

Towards improved health service quality in Tanzania: An approach to strengthen routine supportive supervision



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Introduction

Effective supportive supervision of healthcare services is crucial for improving and maintaining quality of healthcare. However, this can be challenging in an environment with chronic shortage of qualified human resources for health, overburdened healthcare providers, multiple roles of district managers, high donor fragmentation and ineffective or inefficient allocation of limited financial resources. Operating in this environment, we systematically evaluated an approach developed in Tanzania to strengthen routine supportive supervision of primary healthcare providers through their Council Health Management Team (CHMT).

The e-TIQH supportive supervision approach

In a first step of this approach a systematic quality assessment was carried out in all health facilities within a council using the so called electronic Tool to Improve Quality of Healthcare – in short e-TIQH (figure 1). For that, the CHMT was supported by community representatives and healthcare providers from the public and private sector to increase objectivity and reduce bias. The assessment also consisted of an immediate feedback to the healthcare providers and joint discussions about how to address the identified quality gaps. In a second step, an annual stakeholder meeting at council level was conducted to further discuss the findings and decide on ways forward. This then provided important inputs for the third step, the routine annual council health planning and budgeting process.

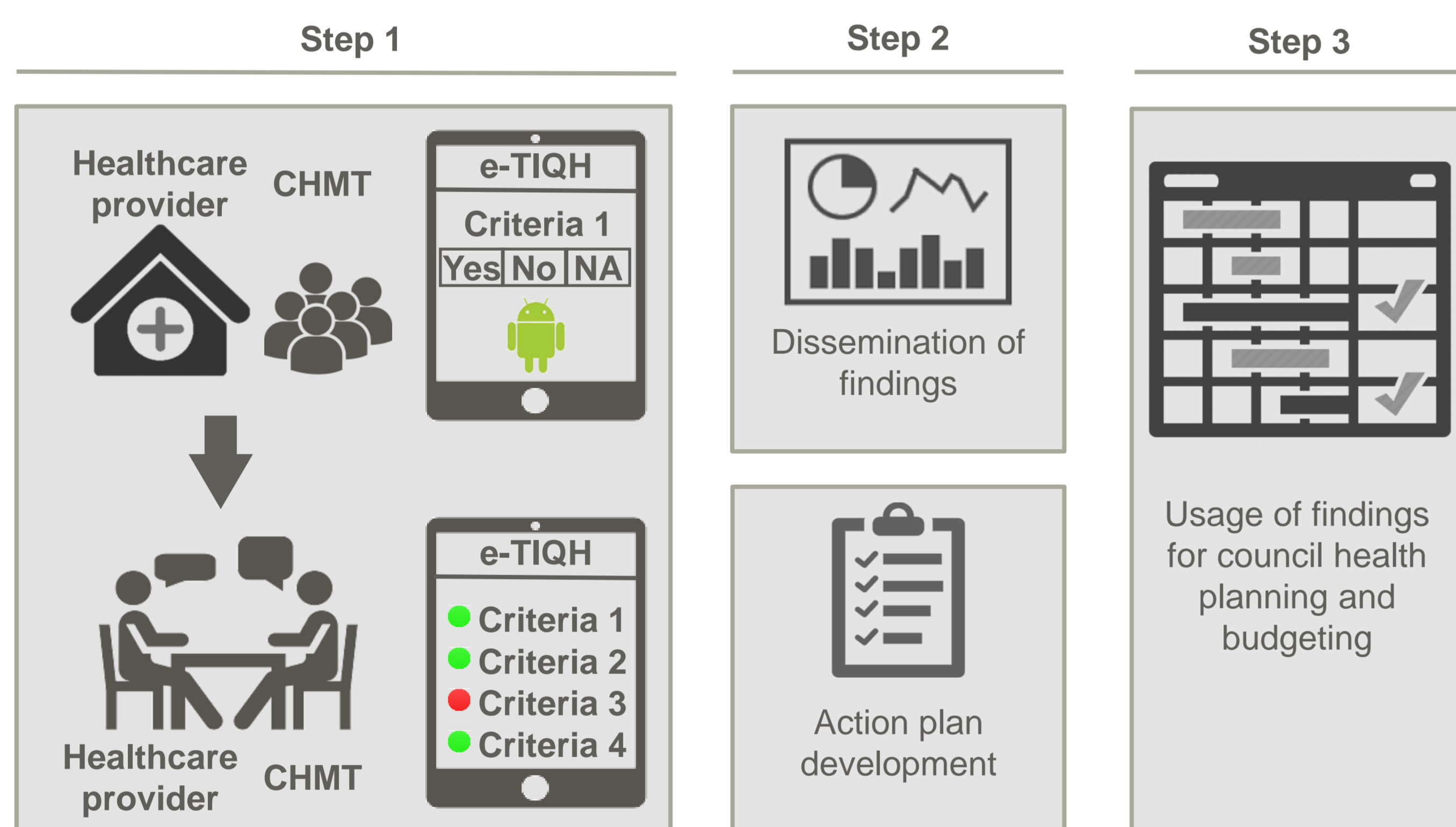


Figure 1: Chart of the three-stage process of the e-TIQH supportive supervision approach

Methods

Mixed methods were used to compare the e-TIQH supportive supervision approach with routine CHMT supportive supervision. Qualitative data was collected through in-depth interviews in three out of eight intervention councils (figure 2). Observational data and informal personal communication as well as secondary data complemented the data set. Additionally, an economic costing analysis was carried out in the same three councils.

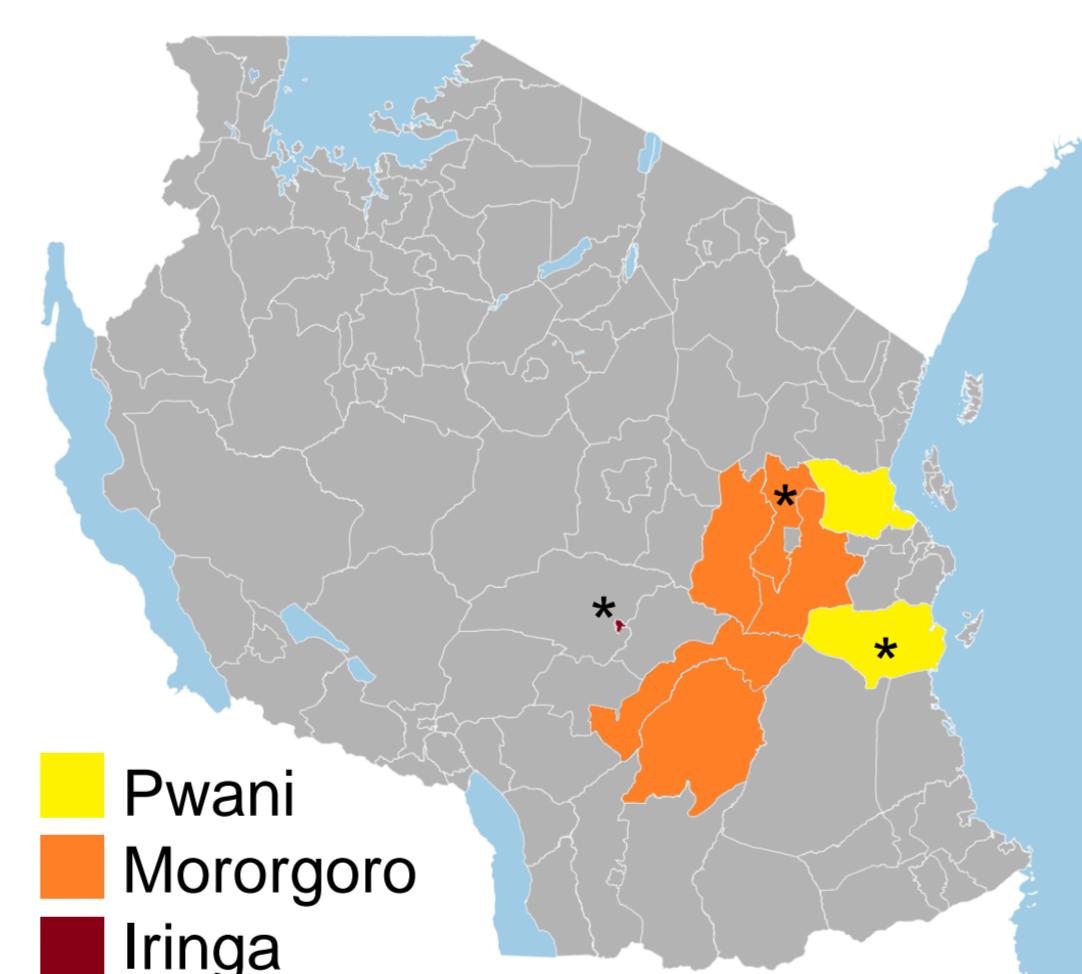


Figure 2: Map of councils where the e-TIQH approach was implemented. Each colour indicates one region. Asterisks mark councils selected for the study.

