Evangelical Lutheran Church of Tanzania

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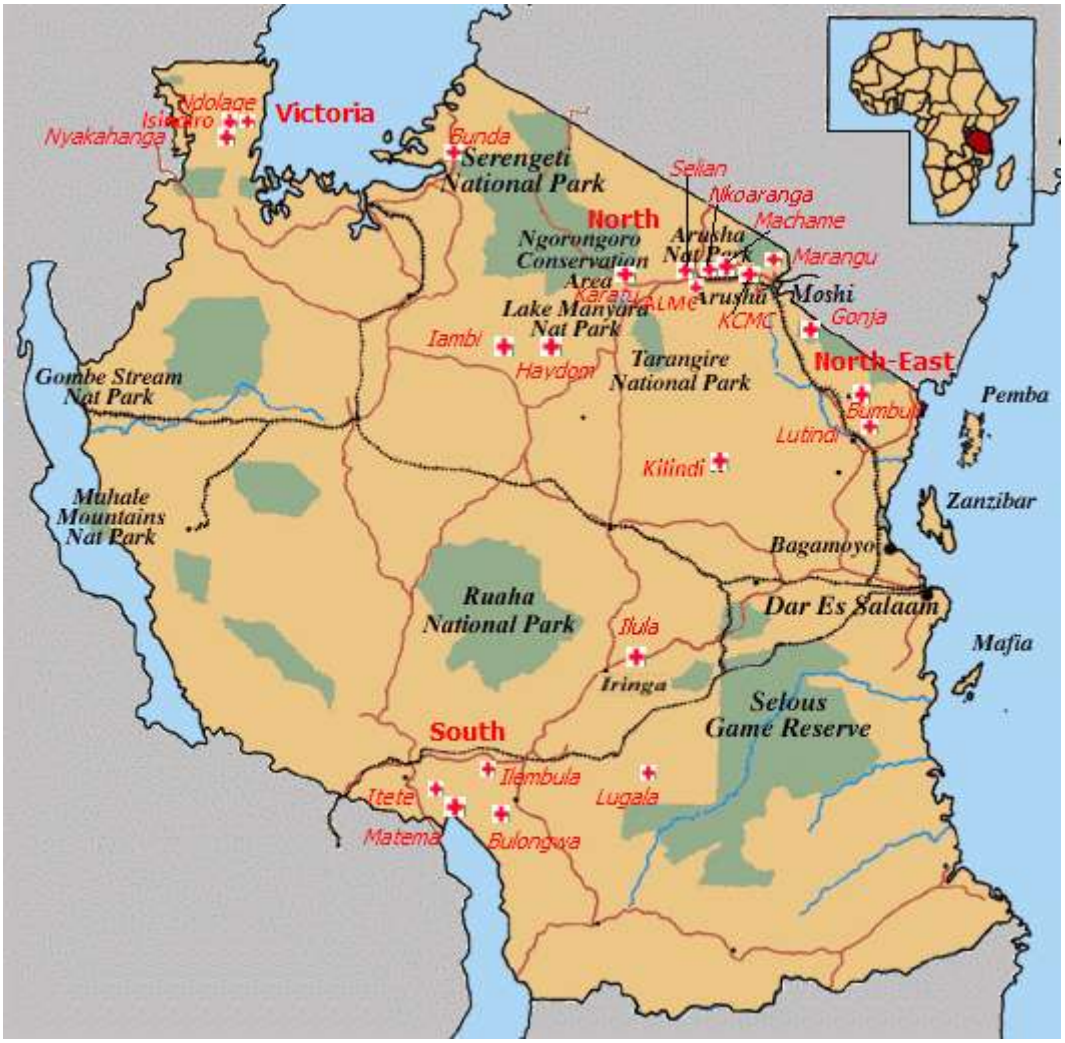

Evangelical Lutheran Church of Tanzania ELCT is divided into 20 dioceses. ELCT has 23 hospitals and 150 health centers and dispensaries all around Tanzania. The Lutheran church health facilities cover about 15 % of all health services in this country. All church hospitals offer 45% of all health services to the population in this country. Often the church hospitals are located in remote areas and serve the poor people who do not always have money to pay their bills.

