacity development and innovation)	Reports of fund establishment	Stakeholders commitment to support QI initiatives
6.4 Strengthen and maintain the National QI Forum	Number al of nation QI Fora successfully conducted	Annual NQIF Reports	Willingness of the stakeholders
6.5 QI Exemplary performance rewards Establish QI awarding system	Number of institutions rewarded for QI performance (N: no of institutions rewarded, D: No. of institutions pares)	Annual QI reports	Willingness to incorporate QI Resources Available

OUTPUTS	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Strategic area G: Promote quality and equitable provision of social welfare services in the country.			
6.1.Incorparated social welfare service data to the HIMS	Availability of social welfare service data in HIMS	Assessment of Quarterly reports.	Commitment of the Ministry.
6.2.Accessible and user friendly information and data to people with special needs	Availability of accessible data to elderly, children and people with disability	Assessment of quarterly report.	Stakeholders' commitment to implement CRC, UNCRPD, PWD Act, LCA.
Reviewed health sector policies, guidelines, strategies and plans to incorporate social issues.	Number of reviewed health sector policies, guidelines, strategies and plans in place.	Assessment of the reviewed document.	Commitment of the stakeholders.
	Number of fully fledged DSW established at LGAs	Approved DSW within LGAs	Commitment of PMO-RALG,PO-PAM & MOHSW

CHAPTER 4:
RESOURCE REQUIREMENTS

4.1 Human Resources

The multi-faceted perspective and multi modal action fronts to take forward QI work imply a significant mobilization and involvement of the work force related to health and social welfare services delivery or its support structures. For management purposes the HSIQA Section staff in collaboration with the Department of Social Welfare (DSW) shall be overall responsible with focal points responsible for key priority areas of (a) capacity development, (b) assessments and certification-accreditation for health and social welfare facilities, (c) safety (including IPC), (d) client and provider focus governance and leadership. Competent public and private firms shall be identified and invited to tender for major tasks that require fast tracked implementation and those that shall be beyond the scope of in-house staff to undertake.

National, Zonal, regional and district level capacity for supportive supervision, mentoring and coaching shall be built and a program for the same developed, financed and it shall be systematically accounted for. Success of QI work shall be hinged on the foundation laid among QITs and WIT at health and social welfare facilities through a supportive supervision and mentoring program and measures to motivate staff to improve the individual and organization performance.

4.2 Physical Infrastructure

The newly established directorate of Health Quality Assurance (HQAD) lacks adequate office space for effective and efficient functionality. The HSIQAS staff is currently housed inconveniently for effective teamwork. There is a need to look at options that should enable the section to have offices that are adjacent to each other for ease of coordination, consultation and meetings. Placing all the staff of the HQAD in the same floor will facilitate harmonious discharge of duties and efficiency in responsiveness to MOHSW management and clients.

At health facilities especially larger Hospitals the QITs shall need dedicated office space. Computerizations of self-assessments and progress reports on QI shall enable various levels to receive and access the information they need in real time and reduce travel costs. To this end ICT infrastructure shall be critical for facilitation of Local and Wide area networking in QI, including linked data bases between QI Central, HMIS, Human Resources and key national programs and tertiary Health Facilities.

QITs shall be at the forefront of sensitizing facility managers to have in place physical infrastructure maintenance and planned preventive maintenance activities within the health and social welfare facilities annual plan of action. In liaison with Health and Social Welfare Facility Design Unit of the MoHSW the HSWQAD shall determine compliance to the ministry's physical infrastructure standards with due regard to QI issues important among which is safety and disability friendliness.

4.3 Medicines, equipment and supplies for Health and Social Welfare

The most recurrent items in the supplies cost estimates comprise paper and printing costs of manuals, checklists, pamphlets and tools.

At health facilities the most pressing problem has been frequent stock outs of medicines and basic patient care equipment and supplies and inputs for diagnostic work. While at social welfare level the most pressing problem has been inadequate budget, uncoordinated data and human resource that makes the department fail to address the challenge facing vulnerable groups, hence vulnerable groups like people with disability, elderly and MVC continued to live in environment where their needs are not met.

