CAPACITY BUILDING FOR HEALTH EDUCATION IN MALAWI

Student Number: 11311
The Module Number: TROP 942
2011-2012

This dissertation has been submitted in partial fulfilment of the requirements for the award of Master in Tropical and Infectious diseases.

Word count: 14.307
“Save Africa through Africans”

St Daniele Comboni
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Acknowledgement

I would also like to thank Helen Bromley, whom I met only few months ago and was an important guidance into the new world of qualitative research. Thanks also to Viv Kimance and all the people from Registry, always ready to assist us for each and every difficulties we faced.

My sincere thanks must also go to all people at Lighthouse Trust for the warm welcome and the help given at every stage of my field research. A special thanks goes the Director Dr. Sam Phiri and the Training Officer, Sam Zimba, who guided me over the time I was there. I would like also to thanks Helen, who patiently helped me in organizing the appointment for the interviews, and Wingston Ng’ambi, who instructed me about the LH training Database.

Many thanks to all of my colleagues from all the different Masters. It was a wonderful experience to share with them the successes and difficulties of this year. “Muchas gracias” to Rosauro, who shared with me this Malawian experience.

Thanks to my family, that like always showed an infinite support and total trust in me. Thanks also because in a so special moment of my life, you are like always caring and helping me without asking nothing back.

Finally, but most important, thanks to “my husband to be”, Fabio. This year wouldn’t be possible without his love, help and encouragement.
EXECUTIVE SUMMARY

Background
The health system in Malawi is facing a deep-rooted crisis. In those settings, the lack of skilled and motivated healthcare workers compromises the quality and effectiveness of the health system. Higher educational programmes, such as Continuing Development Education, have been recognised essential to maintain and improve the knowledge, skills and performance of HCWs and therefore to contribute to the improvement of the service. The recent literature emphasized that to develop human, institutional and societal capacities, it is crucial to create, implement and sustain efficient strategies to strengthen the health system.

Aim and objectives
This study aimed to conduct an assessment of capacity building in post graduate health education in Malawi. The three main objectives are:

1. To assess the existing capacity at individual and institutional level
2. To identify capacity needs from the point of view of individuals and from the one of the institutions
3. To use a CPD course to evaluate the capacity of local organisations to deliver such a course, and to explore participants satisfaction concerning the fulfilment of the capacity needs

Methods
Qualitative method was used in this study. Data collection was conducted through in-depth interviews with Health Care Workers (18) and with Key Informants for the most important institutions involved in CPD provision in Malawi (8). Interviewing health workers and stakeholders allows to examine the capacity building process at different levels: individual (health workers) and institutional (stakeholders) – both equally important in the process. Data analysis was carried out using the thematic framework approach.
Result

The current CPD system is not well perceived and seems to be too prescriptive, especially, for cadres under the nurses council. In contrast, stakeholders do not appear aware of that. CPD provision in Malawi has to face several challenges. The lack of an evaluation system and the insufficient funding – the latter resulting in a lack of infrastructure and equipment –, were hereby identified as major issues. Moreover, the HR shortage causes an inadequate number of facilitators, and affects health workers' schedule. It implies that the time caregivers use for learning is subtracted to their working hours. That is likely to compromise service delivery. Furthermore, stakeholders considered distance learning a valid alternative to traditional learning. Nevertheless, both stakeholders and health staff recognized some existing challenges: lack of access to computers and to the Internet, absence of competencies computer knowledge, and unstable electricity supply. At last, the pilot CPD had a positive outcome for both groups. Participants appreciated the content and the teaching strategies used.

Conclusion

It is crucial that health workers are properly informed on the importance, meaning and rules of CPD. Clear career paths have to be established to motivate HCWs and improve their performances. Moreover, concerted efforts are needed to create more opportunities for a continuous education and training, relevant to the needs of local workforce. Although distance learning programmes have a great potentiality, at the moment several are the constraints that limit their applicability in Malawi. Nonetheless, an adequate planning might overcome those issues in the future. Lastly, LH showed to have commitment and capability to effectively provide in-service training.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHWO</td>
<td>Africa Health Workforce Observatory</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>COs</td>
<td>Clinical Officers</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>FDG</td>
<td>Focus Discussion Group</td>
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<tr>
<td>HBC</td>
<td>Home Based Care</td>
</tr>
<tr>
<td>HCWs</td>
<td>Health Care Workers</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Test and Counselling</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and communications technology</td>
</tr>
<tr>
<td>JLI</td>
<td>Joint Learning Initiative</td>
</tr>
<tr>
<td>KCH</td>
<td>Kamuzu Central Hospital</td>
</tr>
<tr>
<td>LH</td>
<td>Lighthouse Trust</td>
</tr>
<tr>
<td>MCM</td>
<td>Medical Council of Malawi</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MPC</td>
<td>Martin Preuss Center</td>
</tr>
<tr>
<td>MPC</td>
<td>Martin Preuss Centre</td>
</tr>
<tr>
<td>NMCM</td>
<td>Nurses and Midwives Council of Malawi</td>
</tr>
<tr>
<td>UNC</td>
<td>University of North Carolina</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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CHAPTER 1
INTRODUCTION AND RATIONALE

“Africa’s main resource to carry it through the next millennium will be its human resources”
(Economic Commission for Africa [ECA], 2000)

1.1 HEALTH SYSTEM EFFICACY AND HR RESOURCES

A health system is defined as the “organizations, resources and people whose primary purpose is to promote, restore or maintain health” (WHO, 2007). An effective health system is the one in which each one of those three elements – organisation, resources and people – works properly and efficiently, both on its own and in synergy with the other two (WHO, 2007) (Fig.1.1).

![Diagram of factors influencing the realization of an efficient and effective Health System](image-url)

Fig.1.1 Factors influencing the realization of an efficient and effective Health System
The lack of skilled, competent and motivated healthcare workers severely compromises the quality and effectiveness of health service delivery, especially in developing countries (Awases, 2004, WHO, 2006 and JLI 2004). This shortage has been, in fact, identified as one of major constraint to the achievement of the three health-related MDGs (Millenium Development Goals) (WHO, 2006, Adegoke AA and van den Broek N, 2009, Palmer 2006).

1.2 IMPORTANCE OF POST-GRADUATE EDUCATION

Higher educational programmes are vital not only for the political and social development of a country, but also for the growth of an effective health system (Bates, 2006). Among those programmes, Continuing Professional Development (CPD) holds an important role to improve health workforce’s performance. “Continuity” is in fact recognized as “one of most relevant organizing principles” for clinical education (Hirsh, 2007).

CPD defines all the educational activities that contribute to maintain, develop and increase the knowledge and skills of health staff (Beshyah, 2012). Therefore, CPD contributes to build the capacity of the health care workforce (Nabwera, 2008). Additionally, “

The World Bank (2000) emphasized that post graduate education promotes the acquirement of “relevant skills”, necessary to create high qualified professionals in different sectors and, at the same time, the development of “enlightened leaders”. Both competent workers and leaders will be consequently responsible for the identification and the solution of local problems.
1.3 ROLE OF CAPACITY BUILDING IN DEVELOPING COUNTRIES

During the “Regional Conference on brain drain and capacity building in Africa”, a group of policymakers from 29 different African countries emphasized that Africa’s main resorts for the future lie in its human resources. They also highlighted the necessity to properly implement capacity building in order to strengthen both individuals and organisations. Moreover, “Revitalisation of Africa’s higher educational system” was considered a crucial and challenging aspect to take in account to build, strengthen and maintain capabilities in Africa. (ECA, 2000).


1.4 MALAWI: HR CRISIS AND NEED TO BUILD CAPACITY

The crisis of health workers is recognised in Malawi as an acute problem. It has been acknowledged as one of the major constraints to the public health service of the country (McAuliffe, 2009; Palmer, 2006 and Mueller 2011). UNDP (2010) emphasized that in order to face the existing wide-ranging crisis in developing countries, it is crucial to develop human, institutional and societal capacities.

This process of building capacity remains a long term, dynamic and phased process (Bates, 2011), whose first step is to assess existing capacity and identify the local capacity needs.
Therefore, the purpose of this research is to conduct an assessment of capacity building for post graduate health education in Malawi.

It will focus on the assessment of existing capacity and of the capacity needs, from the perspective of both health workers and managers, and members of different medical institutions. Interviewing health workers and the main stakeholders, involved in postgraduate education allows to examine the capacity building process at two different levels: individual (health workers) and organisational (stakeholders) – both equally important in the process. The last objective uses a pilot CPD course – delivered in partnership with LSTM – to investigate whether the local organisation has the capacity to deliver such a course and to see if that meets the capacity needs of the health workers.
This literature review aims to provide an overview about the current knowledge on capacity building and its main approaches in developing countries. Then it will summarize the existing literature about the HR crisis, especially in Malawi, exploring the causes of this crisis and the potential factors that could mitigate it. Eventually, a section will be dedicated to review and critically appraise the literature about the role and importance of Continuing Professional Development.

2.1 CAPACITY BUILDING

The recent literature emphasized that to develop human, institutional and societal capacities is crucial to strengthen the health system and to reach the MDGs. These capabilities should support a sustainable and long-term development, based on home-grown strategies generated and managed by those who will benefit from them (Lansang and Dennis, 2005, Milèn, 2001 and World Bank, 2005).

2.1.1 Definitions

The concept of capacity building received increasing attention over the last two decades. Milèn, in a document for WHO (2001), defined capacity as “the
ability of individuals, organizations or systems to perform appropriate functions effectively, efficiently and sustainably” and capacity building as “the process of strengthening of abilities to perform core functions, solve problems, define and achieve objectives and understand and deal with development needs”. In a more recent document, UNDP (2009) combines these two definitions, describing capacity development as a long-term “process through which individuals, organizations and societies obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time”.

2.1.2 The multilevel approach

The effectiveness of any capacity building efforts as well as how the capabilities are utilized is influenced by the external context (i.e. rules within an organisation or policies of a country and so on). Therefore, the process of Building Capacity has to act not only at individual level, but also at higher levels (Milèn, 2001, UNDP, 2010 and World Bank, 2005).

The most recent and used classification of these levels is proposed by UNDP, which recognizes three of them (2010): the “individual level”, the “organisational level” and a wider one, known as “enabling environment”. The first refers to capacity building at the level of single individuals, in order to improve skills and knowledge and therefore performances of the workers. In the “organisational level” different groups of individuals may work together within organisation with proper rules or procedures. In this case, capacity building is related to all the necessary capabilities needed to shape those rules and processes that allow the efficient functioning of the organisation. Eventually, the “enabling environment” refers to the social system within which individuals and organizations work. These three dimensions influence each other. The strength of a single level is determined and influenced, at the same time, by the strength of the other two.

Previously, different classifications of these levels were proposed (see table 2.1). Although there is agreement on the two lower levels of the system
(organisation and individual level), what UNDP calls “enabling environment” has been in the past defined with different terms. The World Bank (2005) and Kostello (1998), used the expression “institutional level”, whereas Hildebrand and Grindle (data extrapolate from Milèn [2001]), divided the concept of “enabling environment” in 3 different dimensions:

1. The action environment (the economic, social and political context in which governments act),
2. The Institutional context of public sector (related to the rule and processes present in the public sector)
3. The task network (that refers to those organisations and institutions related to a specific task).

There are some differences in those classification systems. However, the need for actions at different levels to build capacity successfully is similar in all of them.

<table>
<thead>
<tr>
<th>CAPACITY BUILDING DIMENSIONS</th>
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<tbody>
<tr>
<td>UNDP, 2010</td>
</tr>
<tr>
<td>Enabling environment</td>
</tr>
<tr>
<td>WORLD BANK, 2005 Kostellos, 1998</td>
</tr>
<tr>
<td>Institution</td>
</tr>
<tr>
<td>Hilderbrand and Grindle, 1998</td>
</tr>
<tr>
<td>Action environment</td>
</tr>
</tbody>
</table>

Table 2.1 Different interpretations of levels in Capacity Building. The data are extrapolate from a document of WHO (Milen, 2001).
2.1.3 Phased process

Capacity building in developing countries is a long, dynamic and diverse process. According to Milen (2001), this process has three phases:

1. **Assessing existing capacity and identifying the local capacity needs.** The author underlined that, at this stage, an important aspect is the early involvement of stakeholders. That approach helps to define correctly the capacity needs, and to set the right objectives for that specific setting.

2. **Developing and testing a strategy for capacity building.** In this phase, for example, a pilot project can be started to test and verify capabilities.

3. **Implementation and monitoring:** in this phase the project is gradually implemented and a system for monitor and evaluation is created.

Later on, UNDP (2010) proposes a circular model of capacity development with 5 elements: the engagement of the stakeholders and the assessment of capacity needs and existing capacity, followed by the formulation of a capacity development propose. That will be then implemented and evaluated (Fig. 2.1).

![Capacity Building Cycle](source:UNDP, 2010, page 21)
Although the number of phases is formally different in the two models, the differences are few. The first two UNPD stages are equivalent to the first step identified by Milèn, and both the models proposed a phase of implementation followed by a phase of evaluation (Table 2.2).

<table>
<thead>
<tr>
<th>Phased Approach</th>
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<tbody>
<tr>
<td><strong>Milèn, 2001</strong></td>
</tr>
<tr>
<td>Assessing existing capacity and</td>
</tr>
<tr>
<td>identifying the local capacity</td>
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<tr>
<td>needs</td>
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<tr>
<td>Developing and testing a</td>
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<tr>
<td>strategy for capacity building</td>
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<tr>
<td>Implementation and monitoring:</td>
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<tr>
<td><strong>UND, 2010</strong></td>
</tr>
<tr>
<td>Engage stakeholders</td>
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<td>Assess capacity needs and</td>
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<tr>
<td>Existing capacity</td>
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<td>Formulate a capacity</td>
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<tr>
<td>development propose</td>
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<tr>
<td>Implement the propose</td>
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<tr>
<td>Evaluate the Capacity</td>
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<tr>
<td>development propose</td>
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</tbody>
</table>

Table 2.2 Different interpretations of the Phased approach to Capacity Building.

### 2.1.4 Sustainability

The final goal of capacity building is to enable organisations and individuals, as well as societies, to be adaptable and to solve problems, in order to achieve sustainability (Bates, 2011).