In ELCT Health Department located in Arusha town in the North Tanzania in a Lutheran Church Headquarters in Boma Road there are different projects working for the health sector. Currently those projects are ICT Project with telemedicine part, MEMS for pharmacy services, Palliative Care Project, Malaria Communities Programme, Primary Health Care, Clinical Quality Assurance, Health Care Technical Services, ARV project and Advocacy Work. There is a different number of staff involved in these projects depending on the funds got from different sources from different countries.

Quality Assurance was started in 2003 with 3 persons in it, 2 doctors and 1 quality coordinator. As a starting point we prepared the **web pages for ELCT hospitals**. Ritva Niemi, Quality Coordinator took the pictures and wrote the English texts and Dr Niemi made the technical part of it. The first important matter to begin to develop the quality of the hospital care together with the hospital staff was **infection prevention**

and control. All hospitals got many handouts and CD-ROMs and lectures concerning about the hospital hygiene issues starting from better needed hand hygiene. All objectives were similar as those pressed out from the Ministry of Health and Social Welfare of Tanzania MHSW in 2005. At that year we arranged together with the MOH a course in Arusha to the doctors in charge and nursing directors from each hospital. The hospitals were already asked since 2003 to establish infection control committees and to have an infection control nurse and a doctor. The guidelines were distributed for this.

The next issue to teach in this infection prevention and control was the use of right antiseptics and disinfectants, how to clean the high-risk areas in the hospital such as laboratory, operation theatre, delivery room, intensive care units and neonatal units. In the same time many other issues were brought to the hospitals from the QA unit. **Respiratory Care Quality Assurance** was very much needed because mostly patients' critical condition in Tz is due to respiratory problems not due to cardiac problems. Global Health Ministries USA donated new oxygen concentrators, pulseoximetries and nebulizers to all ELCT hospitals. The use, maintenance and service were taught. The initiator for this project was prof Norman Olson from Stanford university and he worked with us many years. Still now in 2010 we will get new hospital devices from GHM Minnesota USA inside the container of Selian Lutheran Hospital.

Continuing Medical Education demand was also emphasized for the hospitals from the beginning because it is one of the quality issues. The hospitals were asked to have at least once a week in a certain day clinical education sessions to all staff members. The CME plan was asked to be included in the annual reports and sent to ELCT Medical Director. Also the Infection Control Committee's meetings minutes were asked to be sent so that the progress could be detected. But no reports came, only from 1 or 2 hospitals. All hospitals were asked to establish a **hospital resource center**, hospital library so that all the books, CD-ROMs and computers could be in safe place. For time being now Haydom and Ndolage have the good libraries as well as internet cafes. Machame and Marangu have moderate kinds but not very safe to donate anything yet. So most of the hospitals haven't yet got a proper hospital reference library. Any books can't be left to the wards. The donations have come from organizations such as Teaching Aids in Low Costs TALC from England, Book Aid International BAI from England and WHO. We are very grateful of all professional material which we have got.

In **Patient Care** part of the quality assurance in addition to respiratory care we have had **Psychiatric Care Project** which Dr Niemi and I together have been in by organizing the courses but now all arrangements have been totally left to the Finnish Christian Medical Society and Tanzanian psychiatric staff. But we were involved with this project 3 years time. Dr. Norman Olson tried to start **Hypertension and Diabetes Clinics** to many hospitals because the need to quality care in clinical area is enormous. Together we tried to improve the **ICU care** also by doing on-site teaching. I myself am an anaesthetist and operating room nurse and have master's degree in health sciences. I have been working in a postoperative intensive care unit with cardiac surgical and neurosurgical patients. In Finland I have had an opportunity to up-date my knowledge in ICU units in the university hospital of Oulu where I have got all my education every time when we have been there.

