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TRIP REPORT

BASICS

ZAMBIA CHILD HEALTH PROJECT
ASSESSMENT OF TRAINABILITY

Lusaka, Zambia

August 14 to September 1, 1995

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ACRONYMS

ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
CMAZ	Church Medical Association of Zambia
CO	Clinical Officer
DANIDA	Danish International Development Agency
DHB	District Hospital Health Board
DHM	Health Center
DHMO	District Health Management Office
DHMT	District Health Management Team
EHA	Environmental Health Assistant
FP	Family Planning
GRZ	Government of the Republic of Zambia
HFS	Health Facility Survey
HIV/AIDS	Acquired Immunodeficiency Syndrome
HR	Human Resources
HRD	Human Resources Development
HRIT	Health Reform Implementation Team
ICM	Integrated Case Management
IEC	Information, Education, and Communication
MCH	Maternal and Child Health
MOH	Ministry of Health
NIPA	National Institute of Public Administration
NGO	Non-Governmental Organization
NSC	Nursing Sister In-charge
ODA	Overseas Development Agencies
PHC	Primary Health Care
PHMO	Provincial Health Management Office
PHMT	Provincial Health Management Team
RN	Registered Nurse
SIDA	Swedish International Development Agency
SOW	Scope of Work
TA	Technical Assistance
TDRC	Tropical Disease Research Center
TNA	Training Needs Assessment
TOT	Training of Trainers
UNZA	University of Zambia
UNICEF	United Nations Children's Fund
UTH	University Teaching Hospital
WHO	World Health Organization

ZCH	Zambia Child Health project
ZEN	Zambia Enrolled Nurse
ZEM	Zambia Enrolled Midwife
ZMOH	Zambia Ministry of Health

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EXECUTIVE SUMMARY

Background: USAID/Zambia developed the Zambia Child Health Project to support the MOH health reform process, (as described in the National Policies and Strategies) that has been underway since 1992 with major support from other donors. The project's purpose is to increase access to key child survival services by strengthening the MOH capacity to deliver three specific child survival activities at the district level (both urban and rural) — control of diarrheal diseases, prevention and treatment of acute respiratory infections and malaria — through appropriate training interventions and the development of adequate health management systems.

This report describes the various activities and results of a three-week needs assessment visit from August 14 to September 1995, carried by BASICS Training Coordinator Dr. Paultre P. Desrosiers and BASICS consultant, David McCarthy. They were to determine the most important areas of training needs and develop a training strategy and initial training plan for first-line health workers.

Terms of Reference: By the request of the MOH and the USAID mission in Lusaka, and as one of the proposed bridging activities in the Project Paper, the team was to carry out the following terms of reference:

1. Review existing MOH training plans and discuss their strengths and weaknesses with the MOH officials.
2. Examine specific performance problems at the district level.
3. Identify the elements which are required to make operating systems function more smoothly.
4. Assess training needs in connection with pre-service and in-service training of existing cadres of first-line health facilities.
5. Assess the existing resources and types of assistance required for national and regional training facilities.
6. Assess progress to date with curriculum development.

In addition, the team participated in a consultative meeting between the Ministry of Health and supporting donors. During our meetings with the Mission, it was agreed that we could not accomplish the SOW as it was originally proposed because many of the key elements that were needed to carry out the terms of reference were not made available to us.

Team Activities: The team met with Mr. Paul Hartenberger, USAID/HPN officer, on Monday, August 14, for briefing, and with Dr. Steven Wiersma of USAID on Thursday, August 17. We then visited key members of the Ministry of Health HRIT, and from the Planning, MCH/FP and Nursing units. From August 24-25, we met with the key staff of the Chainama Hills College Hospital and the School of Nursing at University Teaching Hospital. We also met with representatives of international agencies and USAID-funded agencies in Zambia. The team

visited and interviewed key staff of the Provincial Management Team (PHMT), District Health Management Team (DHMT) and health center staff in the Lusaka, Copperbelt and Central Provinces. During the third and last week of our trip, we participated in a consultative meeting between the Ministry of Health and the supporting donors. On August 31, the team debriefed with the USAID mission and handed in their draft report.

Findings and Accomplishments:

Field Visits: The team met with many of the key persons of the MOH, visited three provinces, and met with representatives of local training institutions, NGOs, and international agencies in Lusaka.

- Although some of the DHMTs visited have the required staff pattern as described in the National Strategic Plan, it was not at all clear to us whether this cadre of health staff had the right skills to assume the overall responsibility for the planning and implementation of health services, as indicated in the health reform policy.

- Current levels of health worker performance were not consistent across both districts and health facilities. The standard of practice for management of childhood illness varied from one category of health worker to the other, and from rural to urban health facilities. Diagnoses are very often made based on the caretaker's complaint, rarely on an adequate assessment of the child. It is not at all clear whether there is a consensus on a working definition for case management of the sick child. The system is very focused on curative care and does not provide a clear understanding of the MOH/PHC strategies aimed at health promotion and prevention.

- There are severe staffing shortages in the rural district health centers due to a variety of reasons, including socio-cultural factors such as marital status, lack of opportunities for additional training in the rural areas, and thus promotion in more prestigious urban clinics and/or hospital settings.

- At almost all the DHMOs and health centers that the team visited, the lack of adequate housing accommodations, water, electricity, transportation, communication systems and adequate schooling facilities were cited as important factors for recruitment and retention of health workers in the rural areas.

- The effect of cultural traditions on the way work is organized, time utilized, and institutional interactions conducted needs to be appraised. There is a lack of information about the health facility catchment area, indicators of the health status of the population, and service outputs available to all levels of the health system.

- By shifting the main responsibility for programing and implementation of the health care system to the district level, the DHMTs will be formulating their programs without an adequately defined resource frame, and they may end up anticipating more resources than are available.

- Information essential for the effective planning of services and monitoring of progress is greatly needed in every DHMO.

- At present, basic curricula in the major training institutions lacks sufficient community-based learning opportunities in health information systems; community needs assessment; problem-solving; planning; and monitoring and evaluation. Staff (tutors) need to develop new training techniques and update basic clinical knowledge and skills.

- In-depth job and task analysis is greatly needed to determine the content of training from the knowledge and skills required to perform the tasks of the polyvalent health worker.

- There is currently no developmental framework for supervision in the PHMOs and DHMOs to identify specific deficiencies in the quality of services, counseling, and health education. Provincial-district structures and better resource utilization within the provinces are needed.

Recommendations: The team made the following recommendations for technical assistance:

1. Participate in the collaborative effort of the MOH to develop a multi-disciplinary curriculum and attend the proposed workshop that will be held in October 1995 for the development of a training proposal.

2. Provide technical assistance for curriculum development for the provincial capacity-building workshop and participate in the coordination and training activities.

3. Provide TA to assist selected DHMs (health centers) to conduct a comprehensive training needs assessment (manpower and HFS).

4. Provide TA to the MOH/HRIT to develop and implement a MOH training strategy (training policy and procedures).

5. Provide technical assistance to the districts for development or review of detailed training plan(s) for selected health centers.

6. Provide TA to selected DHM(s) and implementing institution(s) to develop training modules (or adaptation of the Management of Childhood Illnesses module) based on the minimum package of health.

7. Provide TA to the districts or/and selected training institutions to adapt ICM training materials for TOT and for first-line health workers in selected health centers based on the needs assessment.

8. Provide TA for field testing and revision of ICM training material in selected DHM.

9. Provide guidance in conducting a TOT training review three months after the initiation of the ICM training, and adjust the training program as needed.

10. Provide TA for the field testing of the ICM curricula for training front-line health workers.

11. Provide TA and training materials as requested to local training institutions for the long-term, pre-service training of some members of the PHMTs and DHMTs in public health, health management, hospital administration, health information systems, and environmental health as requested by the MOH.

12. Provide TA and training materials to local training institutions for the long-term, in-service training of some members of the PHMTs and DHMTs in interpersonal communication, community partnership, and other related areas such as FP, HIV/AIDS, and safe motherhood.

Conclusions:

- The ZMOH is engaged in the development of a new approach to health care with the enactment of the Health Reform Bill. This political commitment will require a reorientation of the concept of health services by both the provider and the population. This will entail a major shift in the behavior of both entities from a focus on curative care to one of community-oriented public health services.

- The central level is not as yet fulfilling its roles of providing direction and the actual frameworks for the implementation this new approach to health care. The PHMOs and the DHMOs are in a transition period in reforming their health systems and as such, they are in the process of developing new relationships as decentralization occurs, with the usual tensions and resistance to the new changes.

- There is considerable confusion as to the roles and responsibilities of the different players, and limited guidance from the central level.

- The transitional period is rather long and this may lead to demotivation of the personnel at all levels of the health care system. Key staff at the central level are overloaded and

find it difficult to give special attention to the demand of the periphery or to individual donor tenuous requests.

- There is a need to assess the degree of change that can be absorbed by all the parties involved in the health reform process and the time frame needed for the implementation of this change.

- To appreciate the benefits of training, real training needs have to be established. We may have to adopt a systematic approach to training that is as follows:

    - Review MOH training objectives
    - Conduct a skills audit
    - Identify training needs
    - Implement solutions

- The MOH/HRIT is now experiencing increasing difficulty in dealing with international donor organizations in terms of planning itineraries for field visits, the need for briefings and de-briefings, and understanding the role and appropriate use of technical assistance and consultants made available to them.

I. INTRODUCTION

USAID/Zambia developed the Zambia Child Health Project (ZCH) to support the MOH health reform process, (as described in the National Policies and Strategies) that has been underway since 1992, with major support from other donors. It is one of four major projects in USAID/Zambia's health portfolio. The project's purpose is to increase access to key child survival services by strengthening the MOH capacity to deliver three specific child survival activities at the district level (both urban and rural) — control of diarrheal diseases, prevention and treatment of acute respiratory infections and malaria — through appropriate training interventions and the development of adequate health management systems.

The five outputs selected to increase the coverage and quality of health promotion, preventive and curative activities that contribute to child health are:

- Establishment of a Health Center-Community Partnership for Improved Child Health
- Improved Pre-service and In-service Training of Health Center Workers
- Strengthening MOH Central, Provincial and District Technical Capacity
- Health Information Systems
- Strengthen the Public-Private Sector Partnership for Child Health

This report describes the various activities and results of a three-week needs assessment visit from August 14 to September 1995, carried by BASICS Training Coordinator and a BASICS consultant. They were to determine the most important areas of training needs and develop an initial training plan and strategy for training for first-line health workers. During meetings with the Mission, it was agreed that the team could not accomplish the SOW as it was originally proposed because many of the key elements that were needed to carry out the terms of reference were not made available to them.

