

REPORT ON
TRAINING HEALTH CENTER ASSESSMENT
ETHIOPIA PUBLIC HEALTH TRAINING INITIATIVE
OCTOBER 17 – NOVEMBER 2, 2004

1.0 BACKGROUND.

Universities collaborating in the EPHTI have come to consensus in the past year that the important area of practical training for health center team students requires critical study and strengthening in the near future. Particular attention needs to be given to role models in the health centers, quality of health service activities, abilities to do effective outreach functions and activities to be performed with the new Health Extension Package. The rapid expansion of university enrollments has significantly increased requirements for practical training facilities, supervisory staff, and transportation. Most observers of health centers used for training in different parts of the country agree that many health centers do not meet standard requirements for effective training.

It is well established that close collaboration between universities, regional health bureaus and local Woreda/district health offices and urban capacity building offices is essential to create and maintain adequate learning environments.

2.0 GOALS AND OBJECTIVES;

2.1 The main goal of this consultative process was to make accurate, detailed observations of physical facilities, staffing, and service programs in health centers used for training by health science faculties.

2.2 A second primary goal was to learn how Training Health Centers (THCs), Woreda (district) Health Offices (WHOs), urban capacity building departments, Zonal health departments, Regional Health Bureaus (RHBs) and university leaders communicate about issues relating to health center team training.

2.3 Top priority and general equipment needs were listed using the MOH standard as reference in the process of discussions with staff at health centers, woreda health offices, zonal health departments, and regional health bureaus. (“A Standard Health Center with Five Satellite Community Health Posts” MOH, Addis Ababa, January, 1996.)

3.0 STRATEGIES AND METHODS.

3.1 TEAM MEMBERS.

Three teams were assembled consisting of national and international experts with experience working with health centers in developing countries. In addition to national and international experts, each team was joined by two senior teaching staff members from the university where the assessment was carried out. (See Annex 1)

3.2 VISITS MADE.

Each team visited two universities for four to six days at each site. One team traveled to Alemaya University and Jimma University. Another went to Debu University, Addis Ababa University and the Defense University College. A third team did assessments at the University of Gondar and Mekelle University.

3.3 MEETINGS.

At each site teams met with university officials, regional and/or zonal health authorities, district/Woreda health office staff, and teaching/supervisory staff concerned with health center training. Teams met university and MOH leaders both at the beginning of visits and the end to debrief concerned individuals when possible.

3.4 HEALTH CENTER/WOREDA HEALTH OFFICE VISITS.

Teams met with health center and district staff at each site who had been informed of the visits in advance. Team members met with staff members most concerned with specific facilities and functions after an initial brief overview visit to the health center campus. All teams used a standardized “check list” of useful information to obtain. Much additional data were gathered.

3.5 MODEL HEALTH COMMUNITIES.

Teams visited at least two model health villages at each university where students had conducted baseline surveys and began doing community based programs in the past year. These communities had been designated “models” under a Packard Foundation program to essential family planning and other reproductive health practices into rural households and communities.

3.6 HEALTH EXTENSION PACKAGE.

The assessment teams regularly asked health center members and district health office staff about plans for the Health Extension Package to be inaugurated nationwide in January 2005.

4.0 FINDINGS.

4.1 UNIVERSITIES.

All universities visited were highly hospitable, and provided time and transportation for the assessment teams. All high level officials expressed keen interest and commitment to improving practical learning environments in all ways possible.

4.2 REGIONAL HEALTH BUREAUS.

A significant range of collaboration between universities and Regional Health Bureaus (RHBs) was observed. Some have frequent communication and work toward specifically agreed upon goals. A few have recently begun new joint programs that involve services and professional training of health center teams.

4.3 ZONAL HEALTH OFFICES.

In some areas Zonal health offices serve as liaison and coordination bodies in times of health emergencies such as drought relief or malaria epidemics, but in others have been phased out. Zonal staff were positive and helpful when present.

4.4 WOREDA/DISTRICT HEALTH OFFICES.

Staff were consistently informative and helpful. Often they did not have appropriately trained leadership; especially noteworthy were absence of health officers (who are specifically prepared for administrative roles). Needs for office equipment were almost always present. Relationships with THC staff are usually close and effective when the WHO offices are on the same campus as the THCs. The new government organization which establishes “Capacity Building Offices” in larger towns with a “Health Desk”, leaves some THCs without direct access to administrative support.