We have always travelled together with Dr Niemi or to the near-by hospitals I have gone by myself or with Dr Olson or with Anna Mahenge, who was appointed as a Quality Coordinator also. We analyzed together the Patient Satisfaction Survey. We prepared together to the ELCT Health Service Charter the Patients' Rights and Responsibilities. We did together applications in 2 different times about the hospital hygiene project to United Evangelical Mission UEM Germany. The Hospital Hygiene Project together with Dr Harald Mayer was started by doing an Infection Prevention Course together with KCMC in 2007. However it came evident that some other kind of approach is needed to improve the hospital hygiene. We started Hospital Hygiene On-site Teaching, took pictures and had lectures to the hospital staff several times while visiting the ELCT hospitals. Even we got a lot of promises from Dr. Harald that there will be funds for this project from UEM there hasn't been. Dr Harald has sent his own money through UEM and still this project runs in that way. Hospital Hygiene is single most important area to improve the care in our hospitals. As to stop smoking tobacco will improve the life of a single person the hospital hygiene does the same for the hospital care.

There were no funds to employ Anna Mahenge, QC who went then to have a position in the Palliative Care Project. The idea was to employ her as an Infection Control Coordinator. We also need to employ an infection control person and she / he will take responsibility of this issue to each hospital. Now no nurse is doing much, no doctor is doing much because this is nobody's business. It is like a side business of otherwise busy nurses and doctors. We need to establish **a bigger organization for the hospital hygiene project.**

From Clinical Quality Assurance CQA we have been together with telemedicine team in arranging the telemedicine course in KCMC. We have provided ELCT and other hospitals with the information of **distant learning and e-learning possibilities** now in 2 years time such as AMREF's short courses, distant courses and e-learning 24 hours in Global Health Learning. Dr Niemi and I have also visited other church hospitals and that has been a good opportunity for me to do the e- and distant learning survey and to see the level of anglican, catholic and other faith based hospitals.

We have had together with Prof David Morley a project called **TALC Course Books to ELCT Learning Institutes**. 9 ELCT schools and colleges got a lot of medical and nursing books especially the WHO Hospital Care of Children and the Nursing and Midwifery. Also 1 government institute Mbeya Assistant Medical Officer Training College was inside this project.

From CQA we have a good cooperation with Dr. Hennock Ngonyani, MOHSW. He is in Inspectorate Unit for infection prevention and control. We have got a new German doctor Alex Supady who has informed himself to be willing to do the quality improvement work in ELCT by starting to make **algorithms to hypertension and later perhaps for diabetes** so that the clinical officers and doctors can follow a protocol in giving treatment for the patients. These two treatable diseases are killing millions in Africa and they have not been addressed properly so far. This is exactly what is needed, protocols and supervision that those are followed to improve the current care. Dr Alex and his wife dr Tonya are working in clinical settings in Selian Lutheran Hospital 3 days per week. **But the manpower to do this work is very limited.**

As a Clinical Quality Assurance issue I continue the WHO programme and the next challenge 2 has been **Safe Surgery Saves Lives**. The 1. Challenge was To reduce Health-Care associated Infections.

- The Global Patient Safety Challenge WHO
  - 1. Challenge: To reduce Health-care associated Infections
  - 2. Challenge: Safe Surgery Saves Lives
  - 3. Challenge: Safe Childbirth Checklist
  - 4. Challenge: Trauma care

Lack of access to high quality surgical care remains a significant problem in much of the world. In industrialized countries reported major complications occur in 3 -16 % of inpatient surgical procedures with permanent disability or death rates ~ 0,4 - 0,8 % In developing world death rates are 5 – 10 % in major surgical procedures and 1 / 150 dies to anaesthesia in sub-Saharan Africa. In developed countries anaesthesia related deaths are 1 / 200 000.

In industrialized countries nearly half of all adverse events in hospitalized patients are related to surgical care. At least half of the cases in which surgery led to harm are considered to be preventable. Known principles of surgical safety are inconsistently applied even in most sophisticated settings. The care is good in western world but they try to make it even better.