The strengthening of existing processes is a key element to reach sustainability (Bates, 2011 and World Bank, 2005). It refers to the necessity of building capacity on what is already in place (i.e. local resources and structures). Once again, the importance of an early stakeholders’ engagement is pointed out as crucial to avoid unnecessary replications, and to assure that a valid, useful and sustainable project will be implemented.

Eventually, a genuine partnerships must be achieved. The cooperation between donors and beneficiaries must be ruled by common aims, sharing comparable vision, equal responsibilities and obligations. In any case, the ownership of the project has to be of the local partner (Milèn, 2001).
2.2 HR CRISIS IN DEVELOPING WORLD


This crisis has two main dimensions: the actual shortage in number, and the poor HCWs’ satisfaction, that impacts negatively on service delivery (Fig.2.2).

The first one is due to several causes: the inadequate number of practitioners produced by training institutions; the migration abroad of health professionals; the deployment to private sector; and the premature death of HCWs (due mainly to HIV epidemic) (Dambisya, 2007 and Awases, 2004). Moreover, the HCWs are often poorly distributed between different regions, and the most severe shortage is observed in rural area.

On the other side, workers often experience low salaries, poor working conditions, lack of defined career paths and poor quality education. All those aspects contribute to reduce their job satisfaction causing in this way a negative impact on the service delivery (Nabwera, 2008 and Awases, 2004).
Fig. 2.2 Roots of the HR crisis in developing world
2.3 HR CRISIS IN MALAWI

Malawi is one of the poorest countries in southeastern Africa: an estimation of the National Statistical Office of Malawi (2008) showed that 53% of Malawians live below the poverty line, while life expectancy is around 50s (World Bank, 2010). In addition to this, Malawi is facing a serious human resources crisis within the health sector. According to a recent report (Africa Health Workforce Observatory [AHWO], 2009), in 2008 there were 20,908 health workers, including 2,739 non-medical professions (mainly administrative and supportive staff). Excluding these, the number of health workers results per 1,000 population to be 1.39, significantly lower than 2.5 per 1,000 population identified as minimum to reach the MDGs (AHWO, 2009). Such a crisis impacts brutally on service delivery in this country (McAuliffe, 2009; Palmer, 2006 and Mueller 2011).

As shown in table 2.3, the migration of health personnel abroad, or from public to private sector, is univocally recognised as the main causes of the HR crisis in Malawi. Other commonly accepted causes of such a shortage are the increased mortality due to the HIV epidemic and the low output of practitioners from the main medical and paramedical school. In this regards, in a study about the prospective of the Malawian parliamentarians about the HR crisis in Malawi, the author reported as the shortage may be linked to the lack of interest among school leavers towards health professions (Muula, 2006). Few authors, also, pointed out as the lack of a proper HR strategy is one of the causes of that crisis (Manafa, 2009 and Palmer, 2006).

A growing literature is trying to identify the reasons connected to the migration of the health personnel, and to suggest possible answers able to mitigate these issues.
<table>
<thead>
<tr>
<th>Reference and topic of the article</th>
<th>HR CRISIS CAUSES</th>
<th>CONCLUSIONS AND RECOMMENDATION</th>
</tr>
</thead>
</table>
| Bradley and McAuliffe , 2009 HR Crisis in Malawi (especially in Obstetric care) | MIGRATION OF HCWS  
- Poor management and supervision  
- Lack of training and of career path  
- In-service training not recognised or rewarded | Needs to motivated HCWs, among the possible methods the cited the use of CPD as non-financial incentive, but also improve skills and performance |
| Palmer, 2006 HR crisis in Malawi | POVERTY AS MAIN ROOT  
HIV EPIDEMIC  
MIGRATION OF HCWS  
- Low pay  
- Inequitable access to training  
- Reduced Job Satisfaction | Needs to improve training capacity in Malawi  
Needs to improve capacity within the MOH’s planning and development |
| McAuliffe , 2009 Work-environment of the middle level provider in Malawi | MIGRATION OF HCWS | Important to think about job satisfaction and work performance (especially for lower cadres) |
| Manafa, 2009 Retention of HCWs in Malawi | ABSENCE OF A HR STRATEGIES  
MIGRATION OF HCWS | Need to address education and training and career development of the employees  
Needs to address relevant needs of the workers |
| Muula, 2006 HR shortage from the point of view of the parliamentarians | HIV EPIDEMICS  
LACK OF INTEREST FOR MEDICAL SCHOOLS (AMONG SCHOOL LEAVERS)  
MIGRATION OF HCWS:  
- Poor remuneration  
- Lack of possibility of higher academic recognition | Utilization of lower cadres (Task shifting)  
Needs for trainers (able to train |
| Muula and Maseko 2005 Survival and retention strategy for HCWs | ILLNESS (HIV EPIDEMICS)  
INADEQUATE NUMBERS OF HCWS PRODUCED BY TRAINING INSTITUTIONS  
MIGRATION OF HCWS  
- Overwhelming responsibility of HCW  
- Lack of access to further training  
- Low salary  
- Low recognition of expertise | Among the recommendation:  
Improve the general working conditions  
Provision of specialist training  
Encourage the establishment of specialist and other training locally to enable HCWs to gain higher qualifications within the country |
| Dambisya, 2007 A review for non-financial incentives for HCWs retention (with Malawi situational analysis) | ILLNESS (HIV EPIDEMICS)  
LOW OUT-PUT OF MEDICAL SCHOOLS  
MIGRATION OF HCWS  
- Poor working condition  
- Non conducive working environment  
- Lack of opportunity for CPD and career development | Among the recommendation:  
Increase access to relevant trainings |

Table 2.3 HR crisis in Malawi. Summary of the available evidence.
Among those, the provision of a well-functioning Continuing Medical Education (CPD) was identified as a promising solution. This non-financial incentive may improve satisfaction of HCWs, enhancing at the same time their skills and performances (Bradley and McAuliffe, 2009 and Dambisya, 2007). In addition, Manafa and Colleagues (2009), identified training as an important incentive to reduce the outflow of professionals.

According to Muula and Maseko (2005), the “overwhelming responsibility” experienced by HCWs (often beyond their training level), and the limited access to training are some of the challenges faced by HCWs in Malawi. Among the numerous recommendations, the authors suggested that the provision of specialist training at local level might enable HCWs to gain higher qualifications within the country. That is supposed to reduce the migration.

To tackle all these issues and consequently to improve satisfaction of HCWs, is crucial to reduce brain drain, deployment to private sector and early retirement in Malawi.

2.4 CONTINUING PROFESSIONAL DEVELOPMENT

CPD includes a wide range of activities: official ones as for example short courses, workshops and conferences; less structured activities as ground rounds, case discussions; other processes as audit and feedback (Forsetlund, 2009).

All those activities aim to develop and increase knowledge, skills, attitude and professional performance of the health personnel (Beshyah, 2012, Mansouri and Lockyer, 2007). They constitute an occasion to improve the personal knowledge, and to maintain those skills learnt during school. Continuing education leads also to the acquisition of new relevant skills (e.g. new techniques or innovative treatment) so that a more efficient job can be
performed. Therefore, CPD is an ethical duty and an individual responsibility of any healthcare workers (Beshyah, 2012).

**2.4.1 Impact on clinical practice**

Different researchers have tried lately to establish the actual impact of CPD on staff’s skills, knowledge, and on clinical practice. Recent reviews reported only a modest effect on clinical practice’s or patient outcomes’ improvement (Mansouri and Lockyer, 2007, Forsetlund, 2009 and Marinopoulos, 2007). However, two of these reviews (Mansouri and Lockyer, 2007 and Marinopoulos, 2007) demonstrated that CPD appears to be effective in both acquiring and retention of HCWs’ knowledge, skills and behaviours.

Several factors seem to influence the effectiveness of CPD activities. Among those: interactive courses, multiple approaches, multiple exposures, and small group activities (Mansouri and Lockyer, 2007, Forsetlund, 2009, Marinopoulos, 2007 and Nartker, 2010). Moreover, the choice of topics relevant for HCWs’ daily practice was found fundamental to improve the real healthcare outcome (Nartker, 2010, Mazmanian 2002 and Shojania, 2012).

**2.4.2 CPD in developing countries**

Many are the challenges related to the implementation of a CPD program in the developing countries, where CPD is a relatively new concept. Also when applied, most of the HCWs are unfamiliar with it (Shojania, 2012). The mandatory participations is not fully accepted from workers, and it is often felt as punitive. In addition the difficulties in the measurement of the real outcomes of CPD and its related costs are recognised as crucial challenges for its implementation (De Villiers, 2008). Finally, the shortage of staff, and the consequent HCWs’ work overload, reduce considerably the time for learning (De Villiers, 2006).
In a recent review about the mechanisms to improve retention and reduce brain drain, continuing education has been acknowledged as a motivational factor for healthcare workers to stay in the job (Willis-Shattuck, 2008). In rural settings, CPD “alleviates professional isolation” so that job satisfaction might be positively influenced (Nartker, 2010).

2.4.3 CPD in Malawi

CPD is a relatively new concept in Malawi. The Medical Council launched the CPD program on the 1st of May 2008. All the cadres enrolled with them were supposed to cumulate 50 points every year in order to get their licenses (Kavinya, 2008). During the time of the research, the system changed and the number of points was scaled down from 50 to 30 credits per year. Non-compliant workers can keep their registration, but they are fined with a monetary punishment the first year, and cautioned by the board the following year. The practitioners in rural areas gets twice the points than the ones in urban settings.

The Nurses and Midwives Council (NMCM) implemented the CPD program only two years ago. Thirty points per year are required in order to become eligible for registration and obtain a license to practice. Besides, all nurses and midwives are supposed to create a “learning action plan” and identify their own learning needs for each year. The activities that aware points are published in a CPD Guidebook for Nurses and Midwives that contains the information needed to understand the CPD programme and the requirements for re-registration with the Council. All the activities and the corresponding number of points gained are illustrated in the guide book for the practitioners.
2.4.4 Distance learning

Distance learning is defined as a kind of learning in which the teacher and learner are in physically separate locations. The learning process occurs through print-based, computer-based (e-learning), or internet-based (on-line) distance learning. The use of these new methodologies has been recently suggested as a valid alternative to traditional training. This is particularly true in developing countries, where the challenges above mentioned hamper the progress of CPD and training in general (Nartker, 2010 and Alexander, 2009). In fact, distance learning may reduce the absenteeism from work, allowing practitioners to attend the needed training. That helps HCWs to improve their skills, knowledge and job satisfaction, without compromising service delivery (Nartker, 2010).

Nartker and colleagues, in their study about distance learning methods used in Tanzania, emphasised that the main benefits of this method, compared with the traditional teaching strategies, are: reduction of absences from work place, due to the more flexibility of the schedule; decreased indirect cost for the learners (that could learn from home); the use of innovative and engaging methods. Some constraints were also highlighted: limited access to computers; limited computer skills of workers; inadequate infrastructure; and unreliable electricity coverage.

However – though distant learning is widely recognised as a valid opportunity for CPD and seems to be effective in improving skills and knowledge of HCWs –, there is a lack of consistency in the studies comparing it to more traditional courses (Nartker, 2010). Moreover, in a recent meta-analysis, all the internet-based learning methods were associated with large positive effects if compared with no intervention. When compared with traditional intervention (face-to-face) the results were heterogeneous with general small effects comparable to traditional methods. Further research are therefore needed (Cook, 2008).
CHAPTER 3
SETTING

3.1 STUDY SITE

The field research was conducted in Lilongwe during a period of 8 weeks, from the 15th of June to the 10th of July 2012.

The researcher worked in collaboration with The Lighthouse Trust that is one of the largest HIV service provider in Malawi. It is a charitable local organisation that functions as a part of the public health sector (Phiri et al, 2004). It operates since 2001 offering to clients HIV testing and counselling, and a variety of other clinical services as: free ART for eligible patients; follow-up and treatment for opportunistic infections for all the clients. Lighthouse Trust’s mission is “to fight against HIV and AIDS in Malawi by providing a continuum of quality care and support and by building capacity in the health sector”.

In the context of Building Capacity for the health sector, Lighthouse is actively involved in training, supervision and mentoring of heath care workers in Malawi, especially in the regions close to Lilongwe’s area.

3.2 PILOT CPD COURSE

A pilot CPD course was delivered on the 9th and on the 10th of June 2012. The topic of the course was “Professional conduct and work ethics”. Such a content was chosen by the assistant director of the medical council, in response to the needs of
clinical officers and nurses, following a team visit of the LSTM education department and Lighthouse Trust to the Medical council, in November 2011.

The main learning outcome was to make participating nurses and clinical officers able to:

1. Explain the need to maintain good practice by undertaking regular CPD
2. Recognise and work within the limits of their own professional competence
3. Identify the rights, duties and obligations for health care professionals
4. Identify when to take prompt actions regarding professional or ethical concerns

The course was mainly conducted inside the Lighthouse Trust’s facilities, although the Saturday afternoon session took place in the IT laboratory of Kamuzu Central Hospital (KCH). The participants (nurses and clinical officers [COs]) were selected by LH training department and by the Director of Kamuzu Central Hospital, according to availability of the health care workers and to specific needs for such a training. The researcher had no influence on the selection of the participants.

The CPD was structured as following (a more detailed outline of the course is reported in Appendix 1):

1. Welcome, registration and introduction to the programme. During this part participants were asked to write their expectation for the 2-day course.
2. CPD in the context of professional practice. In small groups, nurses and clinical officers were asked to explain the meaning of CPD; how it may help them in their career; and what were the CPD topics they were more interested in. The group work was followed by a general discussion with the facilitators.
3. Introduction to professional conduct, work ethics and personal competence. In this session of the programme, participants broke into groups and discussed an ethics scenario per group. Afterwards, a class discussion followed.
4. IT task – KCH IT laboratory. Participants went to KCH laboratory where they had occasion to use computers and the memory stick
given to them at the beginning of the course, and to read some articles about ethical conduct in Malawi (Muula, 2004 and ). After the IT task, participants came back to class where we briefly discussed their experience of it.

5. Review of day 1.

6. Introduction to rights and responsibilities of health care professionals. working in groups, participants reflected about “the rights” and “the responsibilities” of health care workers. Each group then fed back the results of their discussions and a discussion followed.