4.5 TRAINING HEALTH CENTERS.

THC staffing patterns were usually adequate, but often showed signs of low morale and motivation, including rapid turnover and unwillingness to participate in expected activities without additional financial rewards. Very few have any in-service training programs. None had any EPHTI learning materials available. No THCs had functional libraries except in those associated with Jimma University. Many THCs had been given irrelevant specialty medical books which were unused and taking up valuable storage space.

Most THCs offered the usual services at the health centers themselves. None were functioning near capacity. Practically no outreach services are conducted other than immunization activities at a few sites in neighboring villages. Occasionally health education and family planning are included. The only exception was in Tigray where effective outreach activities are standard parts of health center programs. All technical staff are expected to make weekly visits to 20 to 30 households as part of their normal duties.

Nearly all health centers have acute needs for diagnostic, laboratory, obstetric and surgical equipment. Most HCs had neither space nor adequate equipment for emergency obstetrical or surgical care. A few new health centers do have space and some equipment for emergency care, but none were functional due to lack of trained personnel, especially trained health officers and nurses. The exception was Tigray where 10 health officers have been trained for doing Caesarian sections though none are functioning yet.

All THCs lacked appropriate cleanliness and sanitary conditions to some degree. Many do not have piped water available in clinical and laboratory settings. Dangerous medical waste including needles and syringes are almost never properly disposed of. Some latrines were full and require pumping. Very few are adequately maintained. Placental disposal is often faulty. The general environment provides negative examples for personal and environmental hygiene for patients and their families.

Physical facilities of health centers are commonly in disrepair and in severe need of structural repair, cleaning and painting. Exceptions are those built recently. Only Jimma and Gondar had living facilities for students. Almost none had residences for service staff (the exception was in the Afar region quite near to Mekelle).

4.6 MODEL HEALTH COMMUNITIES.

Assessment teams visited rural “model health communities”. These are in early stages of development with baseline studies just completed and a few health activities started by students in the past year. Unfortunately they are mostly ten to fifteen kilometers from the THCs and almost always require vehicles to reach them. None are located near enough to be reached by normal walking either by students or service staff of the THC.

4.7 HEALTH EXTENSION PACKAGE (HEP)

All Woreda Health Office staff interviewed were well informed about the launching of the HEP in their areas. They reported on how many health posts are available and plans for building more by community organizations. They are preparing for carrying out administrative functions with the new program. Few health center staff were conscious of this major new program. Some had heard about the HEP but were not clear about any role, if any health centers will have in implementation.

4.8 LENGTH OF PRACTICAL TRAINING.

Some health officers were asked whether the amount of time of eight (8) weeks for training in health centers is sufficient for students to learn essential skills. There was strong opinion expressed that the four months originally given for THC training was much better and even that was not sufficient.

5.0 DISCUSSION.

5.1 UNIVERSITIES.

University staffs seem to have increasing awareness of the importance of practical training in health professional development. Needs to share resources in order for students to obtain minimal essential training are becoming more clear. In some settings it may be necessary for universities to take initiative and leadership.

5.2 REGIONAL HEALTH BUREAUS.

The advantages of close collaboration with universities seems very clear in some RHBs such as in the Amhara Region where Gondar is situated and where recent contracts have been signed for joint operation of new post-basic health officer training. The expected roles of health centers to play in the future, especially in relationship with the new Health Extension Package needs to be clarified and with particular reference to in-service training and technical support.

5.3 WOREDA HEALTH OFFICES.

These administrative organizations have important roles in development of the HEP and other district (Woreda) health services. Their relationships to the THCs need further definition with regard to the types of practical training that students should receive. Relationships when the closest administrative center is in an urban “capacity building office” also need to be worked out.

5.4 TRAINING HEALTH CENTERS.

There is no question that THCs require significant strengthening in a wide variety of ways ranging from new equipment to additional facilities for doing emergency obstetrical care. It seems that universities need to be active leaders in this enhancement process.

More clarification is needed regarding the future roles that health centers will be expected to play within the health service system. Will they primarily be places for curative services, or will preventive and promotional health activities still have essential roles to play? Are outreach activities into surrounding communities still considered important for significant changes in health behavior?

5.5 MODEL HEALTH COMMUNITIES.

This effort to provide students with opportunities to provide family planning services and other essential reproductive health care at home and community levels has been slow to develop. Partially this has been due to unexpected conditions such as the drought emergency. However it seems likely that the low priority previously given to practical training has prevented the program to make significant progress. Collaboration of students with the HEP in reproductive health might be a useful direction to consider. Identifying model communities that are being used for immunization (EPI) sites within walking distance THCs might be added as model health communities.