In developing countries studies confirm the magnitude and pervasiveness of the problem: poor state of infrastructure and equipment, unreliable supplies and quality of medications, shortcomings in organizational management, inadequate capacity and training of personnel and severe under-financing all contribute to the difficulties Safe Anaesthesia is essential. In 1960's was 1 / 5000 chance of death undergoing general anaesthesia in western world but improved safety and monitoring standards have significantly reduced unnecessary deaths in developed world 1 / 200 000 Anaesthesia related deaths in developing countries appears to be 100 – 1000 times higher, indicating a serious, sustained lack of safe anaesthesia qualified personnel with adequate knowledge is needed. Scheduled preparations for operations are not done.
Now this programme with introducing **the Surgical Safety Checklist** is done in 12 ELCT hospitals and it shows all the deficits what the statistics also show. Patients can come to operation theatre without getting any skin washing preparations in the evening before and in the morning or any other preparations. The operation rooms ORs are not cleaned and disinfected properly between the patients and with right disinfectants. Anaesthesia nurse is left alone to give the anaesthesia and that is an unnecessary risk. There are no functioning suction machines inside ORs if the patient vomits or saliva or sputum goes to the lungs and the patient gets aspiration pneumonia and dies to that. Anaesthesia staff in some hospitals is nurse attendants who have never in their studies even been in ORs or a nurse who do not know the basic principles to work there. Anaesthesias are not safe. Doctors and COs are not familiar how to prepare and clean the operation site. They are not familiar with the special environment of operation theatres and behaviour there. All what is done inside ORs is good to document to anaesthesia record. To count all gauzes, sponges and swaps, sharps and needles before the operation and after and document has to be done. To check, just like a pilot that all necessary preparations have been done and documented before taking off. That makes flying so safe because all minutes and checkings are done and written that they have been done.

However because **Clinical Quality Assurance** is a wide area it is possible only to touch, to concentrate in some small parts of it. **This letter is an invitation to dentists, doctors, specialists, tutors, teachers, physiotherapists, pharmacists, occupational therapists and other health care professionals to come and work in ELCT hospitals to improve the hospital care.** It is possible to come and work in one hospital or to travel and work for all of them as we do from ICT unit and CQA from ELCT Headquarters Arusha. It could be some important area such as diabetes care or asthma care or Integrated Management of Childhood Illnesses or something else to develop together with our staff in all or in certain hospital.
There are dental units in some of ELCT hospitals but no permanent workers, or not well-equipped or no money to check school children. Dentist could do a lot by teaching the staff and perhaps also providing some equipment and devices. Physiotherapists are very few in this country. Sometimes few are coming from different countries but they do not stay long time. But that is also a possibility to come and work a shorter time depending on the situation of a person or a family. There are quite a number of young volunteers from different countries in ELCT hospitals such as medical students, nursing students, kindergarten teachers in orphanages and high school students who stay 1-3 months, some even a year.

It is not possible to say exactly which hospital needs what kind of specialists but we from ELCT Health Department can guide those willing to come to a best possible place according to the specialty and wishes. ELCT Services Office in Dar es Salaam will help to get the Registration for Professional Boards and Residence Permit. For shorter time 3 months- 1 year Resident Permit Class C is required and that can more easily acquire also from Arusha immigration office. The documents needed are: the reference letter from your working place from your country, 5 passport pictures, copy from passport (and entrance visa), CV and 500 US$ for a shorter time. For longer time or for a professional work in addition for the above mentioned ELCT or one of the dioceses will write an invitation letter and the costs will be more than for a shorter period. For qualified health personnel this process to get all permissions is better to do beforehand coming to the country.

The next important matter is the funding and for time being there are no funds directed to get more health care personnel but this letter can hopefully influence also our funding organizations in Denmark, Finland and Sweden. The ELCT Quality Assurance Project (QA) was started in 2003. The project launched its general objectives for all the ELCT hospitals in that year. It is one of the Managed Health Care Programme projects. MHCP was started in 1997 with financial support from **Church of Sweden (CSM), Finnish Evangelical Lutheran Mission (FELM) and Danmission /Danish Mission Council Development Department (DMCDD).** However because Quality Assurance is a wide concept and many activities could be put under this umbrella the unit is now called Clinical Quality Assurance (CQA).

With respect and concern,

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Table 1. ELCT Social Services and Women's Work / Managed Health Care Programme / Clinical Quality Assurance Unit