II. BACKGROUND

The purpose of the ZCH project is to "increase coverage and quality of health promotion, preventive and curative activities that contribute to child health." This will be achieved through strengthening the capacity of the health delivery system to make the most effective use of national resources in providing for basic health needs of the population. There are a number of activities and actions which must be completed early in the course of the project. Most of these early actions, which would take place during the first two years of the project, relate to capacity building at the provincial, district and health center levels through the provision of substantial technical assistance to develop and strengthen the management of decentralized systems; training a cadre of health care personnel in critically needed skills; increasing the knowledge and data base needed to rationalize the health delivery system with respect to drugs, human resources, and facilities; and providing much needed logistics infrastructure and medical supplies. Training of health center staff was identified by the design team as an area of immediate need and a target opportunity for USAID assistance. Current plans call for staffing the health centers with a multi-disciplinary health worker who will be trained to carry out the tasks now performing by four different categories of health agents (the clinical officer, the nurse (midwife), the Zambia enrolled nurse, and the environmental health technician).

To maintain momentum in USAID's involvement in the health reform process and to facilitate future program implementation, certain activities have been proposed to be conducted before the project officially begins. One of the important bridging activities is the assessment of trainability in connection with pre-service and in-service training, including assessing the national training plan, national and regional training institutions capabilities, district capacity building, and health center staff skills in prevention and treatment.

III. PROPOSED TERMS OF REFERENCE

A. Team Members

The team was composed of BASICS Training Coordinator Dr. Paultre P. Desrosiers, BASICS consultant Mr. David McCarthy, and Mrs. Annie Mbilishi Zimba, MCH unit.

B. Terms of Reference

The purpose of this trip was to determine the most important areas of training needs and to develop an initial training plan and strategy for training for first-line health workers.

The proposed terms of reference included the following objectives:

- Prior to travel to Zambia, review the draft project paper and any other documents pertaining to training in Zambia.

- Develop a plan (and tools) for the TNA for discussion with USAID mission and MOH counterparts.

- Review any existing MOH training plans and discuss their strengths and weaknesses with the MOH officials.

- Conduct the TNA in the priority areas by:

    1. Examining specific performance problems at the district level.
    2. Identifying those elements which are required to make operating systems function more smoothly.
    3. Assessing training needs in connection with pre-service and in-service training of existing cadres of first-line health facilities.
    4. Assessing the existing resources and types of assistance required for national and regional training facilities.
    5. Assessing progress to date with curriculum development.

- Use information obtained to develop initial training plan to:

    1. Improve and/or develop future in-service training programs for providers of first-line health facilities.
    2. Improve and/or develop strategy for periodic supervision and monitoring of health providers performance at the district level.

- Submit a draft trip report to USAID and ZMOH.

C. Team Schedule and Activities

August 14 - 17	Briefing by USAID Prepare for field trip
August 16 - 19	Meeting with key staff of the MOH

August 20 - 25	Field visits Lusaka Urban DHMT Copperbelt PHMT Central PHMT
August 28 - 31	Meeting representatives of the International agencies Prepare recommendations and report Brief USAID mission

IV. TEAM ACTIVITIES

A. Field Visits

The sites were selected after consultation with MOH officials in the Central, Provincial and District Health Management Teams, and with the USAID mission. The team visited three provincial health offices, including five DHMTs and five health centers. It was originally planned to visit in the Southern Province with DHMTs in Siavonga and three health centers, but because of time constraints and the need to meet with key players at the MOH (HRIT) and some members of the donor community (ODA, SIDA, DANIDA), the team was forced to cancel its trip. (See Appendix A for people interviewed and Appendix D for tools used during interviews.)

Field Visits Findings

1. Examination of specific performance problems at the district level

It has not been possible to examine accurately at this time any specific performance problems pertaining to individual members of the District Health Management Teams because many of the proposed human resources development activities were not implemented and are awaiting enactment of the Health Bill by the Parliament of Zambia. Although some of the DHMTs visited have the required staff pattern as described in the National Strategic Plan, it was not at all clear to us whether this cadre of staff had the right skills to assume the overall responsibility for planning and implementation of health services as indicated in the health reform policy. In many instances, there was no organizational chart or job specification which clarified the staff members' responsibilities and the relationships between them. There were no current information about priority health needs of population in their catchment area, no current levels of coverage for specific services, no guidelines or specific work plan for supervision of the health workers, and no established checklists and procedures for the procurement of supplies and/or equipment. Nevertheless, there was an eagerness and commitment to the health reform in all the PHMTs and DHMTs visited. Staff members from all the PHMOs and DHMOs visited requested additional training to be proficient in the tasks that would enable them to perform their new

functions as stated in the new health policy. They are beginning to take a proactive role, both in developing their own action plans and in taking a leadership role in solving their own problems.

Current levels of health worker performance were not consistent across both districts and health facilities. The standard of practice for management of childhood illness varied from one category of health worker to another, and from rural to urban health facilities. Diagnoses are very often made based on the caretaker's complaint, rarely on an adequate assessment of the child. It is not clear whether there is a consensus on a working definition for case management of the sick child. The system is very focused on curative care and does not provide a clear understanding of the MOH/PHC strategies aimed at health promotion and prevention. Many health workers feel that they are overworked and do not have enough time to conduct any type of adequate physical examination of the child. All health centers visited expressed the need for more actualization of their staff's skills. This includes prenatal and perinatal care, safe motherhood services, immunization services, case management of the sick child, IEC, disease surveillance and monitoring, community organization, and structure and management of health activities. In addition to a possible lack of knowledge and skills, several other factors may influence the overall job performance of the health worker at first-line facilities. A number of organizational and environmental factors, such as recruitment and personnel selection, work organization, resources and equipment, incentives and rewards (especially), and this transitional phase of implementation of the health reform can surely affect performance problems at all levels of the health care system. Health workers at the rural districts health centers are less equipped and more frequently lake adequate skills in basic areas of community health and have no or very little health information management skills. Nevertheless, in most of the places that the team visited, the health workers were very optimistic and seemed to expect a lot from the health reform.

2. Elements which are required to make operating systems function more smoothly

During the team's field visit, they identified a number of relevant obstacles that can serve as barriers to achieving the health reform vision for training first-line health workers. Performance problems can be affected by many organizational and environmental factors. It is important to consider the context of the problem in the initial assessment process. These are some of the contextual problems encountered:

Recruitment and Selection

Recruitment and personnel selection still remain the prerogative of the central level and are subject to the influence of a number of variables amid the formation of the Health Board. An examination of recruitment and personnel selection, and the establishment of new standards and procedures might be appropriate. There are severe staffing shortages in the rural district health centers due to a variety of reasons, such as marital status, lack of opportunities for additional

training in the rural areas and thus promotion in more prestigious urban clinics and/or hospital settings.

Housing Accommodations

A major barrier to improving the health care system in the rural areas is the lack of adequate housing accommodations and living conditions. This can considerably affect the MOH proposed redistribution of trained staff in the rural health centers. In almost all the districts and health centers that the team visited, the lack of adequate housing accommodations, water, electricity, transportation, communication systems, and adequate schooling facilities were all cited as important factors for recruitment and retention of health workers in the rural areas. The ability of the MOH to attend to these identified problems in a relative short period of time will greatly impact on the proposed health reform strategy to redress the previous urban bias. For these reasons, the MOH has embarked on an ambitious five-year Health Sector Support Infrastructure Project funded by the World Bank to address these problems by rehabilitating deteriorated health centers, improving staff accommodations, and upgrading water supply and sanitation.

Adequacy of Management and Organizational Procedures

The necessary managerial tools are not yet developed to facilitate the smooth transition from the old top down system to a more participative and inclusive management. Guidelines need to be developed and used as planning tools or for monitoring management improvement. The effect of cultural traditions on the way work is organized, time used, and institutional interactions conducted needs to be noted or appraised. There is a lack of information about the health facility catchment area, indicators of the health status of the population and service outputs available to all levels of the health system. Needs were identified for prospective training in applied health management with a lot of emphasis on communication, personnel management, community assessment, problem-solving, planning, and monitoring /evaluation.

Financial Management

The type of proportional shift in resources allocation proposed in the new Health Sector Reform can be severely hampered by shortcomings in government health sector expenditures. In addition, by shifting the main responsibility for programing and implementation of the health care system to the district level, the DHMTs will be formulating their programs without an adequately defined resource frame, and they may end up anticipating more resources than are available. There is need to develop guidelines which will address different aspects of financial management related to general accounting, cash disbursements, accounts payable and purchases, payroll, and petty cash.

Quality and Uses of Information for Policy Making

There is a severe underutilization of the little health information that exists about key issues, both at the periphery and other levels of the health care system. Since the province and district health systems will be involved in the management and use of information generated by the various institutions and health facilities in their respective geographical areas, guidelines need to be developed to facilitate, among other things, the planning of the information system, record keeping (health center and district levels), data collection, and analysis and dissemination of information and its use for management decision-making. Information systems are needed that provide types of information such as target population, coverage of key interventions, and availability of pharmaceuticals products, supplies and equipment at each facility.

Incentives and Rewards

There is a lack of an effective system of incentives and rewards which can be seen in low staff motivation and dissatisfaction with the style of management, salaries and conditions of employment. Improvement can be obtained by a skillful manipulation of organizational and environmental elements. In some districts, the health workers get 10 percent of the revenue of the health center when the user fees system is instituted, but for now, the benefits are negligible.

National Policies

The national policies need to be revised to conform to the desiderata of the new health reform strategy and adapted to the reality of the districts. It is important to identify issues such as the supply of drugs for CDD (drugs for dysentery and cholera) and ARI (drugs for moderate and severe pneumonia) in health facilities, and what categories of health worker(s) are able to prescribe those drugs; home case management of ARI and diarrhea, including recommending home fluids and foods during and after diarrhea; breastfeeding; malaria prevention and case management; measles and nutrition case management; and advice of sick children, immunization, and essential drugs for first-level health facilities. Training is an inefficient use of resources when it is applied to situations in which unpredictable policy decisions are likely to play a predominant role.

Supply and Equipment

Although the MOH is committed to providing adequate and suitable medical equipment, installations, furniture and fittings to the health facilities, today many are working without the above elements which are considered key in the provision of the minimum package of health services. Many health facilities have no established checklists and procedures for the procurement of supplies and drugs. There are no established procedures for inventory control and no adequate storage facilities.

National Drugs Policy

Many key elements of a National Drug Policy have not been addressed; these are closely related to the effective and efficient provision of the minimum package of health services at all levels of the health care system. Regulation, legislation (including licensing, registration, and marketing), selection of drugs for different health care levels, and rational drug use need to be formulated. The current drug kit system for rural health centers is considerably linked to the cooperating partners and is not sustainable. Many health centers are experiencing drug shortages very often because of a miscalculation of the center's utilization rate and the lack of an adequately established logistic system.