7. Course evaluation and close.
CHAPTER 4
METHODS

4.1. AIM AND OBJECTIVES

The aim of this research is to conduct an assessment of capacity building for postgraduate health education in Malawi. Three objectives have been identified to achieve this purpose:

1. To assess the existing capacity from the point of view of individuals and from the one of the institutions
2. To identify capacity needs from the perspective of the actors involved (health workers on one side and managers and members of different health organizations on the other)
3. To use a CPD course to evaluate the capacity of local organisations to deliver such a course and to explore participants satisfaction concerning fulfilment of capacity needs

4.2. STUDY DESIGN

To achieve the objectives mentioned in the previous section, a qualitative research methods were used. According to Malterud (2001), the purpose of qualitative research is to “investigate the meaning of social phenomena as experienced by people themselves”. In this study, qualitative tools have been used in order to study and explore post graduate health education in Malawi through an in-depth understanding of
personal experiences, views and opinions of the actual participants to CPD trainings (HCWs), and of the people involved in the development of those activities (Stakeholders).

With regard to the first objective, a quantitative approach will be also used. Information about the number of health care workers trained at Lighthouse and their demographics have been collected regularly since 2008 in a training database. The analysis of such a database contributes to define the “existing capacity” of HCWs. On the other side, it is a trustful indicator of Lighthouse Trust’s capabilities in deliver training (objective 1 and 3).

Table 4.1 displays the objectives and main methods followed to achieve them. It also explains the rational for behind this choice.
### Table 4.1 Research Objectives, Methods and Justifications.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Methods</th>
<th>Rational</th>
</tr>
</thead>
<tbody>
<tr>
<td>To assess the existing capacity</td>
<td>At individual level</td>
<td>In-depth interviews with HCWs</td>
</tr>
<tr>
<td></td>
<td>At institutional level</td>
<td>In-depth interviews with Stakeholder from the most important medical institutions Analysis of the training database of LH</td>
</tr>
<tr>
<td>To identify capacity needs</td>
<td>At individual level</td>
<td>In-depth interviews with HCWs</td>
</tr>
<tr>
<td></td>
<td>At institutional level</td>
<td>In-depth interviews with Stakeholder form the most important medical institutions</td>
</tr>
<tr>
<td>To use a CPD course: to evaluate the capacity of local organisations to deliver such a course and to explore participants satisfaction concerning fulfilment of capacity needs</td>
<td>In-depth interviews with Stakeholders from Lighthouse Trust and the LH facilitator of the CPD course</td>
<td>To explore their experience in the process of planning and delivering the CPD course and their perception about their capacity in the delivery of such a course</td>
</tr>
<tr>
<td></td>
<td>FGDs with all the participants to the CPD</td>
<td>To explore common feelings about the experience they shared and to highlight interactions and relationship between these two cadres The issues raised during the FGD were followed up with in-depth interviews, to gain a more detailed understanding of personal views about the CPD course, especially the teaching methods and fulfilment of perceived needs.</td>
</tr>
<tr>
<td></td>
<td>In-depth interviews with HCWs who took part to the CPD course</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unstructured observation during the CPD course and LH Meetings</td>
<td></td>
</tr>
</tbody>
</table>
4.3. PARTICIPANTS AND SAMPLING

Literature shows capacity building as a multi-dimensional process involving not only single individuals, but also interlinked levels (Milèn, 2001). As people act in a wide environment, in fact, also organizational and system levels must be taken into account (UNDP, 2010). Thus, all the objectives will be examined considering the points of view of the two different classes of participants involved: Malawian Nurses and Clinical Officers (Health workers), and members of relevant Malawian medical organizations (Stakeholders).

Ritchie and Lewis (2003, pages 77-78) describe a purposive sampling as a methods of sampling able to ensure that all essential elements of the discussion topic are covered, also allowing the inclusion of some element of diversities.

**Stakeholders:** A purposive sampling was used to select key informants of the most important medical institutions involved in training. Key Informants are defined as people that “as a result of their personal skills, or position within a society, are able to provide more information and a deeper insight into what is going on around them” (Marshall, 1996). In the current research, their expertise and their institutional role made them a valuable source of information about post graduate health education in Malawi. The administration office of Lighthouse Trust helped to contact the stakeholder and to schedule the appointment.

**HCWs:** The main selection criterion of the HCWs was the participation in the pilot CPD course delivered in partnership with LSTM. As previously mentioned, the researcher did not have any role in the selection of these practitioners. All the participants to the CPD course took part in the two FGDs; whereas, a purposive sampling was used to identify nurses and clinical officers for in-depth interviews. The criteria selected for the recruitment of the interviewees were the following:

1. Cadres (to ensure that both Nurses and Clinical Officers were equally represented)
2. Gender (to ensure that both sex were represented)
3. Sending Institution (to ensure that the nurses and COs were from different employer)
Qualitative research has a tendency to use small samples, in order to collect in-depth data to form hypotheses (Miles & Huberman, 1994). The total number of participants was 26: 8 were stakeholders and 18 HCWs. All the 8 stakeholders were interviewed. Among the HCWs, 17 took part to in the 2 FGDs and 9 of those were also interviewed. In addition, also the LH facilitator of the CPD course was included among the interviewees. The participants to be interviewed were chosen as diverse as possible within the pull of the CPD participants in order to capture the wider range of perspectives and enrich the collected data (Tuckett, 2004).

4.4. DATA COLLECTION

4.4.1. An overview

Data were collected through in-depth interviews with stakeholders and HCWs and through FGDs with HCWs. Both, interviews and FGDs were conducted in English directly by the researcher itself. A word for word transcription followed. Topic guides for the FGDs, for stakeholder’s interviews and for HCWs’ interviews were developed to provide a flexible outline, in order to guide the collection of information, assuring at the same time that all the key issues and the subtopics relative to the research were explored (Appendix 2).

The development of topic guides enhanced consistency in the data collection and ensured that all the relevant issues were covered. However, considering the iterative nature of the research process, the topic guides were adapted and slightly modified after that the early interviews were conducted. The key themes of the topic guides were identified both on the basis of the objectives, but also through the themes emerged in the literature review.

Moreover, a log diary was kept over the full time of the research. All the relevant observations and information after each interviews and group discussions were write down on a notebook. Moreover, annotations were collected during the CPD course and during other unstructured moment and daily activity of LH personnel.
4.4.2. FDGs with HCWs

Two FGDs were facilitated with the participants to the CPD-course. The number of participants to each FGD was between 8 and 10 (Powell and Single, 1996); both took place in the same day after the CPD course in the LH classroom.

This qualitative collection tool was chosen in order to capture the attitudes and the needs of the health care workers (Kitzinger, 1995). Besides, according to Wong (2008), focus groups for HCWs can be used to explore issues related to the development of strategies for the improvement of the medical education and professional development.

Although FGDs are usually as homogenous as possible, in this research we aim to capture a wide diversity of views of HCWs in general and not of a specific cadre (Tuckett, 2004). So the members of each FDG were heterogeneous for what concerns sex, cadres (Nurse and Clinical Officers) and sending institutions. Efforts were made to ensure that the groups were balanced in terms of gender and sending institutions.

4.4.3. Interviews with HCWs

The information collected during the FGDs were analysed and an initial interpretations was done. The emerging themes were followed up in the in-depth interviews with some of the HCWs who took part to the CPD pilot. Through open ended questions the researcher aimed to allow the participants to express freely their own ideas, without any fear for judgment from others. If needed, probing questions and prompting questions were used to obtain a deeper understanding about their perspective.

As it appeared that no new information was emerging from the data, the researcher is confident that the research reached the saturation point.

4.4.4. Interviews with Stakeholders

In-depth interviews, rather than a focus groups discussion, were chosen for two main reasons:
to overcome the logistical challenge of bringing together different and busy respondents

- to obtain a detailed understanding of each stakeholders’ perspective concerning capacity buildings, existing capacity and capacity needs in general and related to their institutions (for postgraduate education).

The majority of the interviews took place in the personal office of the stakeholder at their preferred time.

Two forms of the topic guide were developed: one for the stakeholder form medical institutions not involved in the course delivery, and one for stakeholder from LH respondents who were directly involved in the delivery of the CPD course (LH Director and Training Manager).

Time and resources constraints (only one researcher) limited the number of stakeholders interviewed, therefore in this case the saturation point might not have been reached.

4.5. DATA ANALYSIS

The analysis was carried out as an on-going process, started at the beginning of data collection through an initial interpretation of the 2 FGDs, the first interviews and the field notes of the researcher (Pope et Al, 2000). The early and provisional interpretation of the data allowed key themes to emerge and helped to shape the further data collection, highlighting themes to be integrated into the topic guide and pursued in the following interviews.

“Thematic framework approach” was used to analyse the data in order to describe and interpret the respondents’ views and opinions and to ensure transparency in data analysis (Smith and Firth, 2011). After completing the collection phase, and after a period of familiarization with the data (multiple reviewing of transcripts) with the intent to identify important and recurring idea, the researcher sorted and grouped them according to similarity and common patterns that emerged from the information collected. A framework was created to guide the analysis and all the data collected
were coded and labelled according to it (Appendix 3). Thematic charts were created to show similarities and differences and to allow the investigator to make connections and inferences from the data (Appendix 4). The description of common features of themes as well as deviant cases allowed the researcher to find common patterns and linkages between the views (explanatory analysis). Finally, the findings were interpreted by relating them to other studies in order to confirm state-of-knowledge and to illuminate important findings which might fill the knowledge gaps.

4.6. TRUSTWORTHINESS

Several attempts were done to enhance credibility. Respondent validation was used to check whether the interpretation of the thought expressed by the respondent was properly captured by the researcher, but the time constraints (the mean length of the interviews was long) made it difficult; maximum attempt to make respondent validation was made (Mays and Pope, 2000). If any doubts about the interpretation raised during the analysis of the data (once the researcher was already in UK), the stakeholders and a few HCWs were contacted via email, for a further clarification. Triangulation – among interviews, FGDs and observations contained in the log diary – was used to test and confirm the information collected in order to assure the credibility of the data (Ritchie, 2003; 43).

Moreover, the maximum attempt to create a positive atmosphere and a confident environment to allow the respondents to feel comfortable and able to express fully themselves, was made; time was used at the beginning of each interview for this purpose. Furthermore during unstructured moment of the CDP course as well as in other activities of LH, the researcher spent as much time as possible with HCWs and with the staff, in order to get their trust and to capture as more information as possible.

The original data was available throughout the process of analysis in digital form, to allow continuous checking of the data. The moderator listened again and again the audio recordings and ensured that the transcripts contained all the relevant
information. Only minor discrepancies were noted and the adequate corrections were made.

The entire process of data collection and analysis has been open and can be clearly exposed, as much as possible, in order to provide a clear account of the process used.

As said above the saturation point has been reached for the topics concerning the HCWs, but probably this is not the case for the stakeholder’s ones.

Eventually, the log book (also by the interviews’ schedule diary) helped to keep the research on track and to allow a proper and efficient data management. This process increased confirmability (Shenton, 2004).

4.7. ETHICAL CONSIDERATION

Informed consent: The purpose of the interview and study was explained to both health professionals and key informant, and informed written consent was obtained from all participants (Appendix 5).

Confidentiality of training database data: the researcher had asked and had been granted the permission to analyse and to use the data contained in Lighthouse Trust’s database by Lighthouse Trust’s Director. Prior to analysing the data, personal identifiers such as names were removed.

Confidentiality and Privacy during interviews: the interviews with stakeholder were conducted in their personal office, whereas the interviews with HCWs were mainly conducted in the library or in the classroom of LH, when those facilities were not used by anyone else.

Confidentiality during presentation of the data: to ensure that confidentiality was not compromised the following step was adopted: where participant’s identifiers that accompany each quote (i.e. sex, age, organisation etc). may have compromised the participant’s anonymity, they were removed.
Ethical Review: Ethical clearance for the research was obtained from the Liverpool School of Tropical Medicine Research Ethics Committee and Malawi National Health Science Research (ANNEX 6 and 7).
CHAPTER 5

RESULTS

5.1 AN OVERVIEW

This chapter presents the findings of this study, starting with the results of the analysis of the Lighthouse’s database. The findings related to the characteristics of the participants follow. Thereafter, the qualitative findings will be reported in accordance with the themes and sub-themes.

5.2 TRAINING DATABASE

Lighthouse collected data about their trainings over the 4.5 years. Data was recorded in 4 different formats (Annex 8):

1. Training design registration form
2. Session registration form
3. Training participant registration form
4. Training facilitator registration form

Data of forms 1 to 3 were already entered into a Microsoft Office Access Database, form 4 data were not entered. Due to the complexity of the electronic structure in use, the data from forms 1-3 were extracted from the database by a data officer from LH, following the researcher’s indications. The researcher entered the information of form 4 into an Excel spread sheet and then analysed.
5.2.1. Training Sessions

LH conducted 153 training sessions over a period of 4 and half years. Among those, 107 were conducted for HCWs (2 events per month). The remaining training sessions were conducted mainly for patients, their treatment supporters and volunteers.

The figure 5.1 summarizes the number of trainings delivered per each year.

![Fig. 5.1 Number of training sessions per year. In yellow are reported the sessions for HCWs and in green the ones for volunteers and guardians. For 2012, the number of trainings refers only to the sessions held up to May.](image)

LH designed 63 trainings in the following areas:

1. Clinical content (mainly HIV and Internal Medicine)
2. Facilitation Skills
3. Managerial Skills
4. Counselling and HIV Test and Counselling (HTC)
5. Home Base Care (HBC)
6. Other trainings

Several trainings had on or more refresher courses repeated afterwards. Therefore, the total amount of training sessions delivered is higher than the number of the designed ones.
All of them except one were classified as “didactic training” (lecture and seminar). One was a “clinical training” with trainer’s facility attachment (HBC Nurse Certification).

Lighthouse facilities hosted 150 of these sessions; the remaining 3 were held in two health centres (Kawale and Area 25).