5.6 HEALTH EXTENSION PACKAGE.

This new large-scale commitment of the Federal government to household based health care provides significant opportunities. Faculties of health sciences may be able to train health professionals for strategic roles in health improvement for under-served populations. Particular attention seems warranted to training students in supportive supervision and provision of effective in-service training.

5.7 LENGTH OF PRACTICAL TRAINING TIME.

It is clear to many observers and graduates that the time allowed for practical training in health centers is seriously deficient. Particularly since health providers are the key actors in vital life, health and death processes, sufficient time should be given so all graduates meet essential minimum standards in skill competencies. Many unnecessary deaths and disabilities will take place unless adequate time is allotted. Overall effectiveness will be diminished unless significantly more time is built into the curriculum.

The problem of insufficient time for practical learning arises from several causes. Many teaching staff in universities do not fully recognize that *practical abilities* to accomplish health tasks is the most important requirement in training health professionals in their pre-service education and training. Some academic teachers believe that cognitive theoretical knowledge is sufficient. Other faculty members try to get more classroom teaching time because they want to defend and expand their academic "territory". All of these factors work to continually decrease time for practical training.

6.0 SUGGESTIONS AND RECOMMENDATIONS.

6.1 HEALTH CENTER STAFF PERFORMANCE.

Nearly all health centers express desires for more in-service training (IST). Intensive weekly IST programs should be planned for all technical staff for a year in advance. Members of the resident service staff should be responsible for implementation with assistance in planning and TOT programs conducted by regional universities. Short courses and workshops in topics such as HIV/AIDS management, program administration and supervision, monitoring and evaluation, mentoring and training, essential nutritional actions and family planning should be conducted on a systematic basis. Intensive training for selected health center staff in such areas as emergency surgical and obstetric care should be planned to staff more distant and isolated health centers such as Debarq in Amhara and Atsbi in Tigray.

6.2 HEALTH CENTER FACILITIES.

Many THCs urgently need maintenance and repair in such areas as cleaning and painting, plumbing repairs for clinical work areas, and repair of cracked walls. Weekly grounds cleanup “campaigns” by concerted effort of all staff would make significant improvements. Many incinerators for disposing of dangerous biological waste need repair. Placenta disposal needs upgrading. Maintenance of latrines requires regular attention as a teaching opportunity for patients and their families as well as basic hygiene. Perhaps universities could provide essential skilled maintenance workers if materials were available from other sources.

Detailed lists of priority needs for equipment needs have been prepared for all facilities visited which were compared with the MOH standard equipment lists (as stated above, 2.3). Reports of the Assessment teams for the respective THCs are and universities are attached (Annex 3). All THCs need to be provided with basic tools for environmental work. Some frequently required items include diagnostic tools such as stethoscopes and ophthalmoscopes, autoclaves, and motorbicycles. Microscopes are frequently non-functional due to difficulty of getting repairs.

Many of the older training health centers need expanded space for services such as laboratories, libraries and upgrading of emergency Caesarian section operations. As no space is allotted for environmental workshops in any THC, it is necessary that facilities be made available for basic training. Many THCs without student dormitories would be greatly benefited if student dormitories were constructed. As numbers are increasing, additional student space is needed even where some facilities already exist.

6.3 EXPANDING SUPERVISORY STAFF CAPACITIES.

High priority should be given to increasing the numbers and competencies of supervisory staff for students in practical training; experienced graduates from degree level programs in all categories should be recruited to join the teaching staff after at least a year or two of rural service. Perhaps a planned development scheme could be built in collaboration with the RHB whereby outstanding graduates would be employed in health centers used for training and then taken on to university staff after one or two years.

A complementary parallel approach would be to consider key health center staff as “associate” or “honorary” teaching staff with a new academic ranking system. These

staff would receive the benefits of intensive professional development with IST and other planned short courses and workshops as well as the respect and acceptance as recognized teaching staff. A third pathway would be to offer “Joint” or “Dual” academic appointments to essential part time teaching staff who work in MOH, RHB, zonal or Woreda health departments. This avenue will soon be implemented with governmental policy support. It would be highly beneficial if financial compensation were also made available.

6.4 INCREASING PRACTICAL TRAINING TIME.

Every possible effort should be given to expanding curriculum time devoted to practical training in pre-service programs of the health center teams. While the government policy allows only three academic years for baccalaureate degrees, there are some options that universities can exploit. The most readily applicable way seems to be using the academic (“kremt”) vacation times either for practical or classroom teaching. Weather conditions may influence schedules in some parts of the country. Perhaps shifting classroom and community based training could be arranged.