3. Training needs in connection with pre-service and in-service training of existing cadres of first line health facilities

Pre-service Training

The health manpower availability and utilization have been greatly influenced by the training process and migration. Training programs have had a tendency to concentrate on individual career development rather than on providing the necessary skills, and have not been consistent with any realistic human resources development strategy. The MOH has proposed to reform the health training institutions to implement the concept of the polyvalent health worker. A national forum of health institutions will be organized to conduct informal discussions and introduce this new concept. The forum will involve key players in the decision to introduce this concept. There are a number of activities that will have a bearing on the degree to which this forum can move from discussion to decisions. At present, basic curricula in the major training institutions lack sufficient community-based learning opportunities in health information systems, community needs assessment, problem-solving, planning, monitoring and evaluation; staff (tutors) need to develop new training techniques and update their basic clinical knowledge and skills.

In-service Training

Provincial Level

Provincial capacity building represents a key element of the Health Sector Reform in Zambia. As part the overall capacity building strategies of the HRIT and following the first consultative meeting held in August 1994 with the regional directors and the results of job and tasks analysis of PHMTs in all nine provinces, it was decided to organize a provincial capacity building workshop. Current needs identified were skills and tools for monitoring; evaluation and the use of health information systems; provision of technical support to districts and hospital management boards; quality assurance on clinical, preventive and health promotion(s); applied research methods; and personnel and resource management.

There is not currently a developmental framework for supervision in the PHMT to identify specific deficiencies in the quality of services, counseling, and health education. Provincial-district structures and better resource utilization within the provinces are needed. They need to strengthen skills and techniques in the identification of health care problems in their respective districts and in the formulation of appropriate intervention strategies. Training in general public health can be organized through the UTH School of Medicine, Department of Community Medicine.

To be able to provide technical support and supervise more efficiently the district-based health care system, some PHMT members should be equipped with a variety of training skills in andragogy (adult training technique), as well as curriculum development; training management and evaluation; clinical training skills in an integrated curriculum in ARI, malaria, CDD, nutrition, UCI, measles, and ear and eye infections.

District Level

The National and District Health Services Act is expected to be signed into law by the end of 1995. It provides the legal foundation for the establishment of boards with local representation to take responsibility for the delivery of health services. The main objective of the health reform is the decentralization of health services to the district level. This implies that authority and responsibility for planning, management, service delivery, resource allocation, and supplementary revenue generation will be transferred to the district and hospital health board (DHB). There is currently no developmental framework for supervision in the DHMTs to identify specific deficiencies in the quality of services, counseling, and health education. There is a need to strengthen skills and techniques in the identification of health care problems in the respective districts and to formulate appropriate intervention strategies.

There is a need to develop a cadre of local trainers and familiarize these trainers with a variety of training skills in andragogy (adult training technique) as well as in curriculum development; training management and evaluation; clinical training skills in an integrated curriculum in ARI, malaria, CDD, nutrition, UCI, measles, and ear and eye infections in the districts. Training of both the DHMTs and the PHMTs can be organized at the same time to facilitate the development team problem-solving approaches to quality improvement. A certificate program in Applied Public Health can be organized at the Chainama College of Health Sciences with the possibility for the participant to later obtain a Master's degree at the UTH School of Medicine. The health reforms have generated an increased workload on DHMTs and first-line health workers without an increase in staff, at the expense of day-to-day operations. Training in teamwork, division of labor, conflict resolution and interpersonal communication, implementation and monitoring evaluation of district health plans, and resource mobilization and utilization can surely ease the burden of both the DHMTs and the health center managers.

Health Center Level

Because of the lamentable situation of many health centers, especially in the rural areas, the MOH is proposing to invest substantial capital in the rehabilitation of selected rural health centers in every district as part of the Health Sector Support Infrastructure Project. The introduction of a cost-effective package of health care services has resulted in the development of new standards and norms at the rural health center level. There are 862 rural health clinics and 553 of them have at least one clinical officer; 203 have no clinical officer; but at least one nurse; nine are only staffed by an environmental health technician; and 68 have no trained health workers and may be staffed by CDEs (*Mr. Elastus Lwando, Chief Clinical Officer*).

Approximately 470 of these 862 health centers will be required to cover a catchment population of 10,000 inhabitants. The MOH is proposing the rehabilitation of about 135 of these health centers with a recommended 10 to 12 bed capacity. The staffing pattern of the prototype rural health centers would have to be adapted to their new role and the package of services that they are now asked to provide. Health workers, especially in the rural areas, lack health information and basic managerial skills and are underutilized in the areas of prevention and health promotion because of inadequate transportation and communication systems. In addition, they need to update and refresh their basic clinical knowledge and simple case management of the most common childhood diseases.

The Nursing Sister In-charge (NSC)

Many health centers (especially urban) are managed by this category of health worker. The NSC training is very hospital-oriented, with about two-third of training time spent on hospital wards. In view of their new role and responsibilities, there is a need for them to acquire skills in finance, data, personnel and change management, participative supervision, conflict resolution, community organization, structure, and empowerment. In addition, the NSCs should also receive updated clinical, hands-on training in various childhood and adult illnesses (package of health services). This category of health workers may benefit from the current available WHO/UNICEF training course on the management of childhood illnesses. Because of the lack of qualified staff in some PHMOs and DHMOs, qualified NSCs and clinical officers (COs) can also be trained as trainers.

The Clinical Officer (CO)

Clinical officers in charge of managing first-line health facilities need to acquire skills in finance, data, personnel and change management, participative supervision, conflict resolution, community organization, structure, and empowerment. In addition, the COs should also receive updated clinical, hands-on training in various childhood and adult illnesses. This category of health worker may benefit from the current available WHO/UNICEF training course on the management of childhood illnesses. These training courses are necessary if these health workers

are to provide technically feasible services at their respective level for which the essential package of services is intended.

The Zambian Enrolled Nurse (ZEN)

Although her training is hospital-based with limited exposure to health centers, this type of health worker is more often than others found at first-line health facilities and should receive updated clinical, hands-on training in various childhood and adult illnesses. ZEN training takes two years and its minimum entrance is grade nine certificate. The enrolled nurse (EN) can benefit from the current available WHO/UNICEF training course on the management of childhood illness. Rumor has it that the MOH may forgo the training of the ZENs and convert them to RNs. This decision may have severe repercussions on the staffing pattern of the first-line health institutions in the rural areas, since many ZENs are found at this level.

The Environmental Health Technician (EHT)

Despite the original training (which is not necessary case management of the sick) of this category of health worker, they are often the only health worker in a first-line facility due to a variety of external factors. There is a need to upgrade the training of this category of health worker in both pre and post-service training. The health assistant could benefit from the current available WHO/UNICEF training course on the management of childhood illness.

As part of the HR development process, a standard package of essential services is being defined for each facility level. The vast majority of health services are delivered at the health center level and provided by the worker who staffs that facility. It is recognized that most of the workers currently delivering care at the health centers have not been trained in all the skills that will be necessary to successfully deliver the desired package. Discussions have been held at the MOH central level as to the need for a "polyvalent health worker" to meet this need. It has been proposed that current workers be trained to meet the polyvalent definition, and that current pre-service training curricula for the various cadres delivering services at the front-line facilities be replaced with a unified polyvalent training curriculum for future cadres.

The RM and the ZEM

There are three registered midwifery training schools in Zambia: the University Teaching Hospital Midwifery School in Lusaka, and the Ndola and Mufulira Schools of Midwifery. Trainees are recruited among qualified RNs with a minimum of one year of practice post registration. Upon graduation, the midwife should be able to perform senior administrative functions, case management of women during pregnancy and delivery, and caring for the neonate and infant. The midwife is a integral member of the PHC team.

The National Health Sector Reform implies a change in the pattern of resource allocation which presently favors deprived groups in the rural and peri-urban areas; to this extent its implementation is likely to involve an interaction of social forces. Beside the legislative demarche of the MOH through the passing and enactment of the Health Bill, the shift in resources will certainly require periodic public reaffirmation at the highest level of the MOH. Support for the health reform should be mobilized and demonstrated widely in the country. The approach should be accepted as a normal and obvious priority of a well-organized health system and produce concrete results. Practical implementation of the National Health Sector Reform is thus the long-term guarantee of support for it; but it does not diminish the value of explanation and training as important adjuncts, especially in the early stages when the approach is struggling to get started. In this respect, special attention needs to be paid to the health worker. With structural reform in the health sector, a remolding of health worker education to reflect this new approach has a crucial role to play at all levels. Prospective students should know from the outset that this is the health service they will be entering after graduation. Existing health workers should especially be helped to reorient their attitudes. Reorientation programs and explanatory materials should be provided. In addition, support should be given to the training institutions in reforming educational curricula and mounting reorientation programs for health and health related workers at different levels.

4. The existing resources and types of assistance required for national and regional training facilities

University Teaching Hospital Medical School, Department of Community Medicine

In collaboration with the Department of Community Medicine, UTH is preparing a Master's degree course in public health. The department has expertise in the field of epidemiology, community health, health system research, and health administration planning. The project can provide TA to strengthen the capability of the school to deliver culturally sensitive and task-oriented training courses based on needs and reality of the field. Audiovisual and other training aids may also be provided.

The Chainama College of Health Sciences

This college can be an important partner in the training of both pre- and in-service training programs. Their current courses seem to be relevant to many of the health sector reform training strategy. TA can be provided to review the curricula, train the trainers, and facilitate the production of training materials and the training of provincial and district training cadres. The college can also be one of the chosen sites for the introduction of integrated case management of childhood illness (ICM) in the region.

School of Nursing Program of the University Teaching Hospital

This school provides basic training for two important categories of front-line health workers: the RN and the nurse-midwife. The RN is generally found in hospital wards and in a managerial role in urban health centers. There are four RN schools in the country. After graduation and midwifery training of four years, nurses are often selected to further their education and admitted to a Bachelor of Science degree program in nursing, with a specialization in family health at the UNZA.

The ZEN and ZEM Training Schools

There are about 15 schools that train this most important front-line health worker; the cheapest to train and the least likely to leave the system in search of higher wages. ZEN schools can be found in almost every province, and some schools have training course leading to a diploma in midwifery (ZEM). Although they are more often found in health centers, their training is hospital-based with limited exposure to health centers.

The National Institute of Public Administration (NIPA), Health Services Training Section

The health services section provides training in health system management (six months), strategic management and planning workshops (for hospital directors and district health board), management information systems and medical records management workshops, and supervisory skills workshops.