5.2.2. Trainees

A total of 697 HCWs attended at least one training session. Table 5.1 shows the number of persons trained per year. The sum of all the trainees per year is more than the total number of trainees: often the same HCW attended more than one training sessions per year, with a mean of 7 training sessions per person. Table number 5.2 summarises the participants characteristics. The age of the participants was calculated from the age of the attendee at the time of his/her first session.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF TRAINEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>796</td>
</tr>
<tr>
<td>2009</td>
<td>1266</td>
</tr>
<tr>
<td>2010</td>
<td>715</td>
</tr>
<tr>
<td>2011</td>
<td>1310</td>
</tr>
<tr>
<td>2012</td>
<td>737</td>
</tr>
</tbody>
</table>

Table 5.1 Numbers of HCWs trained per year

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL NUMBER</td>
<td>331</td>
<td>366</td>
</tr>
<tr>
<td>MEAN AGE</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>MAXIMUM AGE</td>
<td>75</td>
<td>74</td>
</tr>
<tr>
<td>MINIMUM AGE</td>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 5.2 Characteristics of the participants
HCWs are “all people primarily engaged in actions with the primary intent of enhancing health” (WHO, 2006). Specifically, the workers were grouped according to 9 professions:

1. Nurse-Midwife
2. Medical Doctor
3. Clinical officer
4. Health surveillance assistant
5. Patient attendant
6. Lab technician
7. Counsellor
8. Medical assistant
9. Pharmacy technician

Nurses are the cadres most commonly trained, followed by Counsellors and Clinical officers (Fig. 5.2).

![Fig. 5.2 Distribution of the trainees according to their professional role](image)

The trainees who attended any of the LH training sessions were employers of different institutions (fig. 5.3), mainly Ministry of Health (MOH), LH itself and Christian Health Association of Malawi (CHAM).
Facilitators

The total number of facilitators is 74 (although the researcher has been told that there were a not known number of missing forms). These 74 facilitators were responsible for all the 153 trainings session conducted (for HCWs, and for patients and volunteers). Many of those facilitators have conducted more than one training session. The trainers were mainly from LH (34 from LH-KCH and 6 from MPC [Martin Prusse Center]) and from MOH (18). The remaining were from different institutions (Malawi Aids Counseling and Resource Organisation [MACRO], Medecins Sans Frontieres [MSF], UNC-project and others). Among the trainers from LH, 28 were involved mainly in the training of volunteers and patients, the remaining 12 in training of HCWs.

All the lecturers were Malawian except for one, who was from Nigeria.

Forty facilitators were men (54%). On average, men were younger than women (37 vs. 43 years). The qualifications of the trainers is reported in Figure 5.4. The most represented are nurse-midwife and counsellors. Seventeen of the facilitator had no medical qualifications. Those were mainly Community Care Supporters or Community Development Supporters.
5.3 CHARACTERISTIC OF THE PARTICIPANTS

The total number of participants was 26: eight were stakeholders (2 women and 6 men) and 18 HCWs (6 men and 12 women).

Key informants from the main medical institutions involved in HCWs training in Malawi were interviewed: MOH (one from HIV Department, one from TB Control programme and one from Reproductive Health Department [RHD]), Malawi College of Medicine (one), Medical Council (one), Nurses and Midwifery council (one) and Lighthouse Trust (two).

The health workers were from 3 different institutions: Lighthouse, Kamuzu Central Hospital (KCH) and Bawaila District Hospital. Besides, the HCWs from LH, came from two different centres: Lighthouse Clinic at KCH and Martin Preuss Centre (MPC) at the Bwaila district hospital. Table 5.3 shows HCWs’ characteristics.
### Table 5.3: Characteristics of participants.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>SENDING INSTITUTION</th>
<th>TOTAL</th>
<th>FEMALE</th>
<th>MALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>NURSE</td>
<td>CLINICAL OFFICER</td>
</tr>
<tr>
<td>FGDS</td>
<td>All Institutions</td>
<td>17</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>LH</td>
<td>8</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MPC</td>
<td>5</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other*</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>INTERVIEWS</td>
<td></td>
<td>10</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>LH</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MPC</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other**</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

* 1 CO was from DHO, 1 CO from KCH, 2 Nurses from KCH
** 1 CO from DHO, 1 Nurse from KCH

The results, coming from interviews and FGDs (HCWs), or from interviews only (key-informants) are presented together; both different opinions and shared themes emerged, are highlighted further in this chapter.

### 5.4 CPD: OPINIONS AND VIEWS OF STAKEHOLDERS AND HEALTH CARE WORKERS

All the stakeholders agreed that CPD is an opportunity for practitioners, not only to improve their skills and knowledge, but also to keep them up-to-date with the new trends and procedures that characterized medical profession. Furthermore, they agreed that the CPD ultimate goal is not knowledge for its sake, but improving
service delivery and that knowledge gained in CPD activities should be translated into an improved quality of the service.

“It’s a key for the health workers to get in line with what happening outside, and the new things that are coming in their field of work, so they can continuing to be relevant (…), so it’s (CPD) a key thing and very important”

Stakeholder-5

“One broad goal or role would be, I think, improvement of health services (…), not only clinical skills, but also health services”

Stakeholder-1

In this regards, though all of them recognised a close relation between CPD and improvement of service delivery, some emphasised that there are no reliable measurements that could show the actual extent of that. According to them, taking part in a training does not mean understand its content, as well as being “a good student” does not always reflect in being a good practitioner. During the first FGD, HCWs agreed on a similar concept: the attendance to a workshop does mean to really participate to it and gaining knowledge from it.

“So a lot of the CPD’s that goes on, is all about health knowledge. Alright? On how to do certain things, on how to add new information that has come in. So what we do not monitor is the skills acquisition of this practitioner. Having learnt here, is he a better practitioner out there? That is not done. That’s a challenge, because you and me know that you could be a brilliant student in class but you could be a terrible practitioner.”

Stakeholder-3

“Because I can just attend, I come late just at the end of the discussion, 5 minute later on and I present my book and someone sings it. This what happen with attendance if I attend from the beginning up to the end I don't participate to it, even if I sleep for the day and at the end of the day I just present my book to be signed and
you signed but by the end of the year I might have maybe 80 or 90 points but actually I haven’t got anything. So there is no mechanism of assessing that. Is this thing working or not?”

HCW-11-CO\(^1\) (FGD1)

The perception about CPD of nurses and clinical officers changed significantly after the pilot CPD course. Before the course, HCWs viewed CPD extremely negative. They defined it as a “punishment”, as a “spy machine” (CPD course’s poster Fig. 5.5) or as a “blackmail” (HCW-15-N).

Being CPD a requisite for registration renewal, the lack of clear information about it, and the difficulty to reach the number of points needed each year, were identified as the main causes of that negative attitude. Concerns arose among the nurses, as long as no points are credited when they attend a training that is not in line with their “action plan”. HCWs also stated that they didn’t receive a proper orientation about CPD. During the FGDs, the COs stated that they found out about it from the newspapers or directly when they went for registration.

\(^1\) HCW-CO refers to a Clinical Officer, whereas HCW-N to a nurse.
“Personally myself as it was… at first when it was just introduced, I had the very same perception that it’s just a punishment that they want to put on us, because there was no sensitization on the importance of the CPD. We have never heard about it.”

HCW-2-N

“It [CPD] came in as something you have to do it, if you don’t do it you are not registered. That means you cannot more practice in the country… so it was like a punishment because the background was not always well explained.”

HCW-12-N (FGD1)

If on one side practitioners criticized strongly the CPD implementation, Stakeholders’ perception was extremely different. Most of them in fact perceived that a proper sensitization was conducted. Furthermore, some of them considered its attachment to registration as a strength. Only few had a different perceptions and stated that was not well perceived by practitioners.

“But what I like about it is that it has been attached to registration so that people should see that aahh commitment to say it is supposed to aahh to update”

“The Nurses and Midwives Council introduced CPD, they held sessions where they called all the nurse leaders from throughout the country. At that nurse leaders meeting they had launched this CPD so they were able to tell us what they were aiming through it so that people should be able to appreciate it”

Stakeholder-4

The HCWs’ opinion about CPD changed completely after the pilot, that was defined as an “eye opener” (Researcher annotation). All of them recognised that CPD is not only essential to improve skills and to keep them up-to-date, but also to deliver a quality service to patients.
“I think is a process how…I can sharpen the skills in order to provide quality care to the patient I see”

HCW-2-N

“I have learnt that it’s very important, because when we meet on CPD sessions, we remind each other some of the things which we are supposed to improve or we are supposed to do. (...) But we think these are like small or refresher courses that can promote our daily work in the department!”

HCW-4-N

Once accepted the importance of CPD, almost all the HCWs suggested that the best way to increase acceptance of CPD was to “talk with people” in order to get their point of view and explain them its real meaning and importance. Several participants also suggested that there is necessity of an evaluation system to verify “if it is really bearing fruit” (HCW-6-CO). Eventually, although none of the nurses or clinical officers were from rural areas, many of them underlined the necessity to address problems related to their colleagues of rural area. “They are forgotten” stated a nurse (HCW-7).

“…then those nurses [from Nurses Council] should plan to conduct maybe sessions for the introduction of the CPD’s, so that more of the nurses should know the importance of the CPD’s and what the importance of it and what is the reason and how it should be conducted. (...) And I believe mostly CPD’s being conducted in central hospitals, districts but we forget about our fellow nurses working in the health Centres”

HCW-4-N

The majority of workers considered CPD and the consequent skills and knowledge improvement useful to development their careers. In spite of this position, few professionals (all COs) expressed the frustration related to the lack of career progression.

“So the more you are getting knowledge the more you advance in you advance in your job”
“In this country Malawi (…) our career has no clearer pathway unlike on the nursing section whereby people can increase their professional career, but here most of the clinical officers they die clinical officer”

On stakeholders’ side, two different opinions were present. Some considered CPD as a source of new expertise and information required to improve their job and consequently their carrier; whereas others emphasised that a HCW may attend more than one training without gaining anything from it, not even a certification. Yet, some stakeholders underlined as Diploma, as well as Master Degrees are recognised and accredited with CPD points (Table 5.4).

<table>
<thead>
<tr>
<th>EXISTANCE OF LINK BETWEEN CPD AND CAREER PATH</th>
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<tbody>
<tr>
<td>“So CPD again provides an opportunity for updating yourself, but also to be in line with what the world is going around in terms of changes. So CPD provides another opportunity for people to learn new things that obviously will be required as you go further with your studies” Stakeholder-2 (when asked about the relationship between CPD and Career Path)</td>
</tr>
<tr>
<td>“CPD is indeed important for ones-career development because like here for you to develop further” Stakeholder-3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INADEQUATE CAREER PATH AS A WEAK POINT OF CPD</th>
</tr>
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<tbody>
<tr>
<td>“Not that much here in Malawi, and I think that's another challenge also, because I think people get tired to attend just 2-day course, and of course that's improving their knowledge, but then people want to have a paper that would recognize the knowledge that they have so something like an academic certificate or an academic diploma would be most ideal to most people.” Stakeholder-5, when asked about the relationship between CPD and Career Path</td>
</tr>
<tr>
<td>“The constrains and the weaknesses of such training is that it never builds you to something, that let me say, that is what you want to do. In other words, you get in-service training about TB control, the next you get training in family planning and another in-service training in something else. (…). If you could add up together, to give you something or it was organized in such a way that maybe after attending five or six of such courses you earn a certificate that you have attended this postgraduate service training, and attend this level of health services, that would be better” Stakeholder-6</td>
</tr>
</tbody>
</table>

Table 5.4: Stakeholder views about the relation between career path and CPD
5.5 EXISTING CAPACITY: HEALTH CARE WORKERS’ PERCEPTION OF THEIR JOB

All the nurses and clinicians were satisfied with their profession, especially because of the capability they have to assist and help their patients. Some nurses emphasised that their job is a vocation. Almost all of them underlined that being a good listener, together with a good attitude towards the patients are essential characteristics for a medical professional. Most of them felt confident to own those characteristics.

“I feel satisfied because I see the patients who came in very sick and now they are fine and able to go to their work, to me it is satisfaction…”

HCW-2-N

Some respondents stated that the lack of supply (drugs and laboratory tests) was a limitation to service delivery and a factor decreasing their job satisfaction.

“At this time we don’t have many drugs…so you help a patient but then maybe you are not sure, because what you could have done instead if you had resources that is not there. So sometimes you lose some confidence…”

HCW-1-CO

“To be knowledgeable”, as well as “to be up-to-date” were also considered important to deliver a good service to patients. However, several of them stated that their study skills need to be improved (“I would say I just developing my study skills now”, HCW-1-CO). The main ways to improve knowledge and skills were considered training and workshops, and consultations with more experienced colleagues. Eventually, only few named the Internet as a possible source of information. Books, aside from the personal ones, were considered difficult to access by most of them.
5.6 EXISTING CAPACITY: STAKEHOLDERS’ OPINIONS

In this section, the views of stakeholders about their own institution in terms of processes in place to deliver a CPD course, HR involved in the delivering, resources and infrastructures dedicated to in-service training, are explored.

5.6.1 Institutions and training processes

Almost all the stakeholders stated that the single institutions are responsible for the definition of the contents of the course and for the choice of the participants. A performance appraisal should guide both these processes. Some of the trainings delivered by HIV department, TB control program or RHD represent an exception, as their content was mostly chosen following new policies or guidelines.

“They (HCWs) come out in the objectives, so they, the institutions plan on what area they want to do the CPD, so the institutions they plan for the CPD…”

Stakeholder-8

All HCWs stated that usually they are chosen to attend a training (“They [the line managers] just gives us a message that maybe this weekend coming you have to attend the training” HCW-8-N). However, several workers from LH specified that they are used to do an annual appraisal to highlight their personal needs and that on the basis of those LH plans the training.

“I just wanted to say that we do need assessment. You are asked what you think are the need you have (…) so everyone can discuss individually and speak to the line-manager and tell what training you want to undergo. So when the trainings are coming, they are most of the time answering to what was found in the need assessment.”

HCW-13-N (FGD1)
5.6.2 RESOURCES FOR TRAINING

Most of the respondents, when asked about HR involved in training, referred mainly to facilitators and lecturers. Only few included the administrative and supportive staff in it. Normally institutions have their own pool of teachers, although in some cases they rely on external consultants from other countries. However, almost all the respondents emphasized that the number of lectures is generally insufficient, whilst some of them also lack of teaching skills.