The HQAD in collaboration with DSW shall determine effective measures to strengthen the supply chain management system to ensure quality, safety, regularity and timeliness in delivering general supplies, equipment, and medicines. Minimum stocking levels (stocking intelligence) for effective functionality of health facilities shall be emphasized without compromises. Similarly, the HQAD in collaboration with DSW shall determine effective measures to strengthen social welfare services delivery.

4.4 Financial Resources and Management

The foundation for QI already shows many activities can be initiated without large chunks of start up funds. Activities such as self-assessments to determine gaps and map out problem areas can proceed after the QITs have undergone initiation sessions. Health care waste management and IPC procedures can be maintained if local cost recovery funds are used innovatively to address gaps in essential supplies. Cost savings can be realized by undertaking capacity building on site instead of taking away staff from workstations. Distance learning can also bestow savings. The respective levels shall budget for costs for supportive supervision, mentoring and coaching in their annual plans. In this way the central level budget for supportive supervision and mentoring shall be kept at a reasonable level.

Institutionalization of QI in terms of its inclusion in health and social welfare training schools curricula shall be well justified by having joint sessions between QI experts and teaching staff to develop relevant training modules. Printing produced manuals; guides and communication materials may involve significant costs considering the need to cover the whole country. Operational research on prioritized QI studies shall be sourced as a reasonable portion of the MOHSW funds dedicated for health and social welfare research.

The largest cost shall be in the bold decision to introduce electronic medical records in the entire health and social welfare service delivery system. However since this will be an activity requiring collaboration with what the HMIS has already proposed to do the largest portion of the costs will be borne by and reflected under HMIS. The HQAD shall put in place financial management procedures that shall oblige all staff to spend funds with strict adherence to planned activities.

4.5 Logistics and Technological Resources

The field oriented nature of the QI work requires availability of transport be assured on full time basis. The largest portion of this category is therefore accounted for by purchase of vehicles (3) and their maintenance.

With additional staff expected to join (Social Welfare Officers, Health Officer, Pharmacist, and Laboratory Technologist) there will be a need to equip staff with at least 6 Computers, a heavy-duty copier and a spiral binder. Tertiary Hospitals' Management Teams, RHMTs and CHMTs shall plan for their transport and supplies logistics for QI in their respective annual plans of action.

4.6 Information and Communication

Information sharing and communication have great potential in setting trends and creating momentum for spearheading QI. Investing in documentation of best practices creates products for wider sharing in media advertisements, posting on the web and use at symposia and thematic forums and meetings. Popularizing QI through publicity events, media airtime talk shows and drama shall be considered. Other cost categories include telephone and Internet use charges as well as costs of awards ceremonies at QI competitions.

Taking the good example from CTC electronic records of patients, it is worthwhile to support the Sector's M&E (HMIS) efforts to introduce electronic medical records. This could be done in a phased manner to cover all levels of care delivery (Dispensary, Health Center, Hospital and social welfare facilities). Phase one could target the social welfare facilities, National Hospital and Referral Hospitals; phase two could take on board all social welfare training institutions, Regional Referral Hospitals and Specialized Hospitals. Phase three could take all social welfare interventions at council level, District and VA Hospitals. Phase four could take on board Health Centers, Dispensaries and communities where community health workers, facility governing committee and para-social workers (PSWs) will be involved.

Communication with APHFTA to solicit private sector compliance to electronic medical records system will be vital due to its costs implications and vis a vis the need to have nationally complete data sets.

CHAPTER 5:
FINANCE PLAN

According to the strategic objectives of this plan, the outputs can be classified into 4 main groups as listed below.

- Those related to capacity building for improved performance of staff and management,
- Those linked to knowledge management which includes reports generation and sharing
- Those connected to coordination and communication
- Those associated with motivation

Appropriate balancing of contribution from each of the 4 output packages is vital. Financing of this strategic plan will consistently consider this fact.