Results

In-depth interviews revealed that compared to routine CHMT supportive supervision, stakeholders' motivation and ownership of subsequent quality improvement measures was higher in the e-TIQH supportive supervision approach.

"In the past this [dissemination meeting] was not done... They [the CHMT] came, did supervision and left to do their [work] (...) Completely different from e-TIQH, because when they came [for the dissemination meeting] they transparently displayed for the whole district [council] how we deliver our services and where the weaknesses are [...] I used to believe that maybe I was the only one with challenges, but when I arrived there, [I saw] there are colleagues of mine, whose conditions were very bad... So, at least I got motivated [that]... I had to work hard in order to reach another level... I was very pleased because I realized that I already reached a certain position. Thus, [I asked myself] what should I do in order to move further?" (Facility in-charge, Mvomero DC)

Motivation ↑↑ Ownership ↑↑

The approach also improved acceptance of supportive supervision amongst stakeholders involved and increased healthcare providers' knowledge and skills, while reducing required human and financial resources. At the same time it led to higher quality of data collected and therewith generated better evidence for follow-up actions, including budgeting and planning (figure 3).

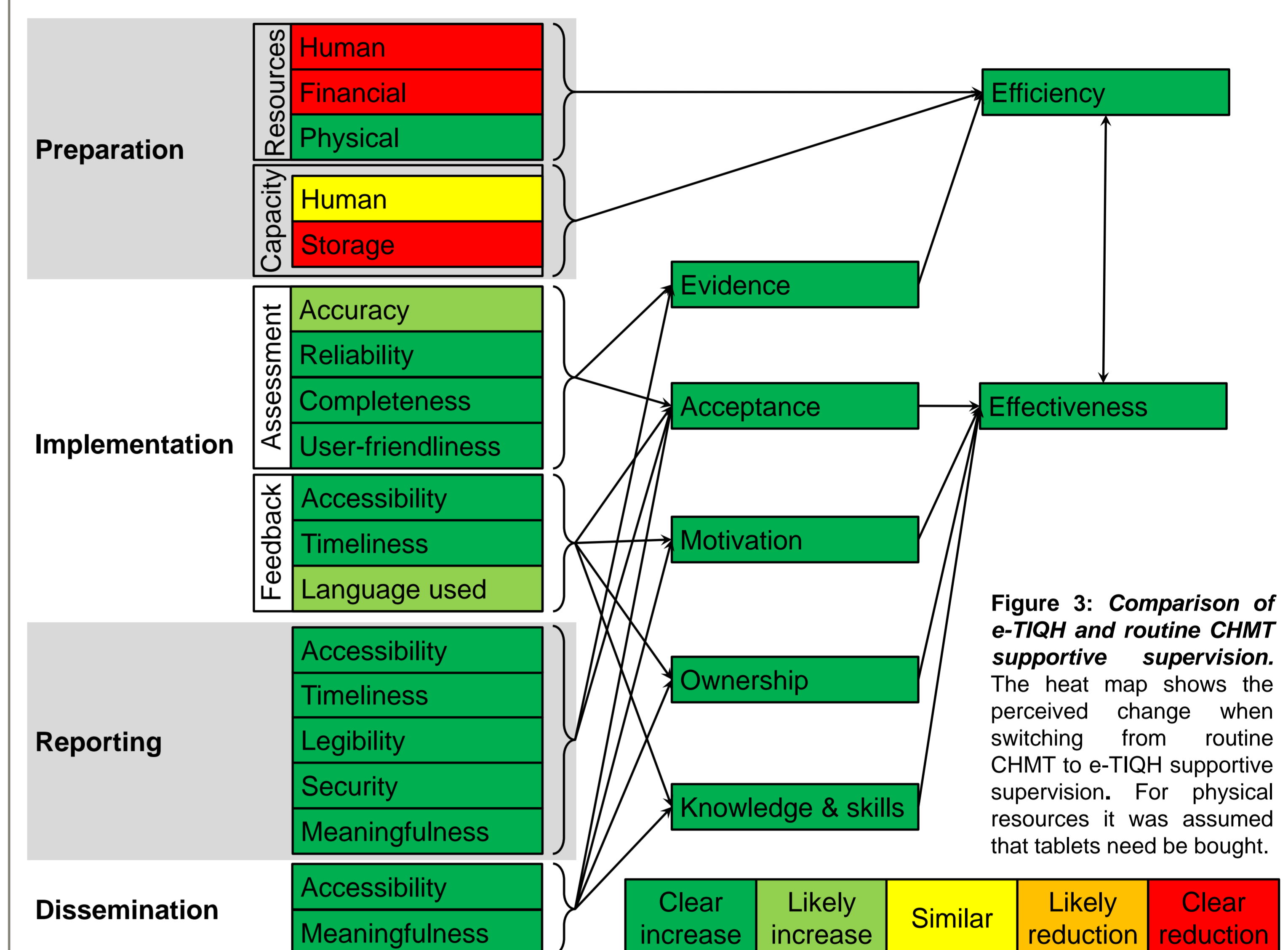


Figure 3: Comparison of e-TIQH and routine CHMT supportive supervision. The heat map shows the perceived change when switching from routine CHMT to e-TIQH supportive supervision. For physical resources it was assumed that tablets need to be bought.