“We need to have adequate teachers because they need to correspond with the numbers of students that we have (…). The human resource that are involved in delivering training aahh if we are talking about those that are delivering training in nursing schools, they actually need to be trained themselves”

Stakeholder-4

Concerning the infrastructures dedicated to training, most of the stakeholders underlined that their own institutions have a conference room, a classroom or both, with a maximum capacity of 20-30 students. In case of need, other venues (hotels or churches) were used. Yet, some of them pointed out that those may not be suitable for training delivering. Anyhow, the general opinion was that, though better than in the past, the infrastructures for training can be implemented further. The lack of available computers – especially for lower cadres – was also mentioned.

The fund for training come mainly from the government, from private donors or other partner as CDC, Global Funds and others. The general opinion was that training needs an adequate amount of money and that for a proper planning is essential to achieve sustainability.
5.7 CAPACITY BUILDING FOR CPD

5.7.1 Problems to be solved to build capacity

The main problem identified by all stakeholders was the shortage of human resources in Malawi. Investigating further this matter, two main aspects emerged: the lack of skilled facilitators (see previous paragraph) and the lack of time dedicated for training. Concerning the latter, most of the respondents agreed that the HR shortage affects the possibility of a HCW to take part to the training: when a HCW leaves to get his training, service delivery is negatively affected. Several of HCWs shared the same perspective.

<table>
<thead>
<tr>
<th>HR SHORTAGE</th>
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<tbody>
<tr>
<td>“the key aspects that one must have to build capacity in Malawi is first of all the limited resources that are available in Malawi” Stakeholder-6</td>
</tr>
<tr>
<td>“Few staff and so you have a challenge in balance this people to provide the service at the same time you need some time for them to go and attend” Stakeholder-7</td>
</tr>
<tr>
<td>NUMBERS OF FACILITATORS</td>
</tr>
<tr>
<td>“The people that are supposed to deliver the training are not available” Stakeholder-5</td>
</tr>
<tr>
<td>“We need to have adequate teachers because they need to correspond with the numbers of students that we have. Malawi generally we have a critical shortage of human resources in the hospitals” Stakeholder-4</td>
</tr>
<tr>
<td>SKILLS OF FACILITATORS</td>
</tr>
<tr>
<td>“…finding the teachers who are willing and capable to train other” Stakeholder-1</td>
</tr>
<tr>
<td>“You will be addressing issues of who is delivering this content. So the skills, skills of the lets call him a teacher or lecturer, ok?” Stakeholder-3</td>
</tr>
<tr>
<td>RESOURCES</td>
</tr>
<tr>
<td>“So funding is big problem in terms of preparations for any in service or CPD” Stakeholder-4</td>
</tr>
<tr>
<td>“And of course it means that the training has to be paid for and so the finance are not available and maybe also technology to deliver the trainings as it supposed to be delivered I think” Stakeholder-5</td>
</tr>
<tr>
<td>ACCESS IN RURAL AREA</td>
</tr>
<tr>
<td>“If you were a remote rural based practitioner, you are looking at issues of access…” (Stakeholder-3)“There are some areas (RURAL) that are really forgotten and there is a need there for CPD and it is a challenge and…” Stakeholder-8</td>
</tr>
</tbody>
</table>

Table 5.5 Main problem to solve to build Capacity for postgraduate education in Malawi
Other two problems were spotted by some respondents: the lack of resources (in terms of funds, infrastructures and new technologies) and the limited access to training for practitioners working in the rural areas (Table 5.5).

5.7.2 Objectives to target in order to build capacity for CPD

The necessity of a proper assessment, capable to identify not only what is in place, but also which needs have to be developed, was stated by almost all the respondents as an important objective to aim for. Some of them also added that a need assessment is in fact essential to develop training with relevant contents, correspondent to the needs of the health care workers (Table 5.6).

Others objectives were the need to aim for sustainability, the necessity to address rural area's issues and the need of a proper coordination and cooperation among different organisations involved in training.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>QUOTATION OF STAKEHOLDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEED ASSESSMENT</td>
<td>“You need to have the areas that health workers need to be trained in!” (Stakeholder-4)</td>
</tr>
<tr>
<td></td>
<td>“To me, I think is the identification of the learning needs that you can plan to meet the objectives of the learners, that’s to me it’s the most important, so you can do it at local level and individual level and institutional level” Stakeholder-8</td>
</tr>
<tr>
<td></td>
<td>“Define where we are doing well and where we are not doing well and what are the gaps and addressing those, because I think this is the way to look at what are the needs which are required in order for us to develop” Stakeholder-7</td>
</tr>
<tr>
<td>OTHERS</td>
<td>“By addressing CPD in the district plans, sustainability can be in a way be guaranteed…” Stakeholder-3</td>
</tr>
<tr>
<td></td>
<td>“My main concern is really developing people who should then develop infrastructure and not the other way round” Stakeholder-1</td>
</tr>
<tr>
<td></td>
<td>“I think it’s to train…first of all are the manager that have to understand what is CPD about, than the facilitator they should also understand, than the nurses, because I think there will be new people coming all the time” Stakeholder-8</td>
</tr>
</tbody>
</table>

Table 5.6: main objectives to target in order to build capacity for CPD
5.7.3 Development needs: Stakeholders’ prospective

There was wide agreement that the developments needs for healthcare workers in Malawi are many.

“Unfortunately as I pointed out in terms of the gaps, the need gaps, you go on clinical side: you have so many needs, you go to the public health aspects: again so many needs”

_Stakeholder-6_

Some of those are related to specific contents to be address in CPD activities, whereas other refers to capacity needs in terms of structures and resources. Eventually, capacity needs related to processes of the training were underlined.

The contents acknowledged were several (table 5.7). Paediatrics (bacterial pneumonia in paediatric age, malnutrition and diarrhoeal diseases) and maternal and neonatal health’s issues were the most commonly stated. Attitude was also recognised as a crucial area of need to act upon by stakeholders and also HCWs. Less specific areas were pointed out regarding public health. Only few respondents signalled organisation and management, leadership and financial management as possible area of major need, aside from general issues.

Research methodology was also recognised as an area of need, only one respondent pointed out that not every one need to be able to do research, however he underlined the importance of be capable of reading research.

Among the needs in terms of resources, the majority of the respondents expressed the necessity of proper infrastructures (classrooms and adequate venues to conduct training), together with an adequate number of computers and an accessible broadband.

“We may need infrastructures, (...) if you want to really provide the capacity building, we need to have for example computer lab, which is available for people to understand some issues, we need to have good Internet connection…”

_Stakeholder-7_

An improved access to in-service training and CDP was also an important need to be addressed as soon as possible, especially for rural area. Talking about teachers
and lecturers, several participants emphasized the importance of the training of trainer, as tool to improve the final quality of the courses delivered. Some of them also raised the need to develop a specific training about teaching methodologies.

Eventually, some of the stakeholders also suggested that CPD will be more appealable and useful for HCWs if more organised and maybe linked more strictly with the achievement of further qualifications (see quotations in table 5.4).

<table>
<thead>
<tr>
<th>LIST OF THE CONTENTS</th>
<th>RELATIVE QUOTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATITUDE</td>
<td>“Maybe we have a problem with attitude (...) so we really need to work on the attitude” Stakeholder-4</td>
</tr>
<tr>
<td></td>
<td>“We have communication problems with patients, because patients complain basically about it and some of us think just that it’s the communication problem that is there. So the other I think this is an area” Stakeholder-1</td>
</tr>
<tr>
<td>PAEDIATRIC AND MATERNAL AND NEONATAL HEALTH</td>
<td>“To acquire that specific skills would be ideal, for example issued to do with paediatrics so if a specialist can handle it a specific area in paediatrics this can help the nurses and the clinicians so they should be able and they should get those skills to also handle them as specialist.” Stakeholder-5</td>
</tr>
<tr>
<td></td>
<td>“And if we are having to reduce this infant mortality we need to do something about diarrhea or diseases which are closely linked to malnutrition as well. And then pneumonia” Stakeholder-3</td>
</tr>
<tr>
<td>PUBLIC HEALTH:</td>
<td>“An improvement in the public health or community health aspects would trickle down to improve even the clinical aspects of this and that disease” Stakeholder-6</td>
</tr>
<tr>
<td>• financial management</td>
<td>“I should mention, also financial management” Stakeholder-7</td>
</tr>
<tr>
<td>• leadership</td>
<td>“You will be looking at leadership, and management skills, you can look at research methods and a bit to do with human resource so how that can manage the people ” Stakeholder-5</td>
</tr>
<tr>
<td>• organisational management</td>
<td></td>
</tr>
<tr>
<td>• research methods</td>
<td></td>
</tr>
<tr>
<td>OTHER CONTENTS:</td>
<td>“But also issues like the cancer and with the cancers and also with the palliative care for those people who need the care” (Stakeholder-5)</td>
</tr>
<tr>
<td>• cancer and palliative care</td>
<td>“The ARV are becoming complicate (...). Now we have more regiments coming out. We need also to have advanced HIV management courses” (Stakeholder-7)</td>
</tr>
<tr>
<td>• advanced HIV management</td>
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</table>

Table 5.7. Development needs expressed by Key-informants
5.8 LEARNING NEEDS: HCWS’ PERCEPTION

The meaning of “Learning Needs” was clear to all the practitioners. Few of them identified learning needs not only as what they need to improve in terms of skills and knowledge, but also as the physical tools necessary to learn (computer, money for school-fees and so on).

<table>
<thead>
<tr>
<th>HCWS’ LEARNING NEEDS</th>
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<tbody>
<tr>
<td><strong>PUBLIC HEALTH</strong></td>
</tr>
<tr>
<td>“I’m really interested to do public health”</td>
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<tr>
<td>“issues concerning like public health, in general, yes, that’s my need”</td>
</tr>
<tr>
<td><strong>RESEARCH</strong></td>
</tr>
<tr>
<td>“I’m interested in most is research! How people come up with this and that…and also like statistic and how people interpret the data!”</td>
</tr>
<tr>
<td>“I also like to have skills in research work because as we are in the field of medicine…”</td>
</tr>
<tr>
<td><strong>FURTHER ACADEMIC</strong></td>
</tr>
<tr>
<td>“An opportunity to move from where I am and earn something. Like I have a diploma now but if I could get an opportunity to get a degree”</td>
</tr>
<tr>
<td>“First I need to pursue a diploma in nursing…so that I can divert to community nursing…”</td>
</tr>
<tr>
<td>“I just need a degree in nursing because I have a diploma in midwifery”</td>
</tr>
<tr>
<td><strong>HIV MANAGE</strong></td>
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<tr>
<td>“This course called advance HIV management this is a course I’m looking forward and if this could come as soon as possible it would be good.”</td>
</tr>
<tr>
<td>“I want also to do HIV and AIDS, am really in love with this stuff.”</td>
</tr>
<tr>
<td><strong>PALLIATIVE CARE</strong></td>
</tr>
<tr>
<td>“What we do is more of palliative care. So a nurse you need to have like aah advanced knowledge, advanced knowledge in that particular field”</td>
</tr>
<tr>
<td>“yes…like, palliative care…a training in palliative care it’s very important. All our patients need palliative care”</td>
</tr>
<tr>
<td><strong>OTHERS</strong></td>
</tr>
<tr>
<td>“…if there is a certain course organised maybe to go deeper into facilitation issues, if there is that opportunity I think its better to attend so that you should be able to may be to do or know which areas you need to do better”</td>
</tr>
<tr>
<td>“On how best I can do the counselling to our patients who are on ARV’s so that they still take the ARV’s for life”</td>
</tr>
<tr>
<td>“My learning need as of this year, I wanted to be very sure with tracheostomy care. And infection prevention…”</td>
</tr>
</tbody>
</table>

Table 5.8 Learning Needs perceived by Malawian Clinical Officers and Nurses
The needs identified by respondents were many. Public health, research, palliative care and HIV management were the most common named (table 5.8). Eventually, the progression to furthers studies and academic qualification was also named among the needs (table 5.9). Furthermore, several workers pointed out as the lack of time is a serious constraints to learning.

5.9 THE FUTURE OF CPD: NEW TECHNOLOGIES

According to key-informants the future of post graduate education in Malawi lies in the incoming technologies: computer (the majority of them), and also mobile phone technologies (few of them). The ones who recognised mobile phones as a possible tool to deliver CPD contents, argued that this technology is widely accessible to people and due to that might be more sustainable over time. Nevertheless, one of them also highlighted as quality might be compromised.

“I think the future is exciting not in that and I don’t know but I think in this country will be ending up with cell phones and technologies that almost it’s been circulated to many area, even rural. (…). You go to the market the woman selling vegetables has a phone”

“It may not be as good as maybe a lecture or even a computer receiving a paper or it may be but I think that the future would have to include that”

Stakeholder-1

According to the majority of stakeholders, distance learning is able to reach more practitioners than conventional methods, reducing the costs related to travel expenses and allowances (especially reducing the flow of professional who go abroad for training). Moreover, it will allow attendants to learn where they want (included at home), but also when they want. This should minimized the interference
of training with the health service delivery. However, several disadvantages were also recognised: the non-reliable and expansive internet connection and the limited access to computers. Though most of the respondents agreed on this, few of them instead do not perceive access to computer as a problem (Table 5.9).

Ultimately, also the little computer expertise of some HCWs was stated among the limitations for the implementation of an E-learning program. Almost all the stakeholders who highlighted this, also underlined that in the future this is supposed to become a minor issue because of the new curricula in medical and premedical schools, which included IT skills.

<table>
<thead>
<tr>
<th>E-LEARNING</th>
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<tbody>
<tr>
<td>“The perspective is huge because is a need for continuing professional development in the health worker in Malawi, the only challenge is the access. So the prospects are huge as I said but I think the issue will be the technological aspect of it so…if the technology comes in I think have a bright future for CPD” Stakeholder-5</td>
</tr>
<tr>
<td>“Some of solutions to that to look at instead of problem resolution we can look at blocks like the distant based learning that is why I was talking about e-learning” Stakeholder-7</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>“So that people can attend reputable course meanwhile here in Malawi and they don’t have to spend money on flights and accommodation, then that would be useful…” Stakeholder-5</td>
<td></td>
</tr>
<tr>
<td>“I think that the advantages that people are at work and they can just go to take the session for two hours and go back to work, so there is a balance that not compromise service delivery”. Stakeholder-7</td>
<td></td>
</tr>
<tr>
<td>“Because it’s the only way to reach so many nurses. You can have a module on internet and people can access the module have and they can have their learning there “ Stakeholder-8</td>
<td></td>
</tr>
<tr>
<td>“The other challenge is the connectivity; we talked about the CPD online. It only supposed the you have steady reliable internet services. In most districts that is that is far from being ideal” Stakeholder-3</td>
<td></td>
</tr>
<tr>
<td>“Internet itself here in Malawi is also quite expansive” Stakeholder-6</td>
<td></td>
</tr>
<tr>
<td>“the IT literacy as well is a challenge in the remote area” Stakeholder-8</td>
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</tbody>
</table>

Table 5.9. Opinions and views about e-learning
From HCWs’ point of view, there was agreement that computer technologies are currently fundamental in the clinical practice of a worker (“Computer is a must nowadays”, HCW-5-CO).