The Evelyn Hone College, Paramedical Department

The College Paramedical Department is composed of five sections which provide specific training in the field of environmental health, medical laboratory technology, radiology, pharmacy, and physiotherapy. The department has also gained experience in organizing workshops and seminars as refresher training courses.

The Institute for African Studies

The Institute for African Studies (IAS) is part of the University of Zambia. The institute is related to various ministries, and national and international institutes. It has been engaged in research, feasibility studies, and the organization of workshops. The health promotion research program is carried out in collaboration with the School of Medicine. The program involves epidemiological and PHC studies, and HIV/AIDS community-based research.

The Tropical Disease Research Centre (TDRC)

As the Tropical Medicine Department of the Ndola Central Hospital, the center specializes in malaria (chloroquine) resistance research and has a great capacity for training.

5. Assessing progress to date in curriculum development

There was no progress at all in the curriculum development process while the team was in Zambia. According to the MOH, SIDA has agreed to finance the process of defining training needs, curriculum development and the initial retraining of some of the estimated 6,400 plus multi-disciplinary health workers. The Ministry of Health plans to organize a workshop for the development of a consensus on the curriculum for the polyvalent health worker during the first or second week of October.

B. Recent and on-going activities

Provincial Training

The only training that has taking placed this fiscal year, as far as child health activities are concerned, was a TOT in cold chain management that was sponsored by UNICEF.

District Training

Fifteen participants from 15 districts were trained in ARI (WHO Standard Manual) and most of them were members of the DHMTs. WHO sponsored this activity.

Private Sector

There were two training sessions of CDD case management attended by 15 and 17 participants, respectively, in Lusaka. (WHO)

Pre-service

UNICEF conducted two workshops on CCD case management for 20 clinical tutors from Chianama and 25 tutors from the nursing schools (the UTH, Ndola, Kitwe, and Mufulira Nursing School, and the 17 enrolled nursing schools).

WHO/CDR sponsored a training program to strengthening the teaching on immunization in the pre-service education program for nurses in Zambia.

WHO proposed to organize a regional training on CCD case management for medical lecturers in the School of Medicine on September 13-23, 1995.

In-service Training

WHO organized a training course in data collection (disease surveillance) in 19 sentinel surveillance sites.

VI. RECOMMENDATIONS

1. BASICS will support the effort of the HRIT and collaborate with other national and international agencies in the development of the "polyvalent health worker" curriculum. Although SIDA agreed to finance the process of defining the training needs, curriculum development and the initial retraining of some of the estimated 3,000 or so health workers, BASICS/USAID will participate in the forum in October 1995 and provide TA as needed throughout the process and collaborate in the training of trainers and some of the facilitators.

2. BASICS will provide TA and collaborate with the HRIT in the development of the provincial capacity building curriculum for a possible workshop in February 1996.

3. BASICS will collaborate with the MOH and URC and other international agencies in the development of assessment tools for an in-depth evaluation of the health centers, the adaptation and field testing of the existing integrated in-service curriculum, and the complementary course being developed for first-line health workers.

4. BASICS will participate in collaboration with a number of local training institutions (Chainama, NIPA, schools of nursing), the PHMTs and the DHMTs in the development of an integrated curriculum for in-service training for first-line health workers, and will assist the training institutions in improving, as needed, their capacities to provide appropriate training in support of the health reform goals. This includes the following:

   - Assisting in course development.
   - Serving as a resource for the development or adaptation of course material.
   - Facilitating linkages with designated U.S. or regional institutions.
   - Functioning as a catalyst to advance private sector training in government institutions and to promote sustainability in these institutions.

5. BASICS will participate in the development of supervisory tools for the periodic monitoring and evaluation of the training program, assess health services delivery and identify areas for improvements. In addition, BASICS will collaborate with selected institutions for the training of potential supervisors in the PHMOs, DHMOs and health centers.

6. BASICS will collaborate with other USAID projects in Zambia and the CARE Community Family Project in the development of training materials and the actual coordination of health workers' training in family planning management, IEC and counseling techniques, the Morehouse School of Medicine STD/AIDS prevention training activities for case management and counseling, and Safe Motherhood interventions in the field.

7. BASICS will collaborate with UNICEF, WHO and other organizations with training-related activities to avoid duplication of the same activity and to facilitate the smooth implementation the MOH health reforms.

8. BASICS will collaborate with the MOH and other training institutions in the development of training curriculum for the training of a cadre of trainers in selected districts to strengthen the capacity of the district to train their own health workers.

VI. CONCLUSIONS

- The ZMOH is engaged in the development of a new approach to health care with the enactment of the Health Reform Bill. This political commitment will require a reorientation of the concept of health services by both the provider and the population. This will entail a major shift in the behavior of both entities from a focus on curative care to one of community-oriented public health services.

- The central level is not as yet fulfilling its role of providing direction and the actual frameworks for the implementation of the new approach to health care. The PHMOs and the DHMOs are in a period of transition in reforming their health systems and as such, they are in the process of developing new relationships as decentralization occurs with the usual tensions and resistance to the new changes.

- There is considerable confusion as to the roles and responsibilities of the different players, with limited guidance from the central level.

- The transitional period is rather long and this may lead to demotivation of the personnel at all levels of the health care system. Key staff at the central level are overloaded and find it difficult to give special attention to the demands of the periphery or individual donor's tenuous requests.

- There is a need to assess the degree of change that can be absorbed by all the parties involved in the health reform process and the time frame needed for the implementation of this change.

- The benefits of a training program are most broadly realized when the training is integrated within a national training development framework.

APPENDICES

APPENDIX A

TRAINING ACTIVITIES PROPOSED DURING BRIDGING PERIOD

Proposed Objectives and Level of Effort

1. Provide TA to the MOH in the development of a Polyvalent curriculum for front-line health worker.

Tasks:

- Workshop for consensus building in October 1995
- Determine institutions to participate in the Workshop
- Identify key players to participate in the Workshop
- Define the Polyvalent Health Worker's profile
- Develop and refine Polyvalent Health Worker curriculum

Level of effort:

(1) Short-term international consultant (2 weeks)
SOW: Assist with the development of the curriculum for the Polyvalent Health Worker

2. Provide TA in the development of the Provincial Capacity Building curriculum for a possible Workshop in February 1996. *

Tasks:

- Review and Revise existing Provincial Capacity Building curriculum
- Revise goals, objectives, content and training methodologies
- Determine training outcomes based on needs assessment
- Revise training schedule and implementation plan
- Develop evaluation and follow up activities

Level of effort:

(1) Short-term consultant (HQ) (2 weeks)
SOW: Refine existing curriculum
(1) Short-term consultant in country (2 weeks)
SOW: Participate in Training
COP/ BASICS

* We really do not know who is now in charge of this activity. This activity was requested by Dr. R. Msiska and its present status is uncertain.

3. Provide TA to build selected DHM capacity to assess needs, plans and manage training activities.

Tasks:

- Develop district capacity to assess needs
- Review and analyze HFS results in focused district
- Prepare task analysis guidelines and assessment tools
- Train key persons that will be involved in data collection
- District staff assess needs
- Analyze needs assessment and determine gaps/learning needs
- Determine trainee targets

Level of effort:

(1) Short-term local consultant (6 weeks)
SOW: Preparation of draft instrument and methodology, analyze HFS results
(1) Short-term consultant in country (4 weeks)
SOW: Assist in the preparation for assessment, develop guidelines and training surveyor

Provide Technical assistance to the DHMO for development or review of detailed training plan for selected health centers.

Tasks:

- Review and refine detailed training plan of action of selected DHMT (Timeline, orientation of trainers/facilitators, participants per health centers, criteria for selection, venue, (transfer of learning process) monitoring and evaluation activities)
- Establish or refine supervisory structure
- Guidelines for training (certification, training policies/standard, etc..)
- Determine institutions that will participate in training activities
- Determine post-training functions
- Develop evaluation and follow-up activities

Level of effort:

(1) Short-term consultant (HQ) (2 weeks)
SOW: Review and refine DHM training plan
(1) Short-term consultant in country (2 weeks)
SOW: Assist with revision of training plan of selected DHM

4. Provide TA to the MOH/HRIT for the development and implementation of a MOH Training Strategy (Training policy and procedures).*

Tasks:

- Select advisory group
- Inventory of health workers in selected Health Centers
- Establish or review MOH training objectives.
- Assess what skills are required to meet the objectives
- Develop standards of performance for each positions (competencies).
- Develop criteria for trainee selection
- Develop criteria for the selection of trainers
- Develop follow-up and evaluation strategy
- Develop criteria for selected DEMO and implementing institutions

Level of effort:

(1) Short-term consultant (HQ) (2 weeks)
SOW: Establish or review MOH training objectives
(1) Short-term local consultant (2 weeks)
SOW: Assist with the development of training strategy

* BASICS Representative should meet with MOH officials to discuss BASICS role.

6. Provide TA to selected DHM and implementing institution in the development of training modules (or adaptation of the Management of Childhood Illnesses) based on the minimum package of health.

- Sensitization Workshop for the introduction of ICM (Feb 6-8 and F/U at end of Feb)
- Select Advisory Group
- Review and affirmation of training needs
- Review WHO/CDR ICM adaptation guide and other ICM documents
- Determine institutions that will participate in training activities
- Identify training venues
- Determine trainee targets for both TOT and first-line health worker training
- Determine post-training functions
- Develop evaluation and follow-up activities

Level of effort:

(1) Short-term consultant (3 weeks)
SOW: Workshop preparation (1 week) and participation (1 week)

(1) Short-term consultant in country (3 weeks)
SOW: Assist with preparation and adaptation of training material

Provide TA to the DHMO or/and selected training institutions in adapting ICM training materials for TOT and for first-line health worker in selected health centers based on needs assessment.

Tasks:

- Prepare an ICM material development plan
- Review ARI, CDD, Malaria/Fever, EPI, Nutrition guidelines
- Establish or refine IEC and drug management guidelines
- Adaptation of feeding recommendation
- Set standards of performance
- Determine gaps/learning needs
- Determine training outcomes
- Develop training methodologies
- Develop supervisory check lists
- Training schedule and implementation plan
- Develop Training materials

Level of effort:

(1) Short-term consultant (HQ) (6 weeks)
SOW: Curriculum development
(1) Short-term local consultant (3 weeks)
SOW: Assist with preparation and adaptation of training materials

8. Provide TA for field testing and revision of existing ICM training material in selected DHM

Tasks:

- Conduct 3-2 weeks training in 3 selected DHM
- Course Director
- TOT at training site
- First-line Health Workers
- Review and refine the ICM curriculum for appropriateness for training first-line health workers

Level of effort:

(4) Short-term consultant (6 weeks)
SOW: Conduct TOT training in 3 selected DHM

(2) Short-term local consultant (6 weeks)
SOW: Assist in TOT implementation and field test

9. Provide guidance in conducting a training review three months after the initiation of the ICM training and adjust the training program as needed.