The costing results confirmed that the e-TIQH approach reduces person time and cost spent during supportive supervision. This was the case despite the fact that the assessment team in the e-TIQH approach was bigger (12 assessors in total) than in the routine approach (10 assessors in total) (table 1). If an equal amount of assessors were to be used the decrease in person time and cost would be even more pronounced, but this reduction in the number of assessors is likely to reduce objectivity and increase bias.

Table 1: Person time and cost spent for one round of CHMT and e-TIQH supportive supervision in an rural council

	CHMT supportive supervision (10 assessors)	e-TIQH supportive supervision	
		12 assessors	10 assessors
Person time	1'189h (149d)	941h (118d)	803h (100d)
Financial cost [USD]	4'124	3'809	3'254
Economic cost [USD]	8'677	7'478	6'334

Main cost driver was the number of days spent conducting the assessment, which could be reduced by seven days because less time was needed at the health facility itself (figure 4).

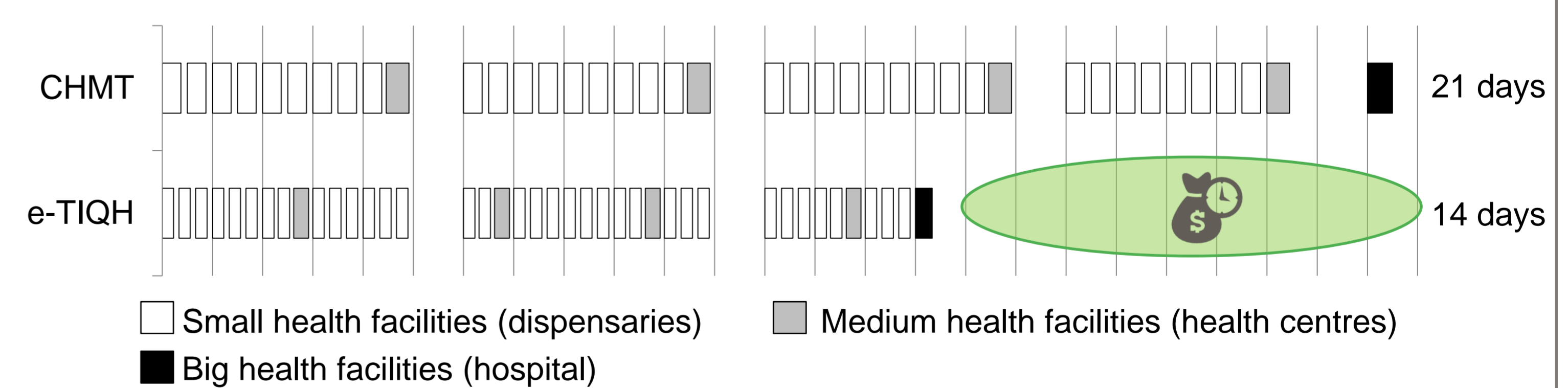


Figure 4: Possible supportive supervision schedule showing assessment days required by each supportive supervision approach in an average rural council. Vertical lines indicate a working day, consisting of eight hours.

Conclusions

The e-TIQH supportive supervision approach:

- ✓ **Reduced time and cost** spent during supportive supervision
- ✓ Made supportive supervision **more effective and efficient**
- ✓ **Increased feasibility and likelihood of implementation** of supportive supervision

Therefore, the e-TIQH supportive supervision approach offers:

- ➔ An option to **make routine CHMT supportive supervision more cost-effective**
- ➔ **Informed guidance** to overcome problems of supportive supervision and healthcare quality assessments **in low- and middle income countries**