The clinical officers considered their IT skills at an average level, all of them stated that they were able to use quite well Word and Power Point, but struggled with Excel and had no problem in browsing information from the Internet. Among nurses there was a broader spectrum of competency: few of them expressed a fair knowledge of computer, whereas the majority stated their lack of any computer expertise (defining themselves “computer illiterate” HCW-13-N). A nurse underlined for example that when she received the flash-disk, during the CPD pilot, she thought it was a “rubber” (HCW-3-N).

“I would say I’m an average, I’m not an expert yeah, I’m just average I know the basics. (...) In the computer I know how to use Microsoft word and I know how to use Power Point a bit of Excel, but not much. Yeah! Publisher and sometimes Open access, but not much”

HCW-1-CO

“...but unfortunately it’s that now that [computer] is not the best way that can assist me mmm... in sharpening my skills. (...) I don’t have the computer at home and this makes the access to the computer difficult and at the same time I do not have the basic knowledge in computer skills.”

HCW-2-N

The challenges reported by the workers, related to e-learning and computer use, match the ones defined by stakeholders. Electricity, cost and coverage of the broadband system and difficulties to access a computer were the most named. Only few of the HCWs interviewed own a computer and the remaining stated they rely on the computers at work, but that those “are often busy”. Among the advantages named, the possibility to browse information from the Internet, to store information, and to reduce the workload of professionals, who might be able to browse the information about a patient simply with a click.
Another emerging theme was the comparison of distance learning to traditional methodologies. Several stakeholders stated that traditional methodology will still have a role to play within the context of post graduate education. The same theme emerged during the first FGD with workers.

“E-learning is not a replacement to face-to-face. The face-to-face is still a method that needs to be used”

Stakeholder-7

“…but also even though all are there [access to computer and connectivity], but I think that face-to-face interaction with a lecturer is more important, because you can learn from the computer, and then if you are asking something you could understand it means that you have to mail need someone, a lecturer, or someone who is there it imply that if you don’t understand it consume your time, but face to face…”

HCW-1-CO (FDG)

5.10 EVALUATION OF THE CPD PILOT

5.10.1 CPD Participants’ opinions

The participants to the pilot CPD course agreed all that, though very different from the usual training sessions, the course was very interesting, relevant to their needs and well-structured. They particularly appreciated the fact they had understood the importance of CPD.

All participants stated that trainings usually consist in Power Point presentations with only little time dedicated to group work. They instead appreciated that group work was the main teaching strategy used during this pilot. Both stakeholders and
participants underlined that group work allowed discussion and interaction between

team members.

“I enjoy most the group sessions because we were free to discuss

on our own, so we could discuss and maybe your friend can correct

you and so you can get the correct answer from your friends… “

HCW-9-N

“During this training I liked the facilitation methods and the group
discussion. (…). Because that everyone was involved during group
discussion, normally we have no time. Everyone was actively
participating with something to say (…) Everyone was
involved….and I think this was good.”

HCW-3-N (FGD 1)

The only critique emerged in the FGD was that participants were expecting more
interaction with facilitators and corrections after presentation of the work done into
the group.

“The other thing we expected the facilitator to come in after we have
presented. We expected the facilitator to come in with what she had
or to come in with the opinion we were doing right for the rights of
health workers and so we expect the facilitator to give us was she
had on the rights…considering the fact that not all of us made all the
right and responsibility of HCWs…”

HCW-13-N (FGD1)

Positive was also the perception about computer session. This was greatly
appreciated by both cadres as an opportunity to switch from a theoretical learning to
a more practical one. The only weakness reported by almost all of them was the
short time dedicated to it, especially because some of them were just “beginners”.

“The course was ok, but maybe the time about the computer was too
short because some of us are not comfortable with the computer…”
At the beginning of the course, the participants were asked to write down their expectations concerning the course. Table 5.10 summarises the main expectation expressed. At the conclusion of the workshop, those were reanalysed and discussed in depth, in order to establish which ones were still to be achieved. The participants agreed that almost all the objectives were met. Only the need of further training about “Basic computer skills”, the necessity to “organise more training related to CPD” and “admission to LSTM (opportunity to study with LSTM)+scholarship” remained written in the poster of “what still need to be done”.

<table>
<thead>
<tr>
<th>PARTICIPANTS’ EXPECTATION</th>
<th>WHAT STILL NEED TO BE ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>“To get a certificate of attendance”</td>
<td>- Organise more trainings related to CPD</td>
</tr>
<tr>
<td>“To get allowance before lessons”</td>
<td>→ Basic Computer Skills</td>
</tr>
<tr>
<td>“To have a chance to study at Liverpool School of tropical medicine”</td>
<td>→ Registration for ADMISSION to LSTM</td>
</tr>
<tr>
<td>“Since it has been a 2 day workshop would request you to go further with these training which will improve health of Malawian patients and working staff”</td>
<td>(opportunity to study with LSTM)</td>
</tr>
<tr>
<td>“Learn more about Ethics”</td>
<td>+ Scholarships</td>
</tr>
<tr>
<td>“Knowledge on computer use with flash disk”</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.10 Participant’s expectations

5.10.2 Organisers’ opinion

The general outcome of the pilot course was judged positively from both the 2 stakeholders for LH and the LH facilitator. They stressed the importance of the

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2 The identifying acronyms used in this paragraph have been changed for confidentiality reasons.
course in changing the negative practitioners’ opinion about CPD, and the full participation and active involvement of participants up to the end of the course itself.

“I think it went very well, one of the interesting things that came out of there was the change in attitude towards CPD. (...) by the end of the course there were different views that CPD is very important that something that need to pursue as HW but then issues of how is handled and the approach has to change. So I think that a positive thing and after they were given a chance, nurses and clinicians, given a chance to use a computer and then have an orientation in an e-learning interface”

StakeholderLH-1

“At the end of the training I think almost each one of us was able to see that the participants that were there in the week end training ably understood why CPD is important because by the end of the day you could hear from a lot of people say that if it was introduced like this at the beginning would have problems in the project.”

LH Facilitator

No major problems raised during the progress of the course. The main difficulties stated by one of them was the need to use the KCH computer laboratory and to walk. Another worry emphasised was the lack of a proper allowance (in the training was given only a “transport allowance”); this fear which regards mainly the time before the training vanished seeing the good participation to the training. On the other side, when asked about the reasons to attend a course all the professionals stated the importance to get an allowance, especially considering their low salary and that training takes place often during their free time (week-ends). Nevertheless, they also stated the importance to renew their knowledge and gain more skills as reasons to attend training.

Eventually, both the stakeholders considered key aspects of a good partnership respect and clear definitions of roles and objectives of the two partners.
“I think I would say when there is a both partner have a say and identifying and respecting partner policies and I think recognizing the strengths yeah!”

StakeholderLH-1

“one, each one of the partner should be able to have clear objectives on what they are doing as individual partners”.

StakeholderLH-2

5.11 SUMMARY OF THE FINDINGS

This research highlighted how HCWs and stakeholders look at CPD in different ways. HCWs perceived it as "a punishment", due to its attachment to registration with regulatory bodies and of the consequent compulsory participation. In contrast, key-informants have generally a positive opinion about it. However, several challenges were identified: the lack of an evaluation system and the constraints in terms of resources (infrastructure and funds), together with the inadequate qualification and the insufficient number of facilitators currently present in the country.

Despite many difficulties (lack of equipment and of a career path), an interesting findings is that HWCS are committed to their job and very keen to improve their skills and knowledge.

In regards to Capacity Building, the HR shortage was identified as the major problem limiting post-graduate health education in Malawi. Aside from the lack of lecturers, due to this shortage practitioners cannot leave their work places to attend the courses without compromising service delivery. An accurate need assessment was recognized as the first step to properly build capacity. In fact, the needs of Malawian are many and diversified according to the setting (especially urban versus rural areas).

Distance learning was identified as a possible solutions to many of these problems. Nevertheless, both stakeholders and health staff recognized some existing
challenges: the limited access to computer, the diverse computer knowledge and the lack of a reliable and cheap broadband.

Eventually, the pilot CPD had a positive outcome for both groups. Participants appreciated both the content and the group work. Also the computer sessions was a success.
CHAPTER 6
DISCUSSION

6.1 CPD IN MALAWI

The findings of this study indicated that in Malawi CPD is perceived differently by stakeholders and healthcare staff. HCWs perceived it as “a punishment”, mainly because of its attachment to registration with regulatory bodies and the compulsory participation. Moreover, according to HCWs there was not a proper sensitization. South Africa and other developing countries faced the same challenges, when they first introduced CPD (De Villiers, 2008).

Key-informants, on the other side, expressed a positive opinion about CPD, though they recognised also some weaknesses of the system: the absence of an evaluating system (to assess the real effectiveness of CPD) and the lack of dedicated time for learning without compromising service delivery. Previous studies in developing countries (Beshyah, 2012 and De Villiers, 2008) acknowledged the same issues. Few months before the Medical Council introduced CPD, an editorial published in the Malawi Medical Journal reported opinions of lower cadre workers and doctors employed at the College of Medicine. The author showed that these opposing views were already present. Higher cadres knew about CPD, and considered it “vital” to update HWCs knowledge, whereas COs and students were unaware of it, or sceptical about its real application (Kavinya, 2008).

The understanding of both the perceptions, of HCWs and of stakeholders, is fundamental to build efficiently capacity at individual and organisational level (multilevel approach) (Milèn, 2001, UNDP, 2010 and World Bank, 2005).
6.2 HEALTH CARE WORKERS’ PERCEPTION ABOUT THEIR JOB

Strong motivation of nurses and clinicians for their job is another significant finding from this study. The opportunity to assist “suffering people” and “see them getting better” were highlighted as a major motivators. Previous qualitative studies conducted with health workers in Malawi also found that “caring for the sick” and “the ability to assist mankind” were strong incentives (Manafa, 2009, Bradley and McAuliffe, 2009).

Practitioners considered attending training and improving knowledge and skills as crucial, not only for career progression, but also to deliver a quality service to their patients. Similarly, other studies identified the possibility to attend continuous education as a powerful motivator (Manafa, 2009, Bradley and McAuliffe, 2009, Muula and Maseko 2005 and Willis-Shattuck, 2008). As demonstrated by Muula and colleagues (2004), Malawian health workers were keen to attend further trainings or to read medical journal articles. This demonstrates the commitment and propensity to improve expertise by Malawian practitioners – a fundamental aspect on which further capacities might be built upon. The analysis of the training database showed that each person attended 7 training sessions on average. That, once again, is suggestive of HCWs’ strong commitment.

The finding from the FGDs and interviews with the staff demonstrated that the main complaints were related to the shortage of equipment. Some of the HCWs see this as a factor affecting negatively confidence in the job. In a recent literate review, Willis-Shattuck (2008) highlighted that financial incentives, career advancement and the opportunity of continuous education are key factors to improve satisfaction. However, they concluded that those are not enough to motivate people: adequate resources and appropriate infrastructure contribute significantly to improve HCWs’ morale. Concerning career development, in our study, some COs expressed frustration about being stuck in the same position for long time. Similarly, the qualitative studies cited above acknowledged the same issue (Manafa 2009 and Bradley and McAuliffe, 2009): the lack of a career path seemed a crucial demotivator, especially for COs. An interesting idea, that raises from our study, came from some stakeholders, who suggested to link the single CPD activities to academic certifications.
6.3 EXISTING CAPACITY: ORGANIZATIONS’ LEVEL

In regards to the infrastructures dedicated to training, there was agreement that, even though more developed compared with the past, they are actually of “average quality and quantity”. Indeed, the need of proper infrastructures and equipment for training (computer, appropriate venues, etc) was recognized.

Concerning HR resource, stakeholders considered the facilitators not in adequate number and in need of further training. Along with those, also the poor amount of funding appeared among Stakeholders’ concerns. Bradley and colleagues (2009), studying the perspective of HCWs and key-informants, reported that both groups agreed that improvements in access and in funding for training were needed. In addition also, Manafa and colleagues (2009) reported that managers and stakeholders judged equipment and funds inadequate.

Similarly, in the Health Sector Strategic Plan for Malawi (2011 – 2016), capacity building for health training institutions (both pre-service and in-service) is among the strategies to improve HR management and consequently service delivery in health sector. The key aspects of this strategy are: provide infrastructures and equipment, reinforce the finance management relative to training, and produce an appropriate number of tutors with required qualifications.

Advertisement and selection of the participants are some of the processes able to enhance training. As Manafa’s study (2009) underline, those procedures are under the responsibility of the single institutions. In our research, participants stated that usually they “are chose to attend a training”. Nevertheless they also recognised that often this choice is made on those personal needs highlighted during their annual appraisal. In contrast, interviews of previous studies (Manafa, 2009 and Bradley and McAuliffe, 2009) described the access to training as completely unfair. This difference could be explained if the study location is considered. Almost all participants in our study were from the same institutions (LH), and the remaining from KCH, both belonging to urban settings in which the opportunity for training are several. On the contrary, the participants in Manafa’s study were from district hospitals of three different regions of Malawi, while the ones from Bradley and McAuliffe were all from rural hospitals. In those settings the opportunity for training are fewer.
6.4 PROBLEMS TO SOLVE AND OBJECTIVES TO ACHIEVE TO BUILD CAPACITY FOR CPD

Another key finding in this study is that the HR shortage impacts also on the training system. This shortage not only generates a lack of facilitators, but does not allow practitioners to leave their work place to attend a training without compromising service delivery. Previous works confirmed the impact of such a crisis on service delivery (Lasang and Dennis, 2004, Muula and Maseko 2005, Palmer, 2006, Manafa 2009 and Bradley and McAuliffe, 2009). However, there are few evidences regarding its implications for post-graduate education.