Tasks:

- Develop strategy for periodic monitoring and evaluation of the training program
- Develop competency based assessment tool to assess post-training progress of trainees
- Share training experiences and lessons learned with other DHMs
- Conduct 3-days curriculum review workshops
- Operation Research longitudinal study by DHM

Level of effort:

(1) Long-term staff training Advisor (2 weeks)
(1) Long-term staff PHC coordinator (2 weeks)
SOW: Revise curriculum, conduct 3-days curriculum review workshop

10. Provide TA for the field testing of the complementary ICM curricula for training front-line health workers.

Tasks:

- World Education develop complementary course
- Consult with advisory group
- Plan for field test of the first-line health workers curriculum
- Select trainees
- Select trainers/facilitators
- Identify venues
- Conduct 3-2 weeks training in 3 selected DHM for first-line health workers

Level of effort:

(1) Long-term training Advisor (6 weeks)
(1) Long-term Child Health Coordinator (6 weeks)
(2) Short-term consultants (6 weeks)
(2) Short-term consultants (World Ed) (6 weeks)

(6) Short-term local consultants (6 weeks)

11. Provide TA and training materials as requested to local training institutions for the long-term pre-service training of some members of the PHMT and DHMT in public health, health management, hospital administration, health information systems and environmental health as requested by the MOH.

Tasks:

- Identify schools, training institutions with existing health related training program
- Select programs with appropriate training capacity
- Establish curriculum advisory group per program/institution
- Develop or refine Public Health, Hospital Administration, Health Information System and Environmental Health programs in selected institutions
- Determine goals, objectives, content outline, lesson plans and training outcomes based on needs assessment
- Develop training methodologies
- Develop monitoring and evaluation strategies per program

Level of effort:

12. Provide TA and training materials to local training institutions for the long-term in-service training of some members of the PHMT and DHMT interpersonal communication, community partnership, and other related areas such as FP, HIV/AIDS, safe motherhood

Tasks:

- Identify schools, training institutions or other international agencies with appropriate training program
- Select programs with adequate training capacity
- Establish curriculum advisory group per program/institution
- Develop or refine curricula for FP management, communication, community partnership, HIV/AIDS case management, and safe motherhood
- Determine goals, objectives, content outline, lesson plans and training outcomes based on needs assessment
- Develop training methodologies
- Develop monitoring and evaluation strategies per program

APPENDIX B

LIST OF CONTACTS DURING FIELD VISITS

List of Contacts

AID MISSION

Mr. Paul Hartenberger, USAID/HPN	**Monday**	**8/14/95**
Dr. Steven Wiersma, USAID/HPN	**Thursday**	**8/17/95**

MOH/HRIT

Mr. Vincent Musowe, Chief Health Planner	**Friday**	**8/18/95**
Dr. Sam Nyaywa, HRIT Team Leader	**Monday**	**8/28/95**
Mrs. Gertrude E. Mundia, Donor/NGO/IDA	**Thursday**	**8/24/95**
Dr. E. Limbambala, QA Coordinator, MOH	**Monday**	**8/14/95**
Dr. Roland Msiska	**Thursday**	**8/24/95**
Ms. Jennifer Nyoni, HRD Unit	**Wednesday**	**8/16/95**
Dr. H.B. Himonga, National Malaria Control	**Thursday**	**8/24/95**

MOH/MCH

Dr. Mary Shilalukey Ngoma	**Wednesday**	**8/16/95**
Mrs. Mary Kaoma	**Thursday**	**8/17/95**
Mrs. Doreen Mwewa, Chief Nursing Officer	**Wednesday**	**8/16/95**

TRAINING INSTITUTIONS

Dr. J. C. Munkombwe, Chainama Hills College Hospital	**Friday**	**8/25/95**
Mr. John Mudenda, Registrar Chainama	**Friday**	**8/25/95**
Dr. M.I. Salem, Chainama	**Friday**	**8/25/95**
Mr. M. Rashid	**Friday**	**8/25/95**
Mr. Alan Mbewe	**Friday**	**8/25/95**
Mr. Elias Phiri	**Friday**	**8/25/95**
Mrs. Justine Moonga, School of Nursing	**Thursday**	**8/24/95**
Mrs. Maureen Chilila, School of Nursing	**Thursday**	**8/24/95**

INTERNATIONAL AGENCIES

Dr. Michael O'Dwyer, ODA HRD project manager		
Dr. Ini Huijts ANCHOR HOUSE	**Wednesday**	**8/16/95**
Dr. Ahmed Magan, UNICEF Health Programme Officer*	**Wednesday**	**8/16/95**
Dr. Arne Poulstrup, Senior Health Advisor		
Mr. Joe Wiseman, Zambia HIV/AIDS Prevention Project	**Wednesday**	**8/16/95**
Dr. Stella C. Anyangwe, Epidemiologist,	**Wednesday**	**8/16/95**
Mr. Winthrop B. Morgan, MPH, Zambia Family Planning	**Thursday**	**8/17/95**
Mr. Michel K. Toko-Puku, CCF	**Friday**	**8/25/95**
Mr. Bjarne Lading Rasmussen, Consultant MOH	**Monday**	**8/28/95**
Dr. Simon Mpuka, CMAZ	**Thursday**	**8/24/95**

List of Contacts during Field Visits

LUSAKA

Mrs. M. Mwanza, DHMT Lusaka Urban

Mr. Kakwele Cheelo, DHMT Lusaka Urban

Mr. Kakubo, Lusaka Rural Chainda Health Center CCF

COPPERBELT PROVINCE

Dr. Lungu, PHMT, Director

Mrs. Bumba, PHMT, Senior Nursing Officer

Mrs. Kazembe, DHMT Ndola Urban

Mr. W. Simukoko, DHMT Ndola

Mrs. Lumbwe, Masala Urban Clinic

Mr. Maswana, DHMT Ndola Rural

Mr. Sondashi, DHMT Ndola Rural

Ms. D. Chitambala Npongwe Mission Hospital

Ms. Kanunga Sekeseke, Mikata health Center

CENTRAL PROVINCE

Dr. Henry Muzia, PHMT, Director

Mrs. Desideria Mvula, PHMT, Senior Nursing Officer

Dr. E.J. Sikasula, DHMT Kabwe

List of Contacts

Mr. H. Fumbeshi, DHMT Kabwe

Mr. D. Mbumwai, DHMT Kabwe

Mrs. G. Silondwa, DHMT Kabwe

CENTRAL PROVINCE

Mrs. A. Matakala, DHMT Kabwe

Mrs. Lungu, Kawsavasa Health Center

Mr. M. Mukololo, DHMT Kapiri-Mposhi

Mr. Richard Ndhlovu, DHMT Kapiri-Moshi

Mrs. G. Mugara, DHMT Kapiri-Moshi

Mr. Mulinga Alinanihis, DHMT Kapiri-Moshi

Ms. Martha Benda, Kakulu Health Center

Mr. Joseph Chali, Kakulu Health Center

Ms. Florence Haabasune, Kakulu Health Center

Ms. M.K. Chizawu, Bwacha Urban Health Center

APPENDIX C

HIGHLIGHTS OF FIELD VISITS

Highlights of Field Visits

LUSAKA PROVINCE

The Lusaka Province has 4 District Health Management Offices, Lusaka Urban DHMT, Luangwa DHMT, Kafue DHMT and Chongwe DHMT. At the Lusaka Urban DHMT, we met with Mrs Mwenza Senior Nurse Officer and the Principal Clinical Officer Mr. Kakwele Cheelo. This DHMT is housed in the Lusaka City Council building and is now managing 22 health centers including nine large health centers with approximately 13 beds each and 13 medium Health Centers with an average of 1 or 2 observation beds. Before the Health Reform, they were coordinating 2 urban health centers, provided MCH services in the peri-urban areas and outreach interventions to hotels and industries around the city (occupational health, UCI, IEC). 8 of the health centers are being upgraded by the ODA to 30 in-patient beds in top of the 13 maternity beds.
The staffing pattern of the District Health Management Organization is may be, at least for now, unique to Lusaka Urban. It is composed of a District Director, two Deputy Directors (Administration and Health Programming), one Principal Clinical Officer, an Accounting, a Chief Environmental Health Inspector, a Senior Nursing Officer, a District Public Health Nurse, a Pharmacy Technician, a Primary Health Care Coordinator, a Quality Assurance Coordinator, and Health Education Officer. There is no official job descriptions for the staff though their functions seem to be well defined at least informally. The Director of the DHMO, a physician, is getting a Master of Public Health, the Deputy is to go for a Master soon, the Public Health Nurse recently received a Diploma in Health Administration and is now getting a Master in Community Health in Ireland, the Senior Nurse has been trained in Arusha (Health Management Course) and has previously received training in Health Planning at the National Institute of Public Administration (NIPA)

There are about 9 Public Health Nurses, 11 Clinical Officers, 11 Nursing Sisters, 50 Registered Nurses and 250 Enrolled Nurses working for the Lusaka urban health facilities.

We purposely choose to visit the Chainda Health Center in the Chongwe Rural District. It is important to notice that Lusaka rural health centers are managed by the Provincial Management Office. The health center has a catchment population estimated at 6,000 where more than 67% of the population are under 15 years of age. The pattern of diseases are similar to that of the general population, the main health problems include malaria, acute respiratory infections, diarrheal diseases, malnutrition and other diseases ranging from eye infections to HIV/AIDS and Bilharziosis. This health center is exceptional in that it is a mixed facility where the community has organized itself as part of a development program and choose to build the facility with the participation of the Christian Children Fund, Inc. and the MOH has allocated 1 Clinical Officer, 2 Enrolled Nurses and 1 Enrolled Nurse Midwife. In this clinic, the health workers provide both curative and preventive services which include UCI, FP, I. E and C. HIV/AIDS counseling. Because of lack of adequate transportation the staff was not able to provide outreach services to the 15 or so villages scattered around the health center catchment area. They have expressed their interest in the new MOH proposition about the "Polyvalent health worker". But when asked

about their training priorities each one of the health workers who were present at the meeting has expressed their specific training interests as such: Clinical Officer case management of the sick child, ZEN (1) family health and ZEN (2) community health.