Health sector funding suffers significant budgetary deficits (HSSP III). Financing of QI strategies will be formulated with this reality in mind. The central government will remain to be the major funder of QI activities. The financing gap will be the difference between the total program and the total projected resource mobilization. To reduce the funding gap, the following measures will be considered;

- Harmonization and alignment of some of the identified packages or activities to other ongoing relevant strategies e.g. QI incentive schemes
- Building on what is already available e.g. existing training modules and guidelines
- Adaptation of experiences and best practices from the region and beyond to the Tanzanian context
- Strengthening partnership with Development partners supporting the health sector in the relevant areas of quality improvement
- Lobbying for more DPs to take QI as focal area of support

QI financing plan recognizes the existence of non-discretionary resources, which are mostly found outside the Government budget frame. Estimated cost of the areas shall be determined by rationalizing estimates reflected in costing templates (Volume II – Phased Implementation Plan). Assessment of the available and projected funds shall be undertaken through mapping of current public financing of QI and DPs resource investments in respective QI projects. The collected data will be used to forecast what could be realistically expected in the coming 5 year period in consultation with DPs. Appeal to the business community to invest in promoting QI in health using their respective Corporate Social Responsibility funds, may also generate additional resources. Social security and health insurance companies including National health insurance Fund shall be lobbied to identify their investment space in financing this plan.

Implementation of QI at the de-central levels can be done with a more diverse sources of funding. Community Health Fund (CHF) money and community contributions are available and accessible in addition to the classical sources, at dispensary and health centre level. At council level, funds from own sources will complement the other sources. All QI activities will be a translation of the other existing strategic plans such as HSSP, regional and council strategic plans, in order to benefit from resources availed through those other plans and reduce overlaps.

In order to assure harmonization and sustainability of QI funding, activities (all approaches) developed by Work improvement teams will be compiled into one comprehensive annual facility QI plan. This will later be included into the facility annual plan and later CCHP in case of the district health facilities or regional plan in case of the regional referral health facilities.

5.1 Budget

Programme Areas	Output Name	Estimated Cost Per Output				
		2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**
	Orientation and communication package for clients	2,776,265,000	3,053,891,500		-	-
	Code of ethics	634,000,000	697,400,000	767,140,000	843,854,000	928,239,400
	Facility performance reports to the community/Council	-	-	-	-	-
	Home Based Care QI procedures manual	359,313,000	395,244,300	434,768,730	478,245,603	526,070,163
	Total: A	**3,769,578,000**	**4,146,535,800**	**1,201,908,730**	**1,322,099,603**	**1,454,309,563**
Safety in health practices and environment	Safe medicines	4,089,070,000	4,497,977,000	4,947,774,700	5,442,552,170	5,986,807,387
	Safe equipment and supplies	411,500,000	452,650,000	497,915,000	547,706,500	602,477,150
	IPC review	4,184,570,000	4,603,027,000		-	-
	Health Care Waste management review	138,245,000	152,069,500	167,276,450	184,004,095	202,404,505
	Critical incident reports	-	-	-	-	-
	Total : B	**8,823,385,000**	**9,705,723,500**	**5,612,966,150**	**6,174,262,765**	**6,791,689,042**

Clinical, diagnostic and nursing care	Standard Case management protocols	200,800,000	220,880,000		-	-
	Nurses SOPs	350,000,000		-	-	-
	Periodic prescriptions audit surveys	721,800,000	793,980,000	873,378,000	960,715,800	1,056,787,380
	Practice errors problem solving reports	934,000,000	1,027,400,000	1,130,140,000	1,243,154,000	1,367,469,400
	Supplies (medicines, delivery packs, vaccines, safe blood and blood products)	45,000,000	49,500,000	54,450,000	59,895,000	65,884,500
	Compliance reports on standards of diagnostic services	330,000,000	363,000,000	399,300,000	439,230,000	483,153,000
	Total:C	**2,581,600,000**	**2,454,760,000**	**2,457,268,000**	**2,702,994,800**	**2,973,294,280**
Quality improvement – Clients and Community focus	Exemplary leadership documentaries	1,249,000,000	1,373,900,000	1,511,290,000	1,662,419,000	1,828,660,900
Integrated QI program for improving processes and systems	Integrated comprehensive supportive supervision and mentoring tool	908,560,000	999,416,000		-	-
	QI mentoring and coaching reports	320,000,000	352,000,000	387,200,000	425,920,000	468,512,000
	integrated QI implementation guidelines and harmonized tools	990,120,000	1,089,132,000		-	-
	Health systems collaborative ventures	500,000,000	550,000,000	605,000,000	665,500,000	732,050,000
	Total: D	**3,967,680,000**	**4,364,448,000**	**2,503,490,000**	**2,753,839,000**	**3,029,222,900**
Quality improvement – standards	Research publications	535,475,000	589,022,500	647,924,750	712,717,225	783,988,948
	Standards and indicators guide	1,138,200,000		-	-	-
	practices documentaries	207,690,730	228,459,803	251,305,783	276,436,362	304,079,998
	Retrievable patient records	247,500,000	272,250,000	299,475,000	329,422,500	362,364,750
	Total : E	**2,128,865,730**	**1,089,732,303**	**1,198,705,533**	**1,318,576,087**	**1,450,433,695**