6.5 HEALTH CENTER OUTREACH PROGRAMS

Since effective preventive and promotional health services require activities by all categories of health personnel outside of the health center walls, it would be highly desirable for outreach programs to be expanded and integrated with the new Health Extension Program (HEP). All technical staff of the health centers and Woreda health offices should have 20 to 30 households for which they are responsible to visit weekly to promote the HEP (as is the current practice in Tigray). Outreach sites should be attended by at least two different categories of staff so that an essential package of preventive services could be offered on a regular basis e.g. immunization, family planning, growth monitoring, environmental health and health education.

6.6 HEALTH EXTENSION PACKAGE PROGRAMS

The new HEP programs offer highly significant opportunities for health science faculties to collaborate and contribute substantially to expanding modern health care to the entire population. Baccalaureate graduates will soon hold leadership posts at the health center and woreda health office levels. Practical training at health centers should include exposure and other experiences with HEP for students soon to graduate. They may be able to participate in in-service training in the health centers and Woreda health offices on a monthly basis when HEWs come for salary and other administrative matters. Degree students might go to nearby outreach visits with HEWs and collaborate in local household health activities.

6.7 MODEL HEALTH COMMUNITIES

The “Model health communities” with reproductive health foci being developed with EPHTI assistance could provide an excellent connection and context for health center team students learning the elements of the Health Extension Package. These communities should be located close enough to THCs so students and supervisors would be able to walk to them, (e.g. 3 to 5 kms). This would also allow service staff to continue interaction in the community when students are not present.

6.8 UNIVERSITY AND REGIONAL HEALTH BUREAU COLLABORATION

The many mutual benefits of close collaboration between can be observed in several settings that the teams visited. Provision of short and long-term training of essential health personnel is a strength of universities. RHBs are able to provide critically necessary resources in program and health facility development. The RHBs and Woreda health offices can contribute in maintaining personnel and programs at high standards. “Joint” or “Associate” appointments can also benefit all concerned.

6.9 ACTION PLANS

Though time was very limited, specialized task groups of the Assessment teams developed draft “Plans of Action” for the coming six (6) months to strengthen practical training in health centers (Annex 2). These activities were planned with the understanding that the essential resources are immediately available and plans could be implemented with no or little additional external costs. These will be discussed with authorities and colleagues with the view to rapid action. Achievements will add to current momentum.

6.10 COMMUNICATION/DIFFUSION

Since the benefits of improved practical training will be shared by many kinds of beneficiaries it will be necessary to inform and gain support from a variety of sources. Officials and professional staff of the Ministries of Education and Health, the Universities and Regional Health Bureaus, and Woreda health offices will be informed about the outcome of the Assessment and documents distributed as soon as possible on an urgent basis.

7.0 ANNEXES

7.1 LIST OF TEAM MEMBERS

Team	Members	Sites	Dates	Remarks
A	1. Dr Don Belcher 2. Dr Kinfе Gebeyehu 3. Dr Fantaye Mekbib 4. Ato Gebre Emanuel Teka 5. Dr Hailu Yeneneh 6. Ato Lemessa Oljira (Alemaya University) 7. Ato Negga Baraki (Alemaya University) 8. Dr Ayalew Tegegn (Jimma University) 9. Dr Meseret Yazachew (Jimma University)	1. Alemaya	October 20 -24	Back to Addis from Gondar on Oct 19
		2. Jimma	October 26-30	To AA on Oct 25, to Jimma on 26
B	1. Dr T/Mariam Ayele 2. Dr Troy Jacobs 3. Ato Assefa Bulcha 4. Dr. Yirgu G/Hiwot (Addis Ababa University) 5. Dr Fikru Tesfaye (Addis Ababa University) 6. Ato Dereje Abebe (Debub University) 7. Ato Tariku Lambiyo (Debub University)	1. Defense /AAU-MF	October 20-22	Back to Addis from Gondar on Oct 19
		2. Awassa	October 23-29	By car to Awassa on Oct 24; back to Addis on Oct 30
C	1. Dr Dennis Carlson 2. Ato Kebede Faris 3. Ms Julia Norem 4. Dr Nap Hosang 5. Ato Amsalu Feleke (Gondar University) 6. Ato Melkie Idris (Gondar University) 7. Dr Gebrezgi Gidey (Mekelle University) 8. Ato Araya Abraha (Mekelle University)	1. Gondar	October 18-22	Stay behind in Gondar after “Piloting”
		2. Mekelle	October 25-29	To Addis on Oct 23 and to Mekelle on Oct 24 Back to Addis on Oct 30