COPPERBELT PROVINCE

The Copperbelt Province has 8 Health Districts, Ndola Urban, Ndola Rural, Kitwe, Mufulira, Kalulushi, Chililabombwe, Chingola, and Luanshya. We paid a courtesy call to the new Director of the PMO, Dr. Lungu and the Chief Public Health Nurse, Mrs Bwemba. Although the Health Reform recognizes the PHMT as the linkage between the central and the operational level of the MOH, the Copperbelt PHMO is at this point not up to part with the proposed organizational structure. In addition, many of the functions and tasks of the staff members are not yet defined and the job descriptions not readily available. Many decisions about the recruitment and personnel selection, work organization, procurement of drugs and equipment are still taken at the central level awaiting the creation of the Health Boards. The capacity of the province to technically support the DHMT is severely in question. And since current staffing of the PHMO needs to be adjusted to fit the expected proposed role it is too early to determine individual training needs or individual performance gap analysis. The MOH is completing a survey of existing staff of all regional offices to identify, among other things, the major stake holders in the province and their relationship to health provision.

We visited Ndola Urban DHMO and met with Mr.W. Simukoko and Mrs Kazimbi respectively Chief Health Inspector and the Principal Nursing Officer. The DHMT has an organizational chart or plan which clarifies the functions and responsibilities of the staff but there are at this point no written norms for all services provided at the facilities and no individual job descriptions. DHMT has developed a plan of action which stipulate the strategies and activities for the effective implementation of the district health care services. There are 20 Health Centers in the district and the staffing pattern in most of these facilities is composed of clinical officers, registered nurses, enrolled nurses, nurse midwives and health assistants. There is no supervision plan and no checklists which would allow the DHMO to identify specific deficiencies in the quality of services and solutions to the most common problems. There is no career development strategy and no opportunities exist for promotion and professional development for some senior staff.

We visited the Masala Clinic in urban Ndola and met with Mrs. Lumbwe, the Nursing Sister in charge. She has a staff of 13 health workers. In the past six months Mrs. Lumbwe has participated in three training sessions (QA, STD and TB/AIDS). The Clinic works closely with the schools in the community and participates in Church fairs to disseminate health information. There is no training plan and decisions about training have always been taken by central authorities. There is no framework for supervision and no mechanism to evaluate the training needs of the health workers.

The Ndola rural DHMO of Masaiti was visited by the team including one member of the PMO Mrs Bwemba who is the Principal Nursing Officer. We met with Mr. Maswana and Mr. Sondashi respectively Director and Deputy Director for Planning. The district has a population estimated

to 200,707 inhabitants with 20% less than 5 and 48.7% less than 15 years of age. There are in total 41 health facilities in the district, this include 26 government health centers, 2 mission hospitals, 4 industrial clinics, 4 private clinics, and 5 mission health centers. There are 31 clinical officers, 31 environmental health assistants, 23 midwives and 125 enrolled nurses working in the district health facilities. There are no public health nurses and a considerable lack of other qualified health workers in many health facilities in the district. A variety of external factors including limiting housing accommodations, and deteriorating living conditions in the rural area and socio-cultural norms, can contribute to the inadequate distribution of health workers in the district.

The DHMT has implemented a user fees system where by for OPD services adult patients pay a flat rate of K500, K200 for children under 15 years of age, K600 for in-patient admission and treatment, K300 for children. 90% of the revenue is used to cover operation cost and 10% suppose contribute to employee incentive. This cost recovery system is working very well in the district despite of the rather very low buying power of the population.

Training capability of the DHMO was assessed and the Team has recommended a number of sites such as the Mwekwla Forestry College, Sandabunga Rest House, the Arthur Davidson Pediatric Hospital, St Theresa Mission Hospital, and the Mpongwe Mission Hospital.

We visited the Mpongwe Mission Hospital which is sponsored by the Scandinavian free Baptist Mission and has actually a total of 120 beds. Beside their provision of medical services, the hospital is very active in the community and provide PHC outreach to the 30,000 or so inhabitants in its catchment area. The pathologies most common are malaria, diarrheal diseases, ARI, tuberculosis, malnutrition and HIV/AIDS. They have no resident physicians on staff but 2 M.D. from Sweden come every six weeks. The 38 health workers of the hospital are among the three commonly known categories (Clinical Officer, Nurse, and Enrolled Nurse). 25% of their out-patient population are children less than 5 years of age. The hospital was identified as a good site for training of health workers in the district.

The Mikata Health Center is a small unit situated in a remote village of rural Ndola with no electricity or water. There are three health workers for a population estimated to 6,000 inhabitants. The most common pathologies again are malaria, ARI , diarrheal diseases, **lot of** malnutrition, eye and ear infections. They have, as in many other rural areas, shortage of staff and the environmental health assistant is forced to do clinical assessment and treatment of the patients. There is a need for refresher course in the most common childhood illnesses in addition of tuberculosis and leprosy control. Although their regular hours of operation are normally 7hrs30 to 12hrs30 and 14hrs to 16hrs they said to be 24hrs on call and during the rainy season they are frequently called for snake bites. They have severe shortage of drugs especially antibiotics. Transportation is considered to be a major problem for both the patient/client and the outreach officer. The accessibility to the health center was not jeopardized despite the introduction of user fees.

CENTRAL PROVINCE

The central Province has 6 Health Districts, Kabwe urban, Kapiri-Mposhi, Mkushi, Serenge, Mumbwa, and Chibombo. We first paid a courtesy call to the Director of the PMO Dr. Henry Muzia and Mrs D. Mvula, Principal Nursing Officer. We discussed about the current situation of the PHMT with respect to organizational structure, the Health Reform and the new role of the Office. They were very keen to the new change and the challenge of providing technical support to autonomous districts. Dr. Muzia is a Malaria expert and has done some worked in Guayana South America. He thinks that the Health Reform has generated motivation and interest, but the roles and responsibilities has yet to be defined. Although the role of the PHMT seems to be limited, the workload is enormous and the staffing quite restrained. He talked about the tentative of zambianization of the health care system where in Mumbwa the District Director who is an expatriate was replaced by a Health Inspector. Training is one of the fundamental elements to improve the quality of services in the province and they are awaiting the HQ decision.

We visited Kabwe Urban DHMO and met with Dr. E.J. Sikasula and his almost complete staff. This District Health Management Team created in 1993 with the new Health Reform, has been very active and patient as to the way the HQ is moving with the implementation process. The DHMT has an organizational chart or plan which clarifies the functions and responsibilities of the staff but there are at this point no written norms for all services provided at the facilities and no individual job descriptions. DHMT has developed a plan of action which stipulates the strategies and activities for the effective implementation of the district health care services. There are 18 Health Centers in the district and each health center is managed by a Clinical Officer. The staffing pattern in most of these facilities is composed of clinical officers, registered nurses, enrolled nurses, nurse midwives and health assistants. Some staff in both the DHMO and the Health Clinics have now more responsibilities on top of their usual professional obligations. There is no supervision plan and no checklists which would allow the DHMO to identify specific deficiencies in the quality of services and solutions to the most common problems. Many of the training activities that were planned did not take place because of lack of funds (DANIDA pulling the plug).

APPENDIX D

DONORS AND OTHER INSTITUTIONAL STAKEHOLDERS

Donors and other Institutional Stakeholders

There are a number of significant factors which have resulted in broad donor and international agency involvement in the public health sector. Historically Great Britain as the colonial power was involved in the formation of the Northern Rhodesia Health Department and has retained a significant degree of involvement ever since. The missionary involvement in health care since the turn of the century has been considerable, especially in rural areas, where mission sponsored services continue to account for 50% of all care.

The lack of trained local medical staff from the beginning has encouraged the utilization of expatriate medical personnel for the delivery of services. The limited number of Zambian physicians being trained even today, coupled with the emigration of a significant number of these, has resulted in the continued presence of an unusual number of expatriate physicians. As an increasing number of donor agencies have put increasing amounts of money into the Ministry of Health in support of the Health Reform process, the need for oversight coupled with the limited number of trained Zambian personnel has resulted in a noticeable increase in the number of expatriates working with and in the Ministry.

USAID, as a rather late arrival on the scene, has been extremely sensitive to the need for collaboration and coordination of its efforts with those of others. As BASICS prepares to enter this rather charged environment, it would be useful to briefly review the activities and roles of the other stakeholders and develop mechanisms for coordination of efforts. From October 16th to the 20th, the Ministry of Health planned to convey a meeting of all the cooperating agencies to review technical issues related to external assistance to the health reforms process. The following is a listing of those who's activities most immediately relate to training, but it is important to note that there are a number of other actors placing similar demands on the same Zambian counterparts.

CMAZ

Churches Medical Association of Zambia (CMAZ), the umbrella organization representing various religious organizations, has 89 affiliated health institutions, and is quite involved in the development of training activities in a variety of ways. Eight of the seventeen training schools for the Zambian Enrolled Nurses (ZEN) are operated by CMAZ member organizations. A significant number of MOH employees in rural areas are also seconded to member facilities. With 29 hospitals and 58 health centers in rural areas, which claim to deliver 50% of rural health services, CMAZ members represent not only a significant proportion of the target workforce for training, but also represent resources in physical plant, opportunities for hands-on case management, and actual or potential trainers.

CMAZ was established in 1970 to provide collective representation for mission organizations in dealing with the MOH. The Annual Council, consisting of representatives of all member institutions, is the main governing body which elects an Executive Committee to supervise the full time staff of the Secretariat. The CMAZ Secretariat is the main implementing agency, who's

previous functioning revolved around negotiating a consolidated budget with the MOH, channeling government grants to members, and assisting members in the implementation of government mandated outreach programs. The decentralization process of the Health Reform has made these functions largely redundant by moving most negotiation to the district level.

CMAZ member organization's experience to date with the health reforms has varied, but there are a number of issues which either have, or soon will arise for most of them. Funding of health institutions which was previously negotiated at the central level will now need to be done with the district, and eventually with district boards. In a climate of reduced financial contributions from abroad, this funding can determine the viability of mission institutions and are bound to be entered into with some trepidation. The services to be provided will be expected to conform to district action plans which will be shaped by MOH guidance as to appropriate service packages at different levels. This will be potentially problematic for missions who's health services are not "stand alone" entities, but rather one element in a range of services provided within the context of that mission or mission community. An example would be the extensive ambulatory services provided by some mission hospitals which might not be considered "appropriate " at the hospital level. Staffing is another issue both in regards to mission run training of Enrolled Nurses for its own needs, and MOH personnel seconded as staff to mission institutions. Personnel decisions made in support of national policy directives might not necessarily conform to mission perceived personnel needs.

CMAZ has responded to the change in circumstances brought about by the reform process by reorganizing itself in ways it hopes will be relevant to its member organizations. The emphasis in this reorganization has been on service, highlighting information, training, and technical assistance. An additional identified area is in the procurement and distribution of pharmaceutical products. It would be difficult to say at this point how successful CMAZ will be in carrying out the role it has defined for itself in the above mentioned areas, but it's member institutions are logical partners for much of the work BASICS proposes for Zambia.

