Coaching and Mentoring Through Existing Government Structures

Background: Why structured QI support?

Teams working on quality improvement need regular support to maintain their efforts and to continuously improve performance. Supervision, mentoring, and coaching is critical but often difficult to operationalize in low resource settings.

Methods: How did we address support?

The EQUIP project employed two people in both countries to work on designing the overall approach, implementation, and research. Two additional people were involved in conducting the learning sessions and in the coaching and mentoring of the quality improvement teams. EQUIP included several members of the district health teams for the learning sessions and the mentorship of the health facility and community teams (Figure 3*)*.

In Uganda, two health facility mentors and two district community mentors were trained on quality improvement, and coaching and mentoring. In addition, four health facility sub-district mentors and 30 community mentors were trained to support the health facility and community teams in the sub-district.

In Tanzania, one health facility and one community mentor were trained, together with two more members of the district team engaged in implementation. The community district mentor was part of the community development office and established a structure for community work where extension workers were included in the EQUIP implementation process. Ten community extension workers were carrying out regular visits to community teams.

Results

During the 30-month implementation period, a total of seven learning sessions were held in Uganda and Tanzania for both the health facility and community quality improvement teams. Mentorship took place eight-to-ten times per year, achieving more than 75% of the planned supervision of teams.

Conclusion

It was feasible to align mentoring and coaching to the district's supervision structures, but the EQUIP project funded transport and communication allowances for the learning sessions and supervision visits to the health facility and community improvement teams. EQUIP was able to build district health team capacity for quality improvement through its own funding, but it additional resources will be needed for sustainability.

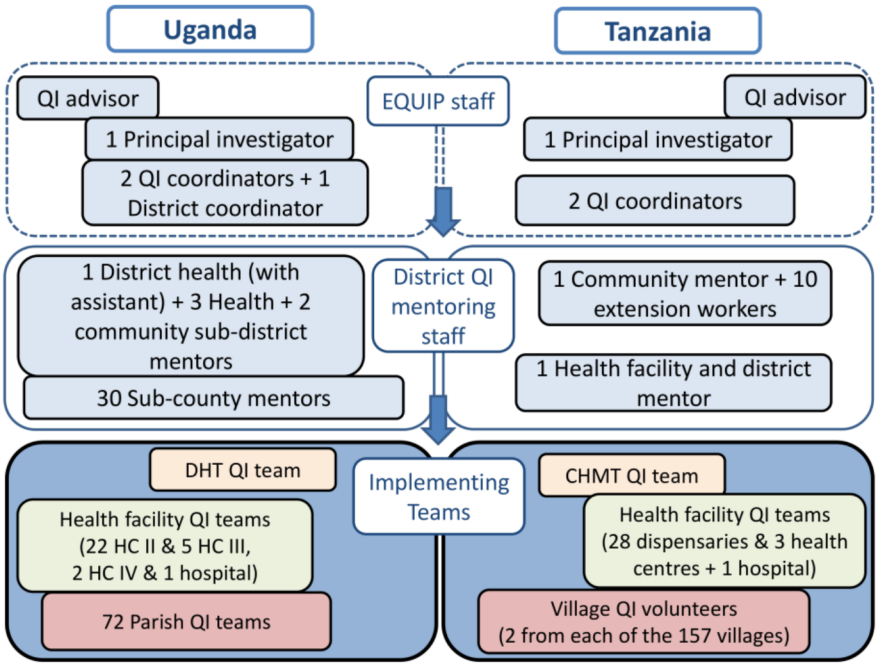

Figure 3: Support structure in Uganda and Tanzania. (**QI** Quality Improvement, **HC** Health centre, **DHT** District Health Team, **CHMT** Council Health Management team)

For further information contact:

Fatuma Manzi (fmanzi@ihi.or.tz) or Yovitha Sedekia (ysedekia@ihi.or.tz) in Tanzania and Monica Okuga (mokuga@musph.ac.ug) or Peter Waiswa (pwaiswa2001@yahoo.com) in Uganda