7.2 6-MONTH ACTION PLAN (as of November 2004)

Programs/Issues	List of Actions	Accountable	Time	Indicators
1. Clean up THC environment-now in bad shape	-Regular cleaning -Schedule sanitation campaigns -Planned maintenance	-THC Team -Universities	Immediate except maintenance that could take 6 months	-Clean compound -Clean THC buildings
2. Environmental Health workshops in THCs-neglected	-Workshop established; tools available -Work schedule in place with appropriate and timely maintenance	-Universities -THC environmental health technicians	Immediate	Functioning EH workshop
3. Standard protocols for quality control of water, food/milk & cottage industries-neglected	-List daily duties to support clean working environment -In-service training -Preparation of standards	-Universities & THCs -THC Management	Six months	-Protocols available -Staff trained in QC -QC implemented
4. Outreach activities-only EPI and some satellite OPDs; others neglected	-Draw effective plan -Secure transportation or plan sites within walking distance -Mobilize resources for outreach	-THCs & universities jointly -Woreda health offices -Communities	-Before deploying students -Immediate	-Comprehensive outreach programs in place -Planned activities implemented
5. The Health Extension Package (poor awareness among THC staff and other partners)	-Clarify relationship with woreda health offices, THCs and role of universities -Raise awareness of THC staff and others -Provide technical support	-Universities -Woreda health offices	Within 3 months	HEP made clear through awareness raising and communication
6. Reproductive Health (poorly equipped; inadequate supplies & contraceptives); no RH references	-Collaborate with local partners (NGOs) to get contraceptive in THCs and outreach -Train providers -Make references available	-Universities -Woreda health offices & THCs -Regional health bureaus -The Carter Center/EPHTI	Within 6 months	-Availability and mix of contraceptives -EPHTI modules & lecture notes on RH available in THCs
7. Management of THCs (lacking strong leadership; no staff)	-Identify competent leaders & role models for students -Undertake joint meetings and share	-Universities and Woreda health offices -Universities, THCs &	-In 6 months -Immediate	-Role models identified and proved -Responsibilities defined

<p>motivation; poor coordination; inadequate supervision; inadequate equipment supplies and poor maintenance)</p>	<p>responsibilities -Have staff motivation mechanisms in place (top up, part-time pays, joint appointment of THC staff) -Develop clear supervision guideline and checklists -Procure essential items -Plan preventive maintenance/repair and implement accordingly</p>	<p>Woreda health offices -RHB, woreda & THC and universities -University (supervisors) -THCs, woreda & THC -THCs & universities</p>	<p>-Immediate -In 6 months -In 6 months</p>	<p>-Incentives in place; interview & observation proves effect -Guideline & checklist in place -Essential items procured -Maintenance done</p>
<p>8. Laboratories (inadequate space; poor organization; inadequate equipment and supplies/reagents; poor maintenance)</p>	<p>-Negotiating with THCs for space -Reorganize labs for effective function (guidelines on proper waste disposal; procedures; color plates; quality control; staff training-refresher) -Procure some equipment/supplies & reagents to support service and training (e.g. at BSc in Lab) -Timely maintenance of equipment; THC staff trained to do so</p>	<p>-Universities -THCs & universities -THCs & woredas; also universities -*ESTC/THCs & RHBs; also university maintenance crew</p>	<p>-Immediate -In 2 months -In 6 months -In 6 months</p>	<p>-Adequate lab space -Lab reorganized, clean, informative -Satisfactory equipment & supply/reagents available -THC staff trained in preventive maintenance; equipment repaired in time</p>
<p>9. Information System (poor recording, reporting and presentation of data; data not used for planning)</p>	<p>-Revitalize good recording & reporting -Encourage & assist in data presentation -Assist in use of data for planning interventions -Give on-the job training</p>	<p>-THCs, woredas and university supervisory staff -Universities -Universities -Universities/ESTC</p>	<p>-Immediate -Immediate -Immediate -In 6 months</p>	<p>-Good recording & reporting in place -THCs activities planned based on data generated -# Of staff trained</p>

*ESTC: Ethiopian Science & Technology Commission (maintains equipment & trains staff at subsidized cost).