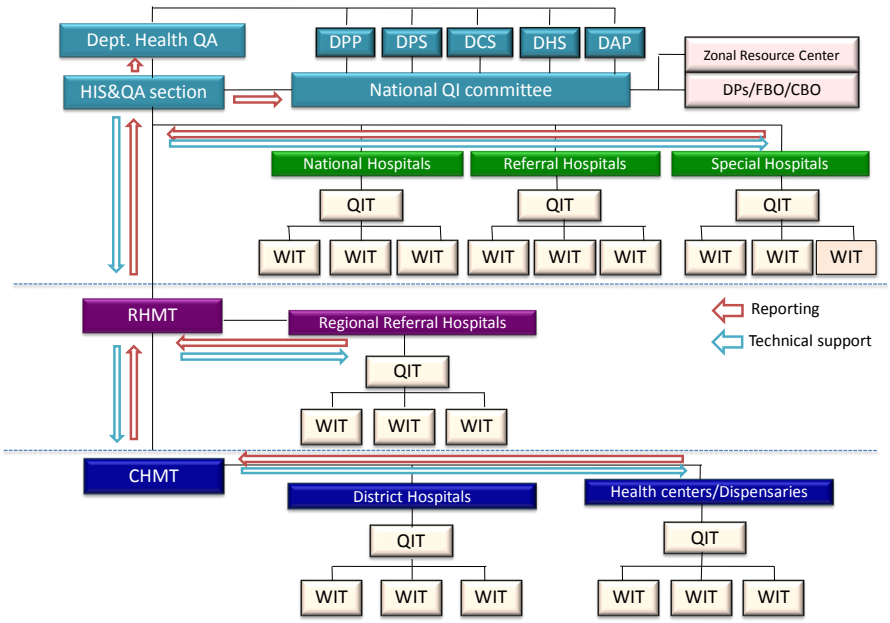
Quality improvement - institutionalization of capacity building	QI training modules	424,000,000	466,400,000		-	-
	Distance learning course outline	545,000,000	599,500,000		-	-
Quality improvement - Motivation	Pooled fund for innovations support	406,250,000	446,875,000	491,562,500	540,718,750	594,790,625
	QI Forum technical report	135,000,000	148,500,000	163,350,000	179,685,000	197,653,500
	Exemplary performance rewards	612,000,000	673,200,000	740,520,000	814,572,000	896,029,200
	Total Objectives: F	**2,122,250,000**	**2,334,475,000**	**1,395,432,500**	**1,534,975,750**	**1,688,473,325**
	Grand Total	**23,393,358,730**	**24,095,674,603**	**14,369,770,913**	**15,806,748,005**	**17,387,422,805**
Total Five years cost		**95,052,975,056**				

	Volume II:	**Estimated Cost Per Objectives Level**				
	Strategic Objectives Name	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2016/17**
A	To enhance client focus in service delivery	3,769,578,000	4,146,535,800	4,561,189,380	5,017,308,318	5,519,039,150
B	To increase patient and staff safety	8,823,385,000	9,705,723,500	10,676,295,850	11,743,925,435	12,918,317,979
C	To improve and sustain standard clinical and nursing practice	2,581,600,000	2,839,760,000	3,123,736,000	3,436,109,600	3,779,720,560
D	To improve management systems and accountability	3,967,680,000	4,364,448,000	4,800,892,800	5,280,982,080	5,809,080,288
E	To enhance evidence for QI	2,128,865,730	2,341,752,303	2,575,927,533	2,833,520,287	3,116,872,315
F	To put in place a catalytic system for motivating applications of QI method and tools on a wider scale country wide	2,122,250,000	2,334,475,000	2,567,922,500	2,824,714,750	3,107,186,225
	Grand Total	**23,393,358,730**	**25,732,694,603**	**28,305,964,063**	**31,136,560,470**	**34,250,216,517**

CHAPTER 6:
IMPLEMENTATION FRAMEWORK

6.1 Structures

All health systems building blocks have a bearing on sector QI efforts. While QI is applicable to all departments and programs of the Ministry of Health and Social Welfare, this strategic plan has devoted greater attention to QI in health and social welfare service delivery facilities. Structures already exist within service delivery settings, for QI implementation: Specifically these are the QITs and under them some facilities have constituted WITs. Where the latter have not been constituted Facility Management Teams shall take steps to establish them as deemed relevant. The following organization chart elaborates the structures for Quality improvement at all levels of care starting with the Central level to District level.