DANIDA

DANIDA has provided significant resources to the Health Reform effort through its financial and staffing support to HRIT and the district strengthening element of the decentralization process. Building on the experience supported by SIDA and UNICEF in three districts, DANIDA has bankrolled the expansion of this experience to all 61 districts. By providing the resources and logistic support necessary for HRIT to take a leadership role, plus putting significant monetary resources directly in the districts, DANIDA's efforts have been key to the success that the Health Reform process has had to date.

Though all elements of DANIDA's project have bearing on BASICS proposed activities, there are three which are especially worth examining in relation to training. These are: district level capacity building; implementation of the basic package of services; and Quality Assurance.

The focus to date in district capacity building has been primarily on planning and finance. Enhancing the ability of the newly formed District Health Management Teams (DHMT) to develop their own action plans and to manage the financial resources to carry them out, has created a base upon which all other interventions will rest. This is especially significant in terms of training, as this same team assumes the roles of supervisors, evaluators and planners, determining the skills and resources necessary and how they can be developed. Rather than the passive recipients of training visited on them from the central level through the vertical program areas, the reform model contemplates teams which are competent not only to define their needs but also to provide or contract training to address them. This model needs to be considered as BASICS develops both short and long-term training plans.

The implementation of the basic package of services for each level of service is the next major initiative of the reform process. This involves the definition of what services will be provided at each type of facility, and what skills and other resources will be necessary to provide them. The package and skills for the health center level have largely been defined, and part of this package conforms to that contained in the ICM model. The basic package of services therefore appears, at the moment, to be the most logical vehicle for ICM, with a number of qualifiers. The implementation will take place in a charged atmosphere where pressures to move beyond planning, for an increased role for the provincial level, and increased district autonomy will be supplemented with pressures for greater involvement of Basic Health Services. Another complicating variable is that the implementation is expected to take place during 1996, an election year. As this intervention is key both in justifying DANIDA's investment to date, and in creating the conditions necessary for their eventual withdrawal, they will be intimately involved in all aspects of this process.

ODA

The United Kingdom Overseas Development Administration (ODA) is the agency with the longest involvement in the training of human resources in the health field both within and outside the country. Zambia is also a priority country for ODA assistance in health and population, and it's current bilateral project, Zambia Health and Population Sector Aid, has been designed within the context of the Health Reform. The project is divided into six components: Human Resource Development; UNZA School of Medicine; Lusaka Urban Health; Family Planning; HIV/AIDS Care; and Kitwe and Ndola Hospitals. Though all of these components have training elements related to BASICS proposed interventions, the one most immediately relevant is that of Human Resource Development (HRD).

The HRD project proposes to address a number of key issues. Personnel costs currently represent 70% of MOH recurring costs, any discussion of redistribution of costs has to address personnel. The skewed distribution of personnel is one of the most obvious inequities of the current MOH system and needs to be addressed not only to maintain the credibility of the reform process, but also to provide the resources needed for its implementation, especially in the rural areas. Lack of adequate compensation, career opportunities and other incentives have resulted in desertion, emigration and low motivation in remaining staff. Responsiveness to community

needs is not generally characteristic of centralized institutional personnel systems, and Zambia is not an exception.

The HRD project is considered a "process" project, to be managed in response to the evolving requirements of the sector. Unlike some of ODA's other components, HRD does not provide resident technical assistance. It is supervised by the ODA Health and Population Field Manager with short-term external technical assistance provided to different elements of the overall program. Primary responsibility for implementation rests with the MOH Planning and Management Unit (PMU) with support from HRIT. A Human Resources Development Specialist has been seconded to PMU from the Cabinet to manage the overall effort. One of the first tasks undertaken has been the attempt to identify the existing human resources. Data from a questionnaire distributed at the district level is currently being entered in a software program which should provide some baseline information. Though the ODA had previously been reticent to support in-service training of personnel prior to the resolution of some of the larger personnel issues, there is a growing recognition that these issues will not quickly nor easily be resolved. At the same time there has been concern expressed by a number of donors of the need for a timely updating of the technical/clinical skills of service providers. These issues merge in the current discussions of the polyvalent health worker or Public Health Officer, and in the implementation of the package of basic services. PMU feels a sense of urgency to forge a consensus on the type of human resources needed by the Ministry and to move forward with the training of this cadre. They are concerned that any training that takes place outside this context will either be redundant, or will divert the resources needed to carry out their training.

Given the above, the need to coordinate any training proposed by BASICS with both PMU and ODA is obvious. Support can be expected for those initiatives which build toward and advance agreed upon goals, as long as they are not perceived as diverting resources or distracting attention from reform priorities.

Netherlands

The Netherlands has been involved in primary health care delivery in Zambia for the past 15 - 20 years, with a concentrated effort in Western Province. This has involved both service delivery by expatriate physicians and training of local staff . Most expatriate doctors enter service upon completion of a specialty internship. After completion of one or two periods of work in Zambia they are eligible for public health training in Holland, from which some return for additional service. Training for local staff has consisted of both in-service and specialized training in Holland. Though early efforts relied on the initiative of individual physicians, they a currently focused within the framework of the Primary Health Care for Western Province project.

This project is oriented toward prevention as well as care, and also contains significant elements of both in-service training and training abroad. One interesting aspect of this project has been the use of operations research to investigate district identified health problems, and the incorporation of the results into training and targeted interventions.

The project has accumulated valuable experience in the strengthening of support skills at the district and provincial level, and in the functioning of boards. Its acting team leader is a Medical Sociologist based out of Mongu. It would be important to identify ways in which BASICS can incorporate some of the lessons learned through this project.

Another effort which has significant implications for BASICS is the recently developed proposal to increase district level capacity through a joint training program with the Pan African Institute for Development (PAID-ESA). This project is anticipated to enter a nine month development stage in October of 1995 and hopes to begin training in mid-1996. The project contemplates two levels of training, a three month certificate, and a nine month diploma program. The former is targeted at district program managers and other potential change agents to be trained to return to the districts as catalysts for change. The latter is designed to provide the necessary skills for district directors of health. Planning calls for two training courses per year over five years, with a total of 150 -200 people qualifying for either a certificate or diploma. As the candidates for both trainings will be drawn from all districts, close coordination will be necessary to avoid conflicting demands on the same personnel.

UNICEF

Eight of the twelve objectives in the Primary Health Care and Nutrition component of the UNICEF draft 1997 - 2001 Programme Strategy are consistent with BASICS overall goals and objectives. The remaining four deal with pregnant women or mothers and thus fall outside the scope of BASICS efforts, but are consistent with related USAID objectives. In addition, four of their program strategies, that is to build district and national capacities for sustained health development; to strengthen the quality of preventive and curative health services; to empower families and communities for improved health and nutrition and to improve access to essential services; are also core BASICS strategies. Given the child health focus of both and the clear priorities for child health in Zambia, there is a logical coherence of vision and strategy which should be developed into a strong partnership.

APPENDIX E

NEEDS ASSESSMENT TOOLS

NEEDS ASSESSMENT TOOLS

Checklist

_____DHMO/PHMO
_____Observer
_____Date

Planning

1. During the past year, has plan of action been prepared for training of health workers?
   Y N
2. Do you have access to basic information needed to prepare a training plan?
   Y N
3. Is there an organizational chart or plan which clarifies the responsibilities of staff members and the relationships between them?
   Y N
4. Are there written technical norms for all services provided at the facility (s)?
   Y N
5. Does each staff member have a job description?
   Y N
6. Does someone in the (Unit, HC...) supervise case management at the facility (s)?
   Y N
7. Is there any coordination for ongoing child survival activities at the facility (s)?
   Y N
8. Is there a clear policy about community involvement?
   Y N
9. Does child survival activities include integration of service delivery?
   Y N
10. Are there any duplication of child survival services offered in the area?
    Y N
11. Do you have current information about the priority health needs of the population in your area?
    Y N
12. Do you have information about the ethnic composition of the area?
    Y N
13. Do you know the current levels of coverage for specific services?
    Y N
14. Is there an explicit strategy for educational activities?
    Y N
15. Do you have information about key health practices for ethnic groups of the area?

Personnel Management

1. Are there enough qualified staff available?
   Y N
2. Do opportunities exist for promotion and professional development of staff?
   Y N
3. Does the system offer adequate job security to staff?
   Y N
4. Is there good communication between staff at different levels?
   Y N
5. Do job descriptions list all types of tasks that will be required of the staff member?
   Y N
6. Are the staff members job descriptions realistic?
   Y N
7. Do supervisors develop specific work plans with their staff at regular intervals?
   Y N
8. Are salaries and benefits adequate to retain competent and well-trained staff?
   Y N
9. Is staff turnover at an acceptable level (one which does not hamper the implementation of planned activities)?
   Y N
10. Does written policies exist for:

Hours of work	Y	N
Salaries and raises	Y	N
Vacation	Y	N

11. Are clear procedures followed for:

Recruiting staff	Y	N
Selecting staff	Y	N
Promoting staff	Y	N
Disciplining staff	Y	N
Hiring staff	Y	N
Firing staff	Y	N

Financial Management

1. Is there a training program budget?
   Y N
2. Do you manage funds for training of your staff?
   Y N
3. Are the budgets used as a tool for evaluating performance on a planned vs. Actual costs basis?
   Y N

4. Do you have access to funds for programs other than training?
   Y N
5. Is sustainability considered in the financial planning process?
   Y N
6. Do you receive funds from the community?
   Y N
7. Are employees required to account for the hours they worked?
   Y N
8. Is the funding source or mix of sources reliable?
   Y N
9. Is funding adequate for the implementation of your training plan?
   Y N

Comments

_____

_____

_____

_____

Training Need Assessment: Ministry of Health, Zambia: USAID/BASICS

Equipment and supply checklist

Province_____	Date__/__/__
Facility Name_____	Facility type_____
Interviewer No._____	

Facility type: __Public __Private
__Mission __NGO
__Other:(specify)_____

Patient and worker accommodation

1.	Is there adequate seating for patients?.	Y	N
2.	Is there a desk for workers.	Y	N
3.	Is there a toilet or latrine.	Y	N
If YES:	Is it locked.	Y	N
	Is it accessible.	Y	N
	Is it clean.	Y	N
	Is it working.	Y	N
4.	Do workers greet patients as they come in. . . .	Y	N
5.	Are health information posters displayed. . . .	Y	N
	IF YES, are they written in the local language.	Y	N

Equipment and supplies

Are the following equipment and supplies present in the clinic

6.	Thermometer.		Y	N
7.	Potable water		Y	N
8.	Needles	Amount		
	Disposable. . Y N	_____		
	Reusable. . . Y N	_____		
9.	Syringes. . . Y N	_____		
10.	Weighing scale.		Y	N
	In working order?.		Y	N
11.	Watch with a second hand or other timing device. .		Y	N
12.	Steam sterilizer.		Y	N
	In working order?.		Y	N