In our research, these problems are particularly severe in rural areas, where the shortage is usually more acute than in urban settings. This misdistribution between rural versus urban centres is marked in Malawi. Although the majority of the population (83%) lives in rural area (WHO, update 2011), the majority of health personnel work in urban centres (Africa Health Workforce Observatory, 2009). Moreover, key-informants pointed out that the needs of rural practitioners might be different from the ones of urban settings.

Conducting a proper assessment on the real needs in Malawi, was considered by all stakeholders the most important objective to achieve to efficiently improve capacity for post-graduate health education. This is in line with the phased approach of capacity building, which recognised the need assessment as one of first step to conduct (UNDP, 2010 and Milén, 2001). It also matches the concept of strengthening existing capacity to aim for sustainability (Bates, 2011).

6.5 DEVELOPMENT NEEDS

This research has highlighted the importance of a proper assessment, in order to choose contents relevant to the real need of practitioners on one side, and to the generic health needs of the country on the other. The needs expressed by stakeholder, in terms of contents, mainly refer to the latter component. In contrast,
the needs identified by health workers might not be representative of all the settings, and are specific only for selected participants. To the authors’ knowledge, there are no published studies examining views and perceptions about capacity needs, and specifically post-graduate health education and CPD. Nevertheless, the choice of a relevant topic, able to fulfil the real needs of the professionals, is known to improve the efficacy of CPD and consequently the real healthcare outcome (Nartker, 2010, Mazmanian 2002 and Shojania, 2012).

6.6 NEW TECHNOLOGIES FOR POST-GRADUATE EDUCATION IN MALAWI

The findings of our research showed that stakeholders considered computer and mobile technologies as a promising opportunity to solve the challenges of post-graduate education. In fact, in their opinion, these might reduce the indirect costs of training for both HCWs and health institutions, allowing also distant students to learn without leaving their work place or their country. On this regards, there is a growing body of evidence recognizing the role of e-learning for training (Nartker, 2010, Alexander, 2009, Cook, 2008 and Khatony, 2009). Some of the disadvantages emerged were the limited access to computer, the poor and expansive internet connection and the diversity in computer expertise of healthcare workers. Those findings are consistent with a previous study in Tanzania (Nartker, 2010). Concerning IT technology in Malawi, Muula and colleagues (2004), found that only 5.3% of the participant had access to the Internet, whereas almost 50% had access to mobile phones; moreover, the respondents of the study of Bradley and McAuliffe (2009), recognized that internet access in Malawi is mainly reserved to office staff, as some of the respondents of our research also stated.

A recent publication on a need assessment for health information in Malawi confirmed that computer and internet technologies nowadays are widely used at central level and for communication between institutions. However, they appear much less accessible at district level and for lower cadres (LeMay and Bocock, 2012).
aim of the study was not to define the best way to deliver CPD, but to assess demand and access to information and knowledge. In this context, mobile phones showed to have a great potential for delivering mainly information. This study also showed that Malawi has a strong oral tradition. Those data confirm our findings, in which HCWs emphasized that the most common methods to upgrade their knowledge are workshops or consultations with senior colleagues.

### 6.7 PILOT CPD

The outcome of the course was fairly good. Both LH organisers and participants were satisfied. No major problems raised over the 2-day workshop, and participants considered met most of the expectations they had about the course.

Among the teaching strategies used, group work was the most appreciated. It was recognized as an interactive way of learning. In this regards, many are the evidences that interactivity is a key strategy to increase the effectiveness of CPD (Mansouri and Lockyer, 2007, Forsetlund, 2009, Marinopoulos, 2007 and Nartker, 2010). Also the computer session was highly valued. In South Africa, Awases and colleagues (2004) showed that many practitioners perceived “innovative training opportunities” as a motivator. Another important finding related to the IT experience of participants, is that the level of computer expertise is different from one practitioner to another.

The concept of partnership is crucial to build capacity. The stakeholder from LH emphasised that key aspects of a good partnership are respect and clear definitions of roles and objectives for both the two partners. Bates and colleagues (2006) described it not only as a relation between two organisations which shared similar concept and responsibility, but also as a process that aims to develop the local partner through a learning-by-experience approach, in order to achieve sustainability. For this reason the ownership of any project should be of the local partner.
6.8 TRAINING DATABASE

The training database showed as LH, over 4 years, held 153 trainings sessions. One hundred and seven were specifically for health personnel (two sessions per month). The facilitators were all together 74. This number includes trainers for volunteers and patients, as well as lecturers for in-service training. It was not possible to separate these two groups. Moreover, 697 HCWs were trained. Of those, 428 were Doctors, Clinical Officer or Medical Assistants and nurses. If this data is compared with the actual staff in post in Lilongwe district, it appear that LH over the past 4 years has trained almost the 50% of Lilongwe (Table 6.1). This data demonstrate that LH has the proper capacity to deliver CPD courses.

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Medical assistants</th>
<th>Clinical Officers</th>
<th>Nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained by LH</td>
<td>22</td>
<td>47</td>
<td>89</td>
<td>270</td>
<td>428</td>
</tr>
<tr>
<td>Current Staff in Lilongwe</td>
<td>44</td>
<td>64</td>
<td>144</td>
<td>652</td>
<td>904</td>
</tr>
<tr>
<td>% Trained by LH</td>
<td>50%</td>
<td>73%</td>
<td>61%</td>
<td>41%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Table 6.1: Numbers of HCWs trained by LH in relation to the total numbers of HCWs in Lilongwe. Data were extrapolated from a document published as collaboration between the MOH and CHAI (Clinton Health Access Initiative) in 2011.
6.9 STUDY LIMITATIONS

This study presents several limitations. Time constraints limited the number of interviewees – especially key-informants – recruited into the study. This was due both to their busy time schedules as well as our time restraints. Because of that limiting factor, the saturations point for the topics related to the stakeholders’ interviews was not reached. The saturation point was instead reached for what concern the HCWs’ perspectives.

LH Training Department was in charge to choose the participants to the CPD course. In this regards, there was a potential for ‘gatekeeper bias’ (Tuckett, 2004). Most of the participants were LH employers, whilst only four came from other institutions. In both case, all of them were from urban settings. Consequently, the full range of possible responses was probably not completely captured.

Lack of experience of the researcher in qualitative research design may be considered a limitation; however, the researcher received formal training and attended a module on Qualitative Research Methods (at LSTM). During the analysis process, to minimized the bias due to inexperience, the “framework approach” was used. This approach is in fact considered as one of the simpler analytic method, useful for researchers engaging with qualitative research for the first time (Smith and Firth, 2011).

Eventually, the stakeholders from LH, as Director and Training Manager Officer of the hosting organisation were also acknowledged as co-researcher. Their role has been mainly logistic, to support the researcher to schedule the appointments. They had no active role in the collection of the data or in the analysis.
CHAPTER 7
CONCLUSION AND RECOMMENDATION

This research has identified several issues that affect post-graduate health education in Malawi. Interviewed HCWs showed a negative perceptions of CPD. In contrast, stakeholders did not appear aware of this. The different opinions should trigger a discourse about the purposes of CPD to find a common ground as a basis for improvement. The current system, especially for the cadres under NMCM, is not well perceived, and it seems to be too prescriptive. Health workers need to be properly informed about the importance, meaning and rules of CPD. In any case, both the councils have to find an appropriate monitoring and evaluation system for CPD, in order to assess its effectiveness over the time.

More opportunities are needed for continuous education and training. Clear career paths have to be established, to motivate HCWs and improve their performances. In this regards, CPD may be linked with an academic certification, as proposed by research participants to improve further health professionals’ motivations, competences and career prospects.

This research also highlighted the importance of the choice of relevant topics. Those should be able to fulfill the real needs of health workers in specific environments. The needs assessment done (relative to “HCWs’ learning needs”), might be not representative for all Malawi. In order to deliver an in-service training, a proper need assessment of the local reality has to be adequately planned. It has to take in account the target cadre and the location of practice (rural vs. urban). In addition, this assessment should evaluate also infrastructures and resources available.

Although the object of this research was not the HR shortage, it appears clear that this aspect has to be considered. Any plan that aims to build capacity for postgraduate health education in Malawi, should take in account that issue. Otherwise it could lead to the design of unrealizable plans. An exhaustive calculation
of the facilitators’ number and qualifications has to be done. It will allow, in fact, a proper planning of the Training of Trainers (ToT) in relation to the real existing capacity and the development needs.

Distance learning programmes have a great potential in improving skills and knowledge of practitioners, in reducing the impact of HR shortage and of the costs of training. However, at the moment, several are the constraints to these programmes in Malawi: poor availability of computers and broad band; limited access mainly for lower cadres (especially in rural area); the disparity in computer expertise of the health workers. These challenges needs to be solved before any implementation of the programme. However, considering the potentiality of this approach and the successes achieved in other developing countries (South Africa and Tanzania), this opportunity cannot be ruled out. A proper, long-term plan needs to be done. A pilot course (based entirely on e-learning or mixed methods as face-to-face and e-learning), may be a possible suggestion. Such a course may be useful to test capacity and identify gaps in terms of e-learning. Anyway, it should be carefully developed and monitored.

Nevertheless, an encouraging result come from the pilot CPD, delivered in partnership between LSTM and LH, which was successfully achieved. Participants resulted satisfied with the content of the course and with the new teaching strategies used. The local organizers were pleased with the course and by the fruitful cooperation with LSTM. In addition, the analysis of the training database proved that LH is actively involved in training delivering, and therefore has the capacity to effectively provide such kind of courses.
REFERENCES


UNDP (2009). Supporting capacity development: the UNDP approach. Available on line at:


Continuing Professional Development for Health Professionals in Malawi: Professional conduct and work ethics workshop  
June 9th and 10th 2012  
Lighthouse Trust, Lilongwe

Facilitated by Dr Helen Bromley (LSTM) and Jane Chiwoko (Lighthouse Trust)

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30-09.45</td>
<td>Welcome, registration introductions and introduction to the programme</td>
<td>Helen Bromley and Jane Chiwoko</td>
</tr>
<tr>
<td>09.45-10.30</td>
<td>CPD in the context of professional practice</td>
<td>Helen Bromley and Jane Chiwoko</td>
</tr>
<tr>
<td>10.30-11.00</td>
<td>Break and refreshments</td>
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<tr>
<td>11.00-12.30</td>
<td>Introduction to professional conduct, work ethics and personal competence</td>
<td>Helen Bromley and Jane Chiwoko</td>
</tr>
<tr>
<td>12.30-13.30</td>
<td>Lunch break and official photograph</td>
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<tr>
<td>13.30-14.30</td>
<td>IT task – KCH IT laboratory</td>
<td>Helen Bromley and Jane Chiwoko</td>
</tr>
<tr>
<td>14.30-15.00</td>
<td>Group discussion and conclusions for the day</td>
<td>Helen Bromley and Jane Chiwoko</td>
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<tr>
<td>15.00</td>
<td>Close</td>
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<tr>
<td><strong>Day 2</strong></td>
<td></td>
<td></td>
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<tr>
<td>08.30-09.00</td>
<td>Review of Day 1</td>
<td>Jane Chiwoko and Helen Bromley</td>
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<tr>
<td>09.00-09.45</td>
<td>Introduction to rights and responsibilities of health care professionals</td>
<td>Jane Chiwoko and Helen Bromley</td>
</tr>
<tr>
<td>09.45-10.15</td>
<td>Break and refreshments</td>
<td></td>
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<tr>
<td>10.15-11.15</td>
<td>Discussion and critical reflection of above</td>
<td>Jane Chiwoko</td>
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<tr>
<td>11.15-11.30</td>
<td>Course evaluation and close</td>
<td>Jane Chiwoko</td>
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<tr>
<td>11.30-12.30</td>
<td>Focus Group Discussion</td>
<td>Paola Gaddi</td>
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<tr>
<td>12.30-13.30</td>
<td>Lunch</td>
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</tbody>
</table>
Aims
The aim is for you to enhance your professional and ethical knowledge and skills and apply that new learning in your workplace. We will be introducing you to some of the key issues, debates and dilemmas inherent in contemporary professional practice. We will also be exploring tools and tips that will help you manage situations at work. Your own knowledge and understanding will be developed through a combination of discussion, case studies, group work, and in-course reading.

In addition, by the end of the course you should be able to:
1. Reflect on problems relevant to your own professional practice and offer ideas for their solution
2. Recognise the limits of your own professional competence
3. Identify the rights, duties and obligations placed upon health care professionals
4. Identify when to take prompt action regarding professional and or ethical concerns

You will also be encouraged to develop self-directed learning skills and to evaluate your own learning. Communication skills will be developed through in-course discussions and presentations of case studies. Group working, problem-solving, reflection, feedback and discussion will underpin much of your learning. We will also be working with computers for a part of the course. You will be supported by experienced teaching staff for the duration of the course.

After the Programme, you should be able to explain why, and how to maintain high standards of professional practice, including the importance of undertaking regular Continuing Professional Development. We hope you will also reflect on your own professional practice.

Course reading
There are two articles for you to read, during the IT session. You will be in the KCH computer lab for this session, with facilitators to support you. As you read the articles, reflect on what we have covered this morning and also, take some notes to bring back to the classroom this afternoon.

Scenarios and questions
Before the start of the course, please read the following scenarios and make short notes on the four questions that follow each of them. Make sure you bring your notes to class.

Scenario 1
You have just started working as a nurse in a busy paediatric ward at a district hospital. As a private donation you brought a glucometer (used for rapid measurement of blood sugar) to the ward and handed it over to the matron. Five days later you want to measure a random blood sugar in an adolescent with insulin dependent diabetes. You can’t find the glucometer. Your colleague tells you that the matron took it home since her husband has diabetes and requires blood sugar monitoring.

a) What are the key ethical issues in this scenario?
b) What action would you take? (if anything)
c) Who else could help you deal with this scenario?
d) What lessons could you learn from this scenario?
Scenario 2
You work at a paediatric surgical ward as the clinical officer and are in charge of the ward. The head of department is out of the country for a workshop. A child is admitted with seizures and focal neurological signs. The surgeons require a CT scan of the brain before surgery. There is only one CT scanner available in the country. Two problems arise: 1. The next available appointment you can get is in 3 weeks time. However, the radiographer said, he probably “can do something” to get an earlier appointment. 2. The parents of the child want to go home as they are afraid that they can’t afford the costs of transport and the examination.

a) What are the key ethical issues in this scenario?
b) What action would you take? (if anything)
c) Who else could help you deal with this scenario?
d) What lessons could you learn from this scenario?