QITs established within health and social welfare facilities are expected to undertake self assessments and apply PDSA approach PDSA approach to institutionalize the continuous QI process in their facilities. Capacitated National team of trainers, RHMTs and CHMTs shall supervise, mentor and coach the QIT. They shall also organize awards for best performers. This is expected to establish a culture of QI amongst health and social welfare facilities.

A National core team of trainers including selected individuals from Zonal Health Resource Centers shall be charged with the responsibility of capacity building and be supported to take forward the capacity building

agenda. This team shall train and re-train the RHMTs and CHMTs. The team shall also design distance-learning materials for imparting knowledge and skills on QI, as a core in-service training program for health and social welfare facility managers and health and social welfare service providers. This in-service distance-learning program shall aim at making every health and social welfare services personnel QI literate. Excelling Tertiary Hospitals and research institutions shall be awarded research grants to undertake prioritized studies and document best practices and lessons for sharing. Such centers shall be awarded contracts for external assessments on a competitive tender basis.

6.2 Health and Social welfare Institutions

Health and social Welfare institutions shall have a major role to promote and uphold the QI agenda. These institutions shall therefore aspire for and work to attain stepwise certification towards accreditation.

Teaching Hospitals shall be encouraged to attain excellence in QI so as to serve as role models as well as centers of expertise and QI research.
Continued capacity building for QI shall be institutionalized at Health and social welfare Training institutions. Best practices, lessons and experiences shall be shared on the web in an attempt to reach out and collaborate with institutions engaged in QI work outside Tanzania.

Private facilities will participate in the QI agenda where the MOHSW will work closely with APHTA and CSSC to ensure they are taken onboard on this important issue.

6.3 Strategic partners

The MOHSW shall encourage the private sector to join the national QI endeavor particularly in partnership with all stakeholders. Under the umbrella of Public Private Partnership innovations and best practices shall be shared between public and private health and social welfare facilities. Requirements for certification towards accreditation shall apply to both public and private sectors. NGOs and other NSAs shall be required to work within a coordinated framework to synergize and harmonize approaches for mutual benefits.

In addition to acknowledging and encouraging continuing strong participation of funding organizations, bilateral Development Partners shall be rallied to mobilize resources and invest in the national harmonized QI program in accordance with their funding conditionalities. Technical input from stakeholders shall be consulted as part and parcel of addressing the sustainability of better health and social welfare services deliverance, client and gender responsiveness, community participation, and focus on needs of special or vulnerable groups

6.4 Key responsibilities

6.4.1 Monitoring Policy implementation

The National Quality Improvement Committee shall be responsible for oversight of enforcement and sustainability of all quality issues in the sector: The HSIQA Section shall play the Secretariat role to the

National Committee. TQIF implementation shall be monitored through annual progress reports submitted to the Tanzania Quality Improvement Forum and a contribution made into the National Health Profile shared at the AJHSR.

6.4.2 Strategy implementation

Implementation of the QI Strategic Plan shall be under the HSIQA Section in collaboration with other ministry sections, units, programs, RHMTs, CHMTs, health facilities and agencies as found relevant

6.4.3 QI routines implementation

Well-chosen QITs are charged with implementation responsibility at health facility (HF) level working closely with WITs in service delivery points and reporting to HF management teams. QITs shall be responsible for summarizing progress reports on QI and presenting these to health facility management. They will also develop QI plan to be included in overall HF annual plan.

6.4.4 Capacity development

A national pool of trainers shall be chosen, capacitated, and tasked to take responsibility for capacity building on QI in the sector. The tasks shall include developing integrated training materials; and developing and implementing training plan for institutionalization of QI training in Health and social welfare training institutions. The national team shall also develop and test appropriate distance learning modules to take care of in-service training needs.