13. Cooker or stove. . . . . Y N
In working order?. . . . . Y N

COMMENTS:

14. Refrigerator. . . . . Y N
<u>If NO, go to question 16</u>

Type: __Electric __Kerosine Condition: __Good
__Fair
__Gas __Solar __Poor

Thermometer inside?. . . . . Y N Temp:____
Temperature chart?. . . . . Y N

Freeze-watch indicator. . . . . Y N
No. of days during the last month:
Temperature recorded____
Temperature above 8C____
Temperature below OC____

15. Frozen cold packs?. . . . . Y N

16. Cold boxes. . . . . Y N
Condition: __Good
__Fair
__Poor

<u>Are the following medicines in stock?</u>

				Quantity
17.	Chloroquine tablets.	Y	N	N_____tabs
18.	Chloroquine syrup.	Y	N	N_____ml
19.	Chloroquine injectable.	Y	N	N_____amp
20.	Cotrimoxazole tablets.	Y	N	N_____tabs
21.	Cotrimoxazole syrup.	Y	N	N_____bottles
22.	Penicillin tablets.	Y	N	N_____tabs
23.	Penicillin injectable.	Y	N	N_____vials
24.	Ampicillin tablets.	Y	N	N_____tabs
25.	Ampicillin syrup.	Y	N	N_____bottles
26.	ORS.	Y	N	N_____sachets
27.	Metronidazole tablets.	Y	N	N_____tabs

28.	Vitamin A capsules.	Y	N	N_____caps
29.	Tetracycline eye ointment. . . .	Y	N	N_____tubes
30.	Iron tablets.	Y	N	N_____tabs
31.	Iron syrup.	Y	N	N_____ml
32.	Oral contraceptives.	Y	N	N_____cycles
33.	Condoms.	Y	N	N_____units

34. Are expired drugs in the clinic. . . . . Y N
IF YES, which ones_____

Are the following vaccines in stock?

35.	OPV.	Y	N	N____Doses
36.	DPT.	Y	N	N____Doses
37.	BCG.	Y	N	N____Doses
38.	Measles.	Y	N	N___Doses
39.	Tetanus Toxoid (TT).	Y	N	N____Doses

40. Are expired vaccines in the fridge?. . Y N
IF YES, which ones_____

41. Are frozen vials of DPT or TT in fridge? Y N

Documentation and record keeping

Are the following items present in the clinic?

42.	Immunization register.	Y	N
	If **YES**, is it up to date?.	Y	N
43.	A stock of vaccination cards.	Y	N
44.	A stock of TT cards.	Y	N
45.	Notifiable disease report forms. . . .	Y	N
46.	Is a patient register kept.	Y	N
	If **YES**, is it up to date.	Y	N
47.	No. of patents seen in last month_____		
48.	Average No. of patents seen per day_____		
49.	Are immunization tally sheets kept. . .	Y	N

END OF EQUIPMENT AND SUPPLY CHECKLIST

Training Need Assessment: Ministry of Health, Zambia: USAID/BASICS

Health Care Worker Interview

Province_____	Date__/__/__
Facility Name_____	Facility type_____
Interviewer No._____	

Introduce yourself to the health care worker. Tell him/her that you would like to ask him/her some general questions about the clinic followed by some questions about his/her job.

1. What are the hours of operation at this clinic?
   opening____ closing____ **Total number of hours**_____
2. How many outreach posts does this clinic operate?_____
3. How many days per month does each outreach post operate?___

4. Is this facility connected to electricity?. . . . . Y N
5. If yes, how many hours per day. . . ___
6. Is there a functioning stand-by generator?. . . . . Y N

7. How often have you had a rupture of stock in the last 1 month?

Item	Number of stock-outs/1 mo.
Vaccines	
Syringes/needles	
ORS	
Drugs	
Cards/forms	

8. How are supplies received? __Delivered to facility
   __Picked up from a central store

9. What is the **most common** cause of a delay in delivery of supplies?
   __Inadequate transport/fuel __Difficulty ordering
   __Insufficient staff __Other:(specify)_____

10. What is your job title?

__Doctor __Registered nurse
__Health assistant __War surgeon
__Dresser __Midwife
__Bare-foot doctor __Other (specify)_____

11. What education have you had?

__No formal education __Primary school
__Secondary school __University
__Diploma __Other:(specify)_____

12. Do speak English? Y N
Do you read English Y N

13. How long have you had this job?

__<6 months __6-11 months
__12-23 months __2-4 years
__5 or more years

14. Do you have written guidelines for your work?..... Y N

If YES, can we see them? __Available __Unavailable

15. Do you have a schedule for supervisory visits?..... Y N

16. Who usually supervises you?

__Doctor __Registered nurse
__Advanced Dresser __Midwife
__Health assistant __Community health supervisor
__No supervisor

<u>If NO SUPERVISOR, skip to question 21</u>

17. How many times have you had a visit from a supervisor:

Supervisor works here and sees worker daily__

In the last six months __(number of times)
In the last 12 months __(number of times)

18. What did your supervisor do last time they supervised you? (**Tick all that apply**)

__Observed immunization technique
__Observed management of sick children
__Reviewed reports prepared by health worker
__Updated health worker on current information
__Discussed problems with supplies and equipment
__Other (specify)_____

19. Did you receive feedback from that supervisory session?. . . . . Y N

IF YES, in what form __Written report
__Oral report
__Other (specify)_____

20. What does your supervisor do to keep your technical skills up to date? (**Tick all that apply**)

__Workshops
__Performance feedback
__Training sessions
__Other (specify)_____

21. Do you have to submit any reports such as the number of patients seen, or the number of doses of vaccine administered?. . . . . Y N

<u>If NO, go to question 24</u>
IF YES, ask the **TYPE** of report, **HOW OFTEN** and if the reports are **UP TO DATE**?

Type of report	**How often/year**	**Up to date?**
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N

22. How do you use the information collected in these reports to help you with your job?

__Ordering stock __Assessing targets
__Doesn't use info. __Doesn't know
__Other:(specify)_____

23. What type of feedback do you get from these reports?

__None __Oral discussion
__Written report __Other (specify)_____

24. What are the most difficult problems that you face in doing your job? (**Tick all that apply**)
__Lack of training
__Mothers don't bring children to clinic
__Staff shortages
__Lack of supplies and/or stock
__Lack of supervision
__Lack of feedback on performance
__Inadequate transport
__Other:(specify)_____

25. Have you discussed these problems with your supervisor?. . . . . Y N

26. How many training sessions have you received in the last 6 months ____
How many training sessions have you received in the last 12 months?____

Apart from yourself, how many health workers working in this facility have received training in the last:
6 months? ____
12 months?____

27. If training **was** received, what was it in_____

Did your last training involve clinical practice?. . . . Y N

Comments

_____
_____
_____
_____

28. In this clinic, at what ages do you give: (**age in MONTHS**)

	First	Second	Third	Fourth
DPT				
Polio				
BCG				
Measles				

29. To whom do you give tetanus toxoid? (**Tick all that apply**)

__ Women of childbearing age (15-49) who come for care themselves
__ Women of childbearing age who bring their children for immunizations or treatment
__ Don't know

30. What days are the following immunizations given?
(**circle days for each vaccine**)

Number of immunization days/week

Measles		M	T W	T	F	Sa	__
BCG	M	T	W	T	F	Sa	__
DPT	M	T	W	T	F	Sa	__
Polio	M	T	W	T	F	Sa	__
TT	M	T	W	T	F	Sa	__

31. Do you have an antenatal clinic?. . . . . Y N

IF **YES**, on what days is the clinic held (circle days)

Number of clinic days/week

M T W T F Sa __

IF **NO**, why are clinics not held? (**Tick all that apply**)

__No training __No staff
__No space available __No supplies
__People do not want this service __Don't know

32. Please tell me all the things you would do for a child with fever in this clinic (**tick all responses mentioned**)

__Determine temperature
__Give paracetamol
__Give tepid bath in clinic
__Give chloroquine injection
__Give chloroquine syrup or tablets
__Admit to hospital or health center
__Give antibiotic syrup or tablets
__Instruct mother to give tepid bath at home
__Tell mother to bring the child back if worse
__Assess immunization status
__Immunize the child if needed
__Refer to another facility if very ill
__Give antibiotic injection
__Other(specify)_____

33. Please tell me the things you would do to treat a child with diarrhea in this clinic. (**tick all responses mentioned**)

__Weigh the child on admission
__Give ORS
__Instruct the mother to give ORS at home
__Instruct the mother to give lafa at home
__Instruct the mother to continue feeding the child
__Instruct the mother to bring the child back if worse
__Weigh the child at discharge
__Assess immunization status
__Give an anti-diarrheal medicine
__Immunize the child if needed
__Instruct the mother to give more fluids
__Admit to hospital or health center
__Other:(specify)_____

34. Please tell me all the things you would do to treat a child with pneumonia in this clinic? (**tick all responses mentioned**)

__Give the child an IM antibiotic
__Give the child an oral antibiotic
__Admit to hospital or health center
__Treat the child at home and see every day
__Instruct the mother to bring the child back if worse
__Instruct the mother to give more fluids
__Instruct the mother to continue feeding the child
__Assess immunization status
__Immunize the child if needed
__Refer to another facility if very ill
__Other (specify))_____

35. Please tell me the signs that would make you refer a child to a hospital? (**tick all that apply)**

__Child is drowsy/abnormally sleepy/unconscious
__Child has had convulsions
__Child is not eating or drinking
__Child has not responded to usual treatment
__Child looks very unwell
__Child has a very high fever
__Other:(specify)_____

36. Have you ever wanted to refer a child to hospital but been unable to do so?
. . . . . Y N
If **YES**, why could you not refer the child?(**Tick all that apply**)

__Hospital too far
__No transport available
__No fuel available
__Mother/parents refused to go
__Parents didn't have enough money
__Other (specify)_____

37. If a ten month old child comes to the clinic who is hot to the touch, has diarrhea, and has received no immunizations, what would you do? (**tick all responses mentioned**)

__Give BCG __Give DPT-1
__Give polio-1 __Give measles
__ Assess and treat the fever
__ Assess and treat the diarrhea
__ Tell the mother to return for immunizations when the child is well
__ Other:(specify)_____

END OF THE HEALTH WORKER INTERVIEW

Thank the health worker for his/her cooperation and answer any questions that he/she may have about the correct recommendations for immunizations or management of sick children.

APPENDIX F

LIST OF DOCUMENTS

List of documents

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