6.4.5 Governance

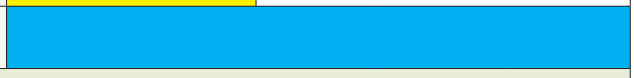
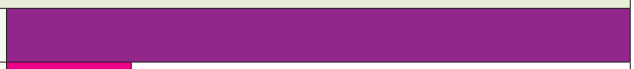
Consolidates annual progress reports on QI shall be posted on MOHSW website for public access. RHMTs that have established newsletters shall post QI information and news in their respective tabloids/ Regional Secretariat websites. HF progress reports on QI shall be presented at HF Governing Committees at least twice in a year. CHMTs shall present QI reports to full Council at least twice a year. The proposed Accreditation body shall have a governing Board to guide its independent functionality.

6.4.6 Assessment, Accreditation

A national pool of assessors shall be established in consultation with QI Stakeholders. Some assessments shall be contracted out to qualified and competent organizations or firms. Accreditation shall require establishment of semi-autonomous to autonomous body (as a Government Operating Agency). Grooming Health and social welfare facilities to aspire for accreditation shall follow the 'Stepwise approach of certification towards accreditation' in collaboration with Development Partners or Stakeholders.

6.5 Phased Implementation Plan

Programme Areas	Expected Output	Implementation timeline				
		2013/14	2014/15	2015/16	2016/17	2017/18
	Orientation and communication package for clients					
	Code of ethics					
	Facility performance reports to the community/Council					
	Home Based Care QI procedures manual					
Safety in health practices and environment	Safe medicines					
	Safe equipment and supplies					
	IPC review					
	Health Care Waste management review					
	Critical incident reports					
Clinical, diagnostic and nursing care	Standard Case management protocols					
	Nurses SOPs					
	Periodic prescriptions audit surveys					
	Practice errors problem solving reports					
	Supplies (medicines, delivery packs, vaccines, safe blood and blood products)					
	Compliance reports on standards of diagnostic services					
Quality improvement – Clients and Community focus	Exemplary leadership documentaries					

Integrated QI program for improving processes and systems	Integrated comprehensive supportive supervision and mentoring tool	
	QI mentoring and coaching reports	
	integrated QI implementation guidelines and harmonized tools	
	Health systems collaborative ventures	
Quality improvement – standards	Research publications	
	Standards and indicators guide	
	Practices documentaries	
	Retrievable patient records	
Quality improvement - institutionalization of capacity building	QI training modules	
	Distance learning course outline	
Quality improvement - Motivation	Pooled fund for innovations support	
	QI Forum technical report	
	Exemplary performance rewards	

Chapter 7:

7.0 MONITORING AND EVALUATION

The frame for Monitoring and Evaluation in the sector is elaborated in the HSSP III 2009-2015. Its shortfalls notwithstanding, the HSSP M&E will be the main guide for monitoring and evaluating QI work. The HSSP III M&E indicators shall be studied with intent to include an addendum of QI progress and impact measurement indicators.

7.1 Proposed mechanisms for monitoring and evaluation

At health and social welfare facility level, the process of self-assessments and internal assessments forms the basis for continuous monitoring of health and social welfare facility QI progress. QITs and WITs shall be responsible for monitoring progress at health and social welfare facility level. Selected indicators on QI shall be identified for tracking within the supportive supervision visits and information from these will be Included in quarterly reports of CHMTs and RHMTs. The HQAD shall report progress on QI at the AJHSR as an integral part of the National Health and Social Welfare Profile.

7.2 M&E periodicity

Health and social welfare facility annual QI plans shall be subjected to mid-year and end of the year assessment to determine the level of performance. This strategic plan shall be subjected to a mid-term review (2.5 years down the line). Using a baseline status, changes at mid-term shall be measured and program adjustments be made accordingly. An end of term evaluation shall be undertaken during the last but one quarter of the final year.

7.3 QI Indicators

The log frame shows indicators at the overall development objective level, goal level and at selected outputs. The strategy aims to attain a high proportion of the health and social welfare workforce becoming QI literate and skilled in application of QI approaches that make a difference. Specifically an effort to institutionalize QI training, both pre- and in-service shall enable effective problem-solving models to be routinely applied in health and social welfare facility QI practice.

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