Scenario 3
You have recently been appointed to be the clinical officer in charge of the general paediatric ward of a district hospital. At home, after a busy day shift, you realize that you have forgotten something at the ward and travel back to the hospital. Upon arrival you find that none of the two nurses responsible for the night shift are available. The ward clerk is still around and tells you that they are “temporarily out”. What is your response?

a) What are the key ethical issues in this scenario?
b) What action would you take? (if anything)
c) Who else could help you deal with this scenario?
d) What lessons could you learn from this scenario?

Scenario 4
You work as a matron in a tertiary hospital and you are part of the hospital drug committee. The head pharmacist chairs the meetings, but they are infrequent and poorly attended. Minutes are written late and are of poor quality. Essential drugs, such as antibiotics are frequently out of stock. Recently you ordered ceftriaxone for your ward, but got a reply that it is not available from the pharmacy. However, the day before you have seen yourself the delivery of a larger supply of these drugs when you accidentally passed by the pharmacy. You colleagues in the ward are increasingly demotivated and you have lost recently two nurses to a private clinic.

a) What are the key ethical issues in this scenario?
b) What action would you take? (if anything)
c) Who else could help you deal with this scenario?
d) What lessons could you learn from this scenario?
APPENDIX 2

In this section are reported the following components:

1. Topic guide used for stakeholder (section number 5 was used only for stakeholder from LH)
2. Topic guide used for HCWs
3. Topic guide used for the FGDs

The LH facilitator was interviewed with a mix topic guide from Section 1, 2, 3 and 5 form HCWs’ Topic Guide and only Section 5 of the Stakeholders’ topic guide.

TOPIC GUIDE FOR STAKEHOLDERS

SECTION 1:
OPENING QUESTIONS

DEMOGRAPHIC INFORMATION
- Name
- Age
- Nationality
- Background (qualification)

INSTITUTION and CURRENT POSITION
- Name, Category (i.e. service delivery, training, management) and location of the institution
- Position held and for how long

SECTION 2:
VIEWS ABOUT POST GRADUATE HEALTH EDUCATION FOR HCWS IN MALAWI

Organization of CPD in Malawi
- Different cadres
- Strengths and weaknesses

Can you describe me how post graduate education for HCWs is organized in your country?

Possible prompts:
- Which are the opportunities for Nurses/Clinician who wants to upgrade their knowledge or maybe their current position?
- Can you tell me something about the CPD accreditation in Malawi…What do you think about it?
- According to you what are the strengths and weaknesses of CPD implementation in Malawi
- Who is responsible of delivering such programs?
### Role and importance of CPD
- for clinical practice and service delivery
- for career path
- for different cadre

### Future of post graduate health education in Malawi
- How to improve it
- Challenges in general
- Challenges in rural area

### What do you think is the importance of post graduate education for HCWs in your country?
**Possible prompts:**
- How post graduate health education impacts on the clinical practice of HCWs? And Service delivery?
- And what about the HCWs career path?

### What kind of suggestions do you have to improve post graduate education in Malawi?
**Possible prompts:**
- What do you think is the future for CPD in Malawi?
- What do you consider the main challenges to this?
- Does those challenges vary according to different cadre? And how?
- What about CPD in rural area?

---

### SECTION 3: EXISTING CAPACITY FOR POST GRADUATE EDUCATION

#### CPD
- System in place for training activities
- Contents definition

#### Target Participants
- Who are they?
- Selection criteria

#### Human Resource

#### Infrastructure

#### Funds For Cpd

### Can you tell me something about the post graduate education within your institution...
**Possible prompts:**
- Does your institution have a “Training department” or any other specific department responsible for training?
  - If no: Who is responsible to deliver training courses or any other CPD activities for your employees?
  - If yes: Can you tell me something about it?
- Who is directly involved in planning and organizing it (Especially for CPD)?
- How are chosen the content of the courses?
- How the quality of the activities is assured?
- How the courses are advertised?
- What are the systems in place to assure the HCWs are aware of the training sessions, that he-she might want to participate to?
- How are selected the participant?

**Possible prompts:**
- Which cadres are mainly involved?
- Which are the selection criteria? Who choose them?

### Who, in terms of HR, is involved in the delivery of training session?
**Possible prompts:**
- What is your opinion about the Human Resources allocated for training?
- Who are the Facilitators? Lecturers? Support staff? Where they come from?
- What kind of professional training or specific qualification is required to become facilitator or lecturer of CPD activities?

### Where are conducted the CPD activities?
**Possible prompts:**
- How do you consider the infrastructures of your organisation for training in Malawi? And what about your institutions?
Are there enough class-rooms? Computer room? Internet? Access to electronic publication or online library? Which are the opening hours of those facilities? Are compatible with shifts?

What about the funds for the CPD activities? What those funds are used for?

SECTION 4:
VIEWS ABOUT CAPACITY BUILDING FOR POSTGRADUATE EDUCATION

CAPACITY BUILDING
- Problem to solve
- Objectives to achieve
- Capacity needs
- Suggestions

Are you familiar with the concept of CB? This is a definition of WHO of CB

What do you think are the key aspects to bear in mind to build capacity for health education in your country?

In this definition there are 3 issues I would like to have your insight about:
- Problems to be solved for postgraduate education in Malawi
- Objectives to achieve for post graduate education
- Capacity needs (What are the main areas of needs for post graduate education in Malawi?)

Possible prompts about:
- Facilities? Class? Computer? Internet?
- Staff: Lectures? In which field? Administrative personnel?
- Funds?
- Participants are interested?
- Which cadre is more important to target?
- What are the most important areas to focus on? (Research Skills-study skills-malaria-Obstetric emergency?)

Which kind of suggestions you will give to people who want to build capacity for health education in Malawi?

SECTION 5:
OPINIONS ABOUT THE PILOT CPD COURSE DELIVERED IN PARTNERSHIP WITH LSTM

VIEWS ABOUT CPD
- Role of LH
- Satisfaction
- Course design and delivery
- Teaching strategy used (memory stick)
  - Advantages
  - Disadvantages
- Utility for participants

DIFFICULTIES

OPINIONS ABOUT PARTNERSHIP

What was your role, as organization, in the delivery of this CPD course?

What is your opinion about this CPD course?

Possible prompts
- What do you think about the teaching strategies used (especially the use of flask disk and group work)? What might be the advantages and the disadvantages of both those strategies?
- How do you think it will contribute to participants practice and knowledge?
- Which were the strengths of this CPD course?
- Which the weaknesses?

What kind of difficulties or problems did you face in running it, if there were any?

Which do you consider crucial aspects of a genuine (and functioning) partnership?
# TOPIC GUIDE FOR HEALTH CARE WORKERS

## SECTION 1:
### OPENING QUESTIONS

### DEMOGRAPHIC INFORMATION
- Age

### POSITION AND EDUCATION RECEIVED
- Current Job
  - Position held
  - Which institution?
  - How long?

### FORMAL MEDICAL/PARAMEDICAL EDUCATION
- When?
- Where? (In Malawi? Abroad? Which school?)
- Future plan

## SECTION 2:
### PERCEPTION and VIEWS ABOUT THE JOB and THEIR SKILL LEVEL

**About the Job**
- Description of the job (what they actually do)
- Satisfaction
- Confidence: Strengths and weaknesses

**About the skills**
- Relational skills
- Study skills
- Computer skills
- Other

Can you describe me your everyday job?

Possible prompts
- How do you feel about it?
- What do you consider your strengths and weaknesses in the clinical practice?
- Or What aspects of your job are you more confident in? and what about the ones in which you are less confident in?

What are according to you the most important skills to be a good nurse/CO?

Possible prompts
- How do you feel about those skills?
- How do you consider your study skills?
- Can you tell me something about your computers skills?

## SECTION 3:
### PERCEPTION OF CONTINUING PROFESSIONAL DEVELOPMENT

What is your opinion about CPD?

Possible prompts
- How does it contribute to your clinical practice?
- How does it contribute to the development of your career?
### CPD
- Views about it
- Usefulness of CME in clinical practice and in their career

**Opinions About Needs Of CPD**

If you were in charge in the Nurses (or Medical Councils), what would you do to make the things better?

**Possible prompts**
- What needs to be changed?
- What do you think is working well?

<table>
<thead>
<tr>
<th>SECTION 4:</th>
<th>OPINIONS ABOUT THE PILOT CPD COURSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td></td>
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<tr>
<td>- In general</td>
<td></td>
</tr>
<tr>
<td>- About Teaching strategy</td>
<td></td>
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<tr>
<td>- About Timeframe</td>
<td></td>
</tr>
<tr>
<td>Expectation</td>
<td></td>
</tr>
<tr>
<td>Reason To Attend Training</td>
<td></td>
</tr>
</tbody>
</table>

**Can you tell me your experience as participant of the course about “Work ethics and Professional Conduct?”**

**Possible prompts:**
- What do you think about the content of the course?
- What about the teaching strategies used?
- What about the time structure

**Do you remember your expectation for this 2day workshop? Can you tell me something about them?**

What do you think about time frame?? Did you have enough time for self-study? Or for discussions? The contact with the teacher was sufficient?

**What are the main reasons to attend to a CDP course?**

**Possible prompts**
- Why?
- What do you expect to receive when you attend a training?
- What is the meaning of receiving allowances when you attend a CPD course?
## SECTION 5: INSIGHT ABOUT LEARNING NEEDS

### Definition Of “Learning Need”

### Personal Needs

Personal need in relation to
- your daily work
- your career

### What is according to you the meaning of “learning need”?

### What do you think yours learning needs are?

#### Possible prompts

- Which are the contents that you consider useful for your profession and about which you would like learn more about?
- For Nurses: Which are the learning needs you defined in the CPD annual plan?
- What do you think might help you in your career development?
### TOPIC GUIDE FOR FGD

#### SATISFACTION with THE COURSE

- **In General**
  - Opinion about the course in general
  - Strengths and weakness (what they liked and what they not)
  - Content and usefulness for your job and career (fulfilment of the perceived need)
- **Teaching strategies**
  - Computer and Memory stick (advantage and disadvantage)
  - Group work
  - Others
- **Structure** (Time frame)

#### REASONS TO PARTICIPATE TO TRAINING

- **Specifically to this CPD**
  - Who told them about it
  - Why they decided to participate
- **Advertisement (in general)**
  - Usually how they get information about Training
  - How they “apply” to participate
- **Reasons to participate in general**
  - Content of the course (Usefulness for their career or for their daily job)
  - Quality of the course

#### VIEWS ABOUT CPD IN GENERAL

- **Personal perception of CPD**
  - Usefulness of CPD in clinical practice
  - Usefulness of CPD for their career
# APPENDIX 3

## Framework for Stakeholders

1. **Generic information**  
   1.1. Institutional Role of the participant  
   1.2. Personal Experience in CPD  
   1.3. Educational Background  
   1.4. Role in CPD and in-service training  
2. **Processes in place for CPD**  
   2.1. Courses Advertisement  
   2.2. Participants  
   2.3. Content  
   2.4. Monitor and Evaluation  
   2.5. HR for Training  
   2.6. Infrastructures for training  
   2.7. Funds for training  
3. **CPD in general**  
   3.1. Importance  
   3.2. Organisation and implementation  
   3.3. Strengths and weaknesses  
   3.4. Role of CPD for HCWs  
   3.5. Role for different cadres  
   3.6. Future of CPD and Challenges  
4. **E-learning and distance learning**  
   4.1. General opinion  
   4.2. Advantages  
   4.3. Disadvantages  
5. **Capacity Building for CPD**  
   5.1. Main problems to solve  
   5.2. Main target to achieve  
   5.3. Main capacity needs  
   5.4. Suggestions to build capacity  
6. **Other issues:**  
   6.1. Post graduate education in general  
   6.2. CPD in Urban vs Rural Area  
7. **CPD Pilot:**  
   7.1. Role of LH  
   7.2. General Outcome  
   7.3. Teaching strategies used  
   7.4. Concept of partnership

## Framework for HCWs

1. **General Information**  
   1.1. Job Description  
   1.2. Medical education  
   1.3. Future plan  
2. **Existing capacity**  
   2.1. Job satisfactions  
   2.2. Strengths  
   2.3. Weaknesses (or challenge) in the job  
   2.4. Way to upgrade knowledge  
   2.5. Skills of a good Nurse or clinical Officer  
   2.6. Computers skills  
   2.7. Research skills  
3. **CPD**  
   3.1. Opinions after the pilot  
   3.2. Opinions before the pilot  
   3.3. BIS Opinions about CPD implementation  
   3.4. CPD and career  
   3.5. CDP and clinical practice  
   3.6. Reasons to attend a training  
4. **Learning needs**  
   4.1. Definition  
   4.2. Personal learning needs  
5. **CPD suggestions to improve CPD system**  
   5.1. Related to the CPD implementation  
   5.2. Others  
6. **Pilot CPD delivered in partnership with LSTM**  
   6.1. Satisfaction  
   6.2. Meet of expectations  
   6.3. Work group  
   6.4. Computer session  
   6.5. The best of the course  
   6.6. The worst of the course
### APPENDIX 4

<table>
<thead>
<tr>
<th>HOW 1</th>
<th>HOW 2</th>
<th>HOW 3</th>
<th>HOW 4</th>
<th>HOW 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.S. to convince someone else to go to the same course.</td>
<td></td>
<td></td>
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<tr>
<td>Remember: why?</td>
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</tr>
<tr>
<td>1. Work closely with the group and other people.</td>
<td></td>
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<tr>
<td>2. Keep good notes of all the meetings and give feedback.</td>
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<tr>
<td>3. Be open to suggestions and be willing to learn.</td>
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<tr>
<td>4. Be transparent and honest with everyone involved.</td>
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</tbody>
</table>

**P.S.** to convince someone else to go to the same course.

Remember: why?

1. Work closely with the group and other people.
2. Keep good notes of all the meetings and give feedback.
3. Be open to suggestions and be willing to learn.
4. Be transparent and honest with everyone involved.

---

In the context of our discussions, the utilization of a chart was crucial for understanding the data. A chart, specifically a bar chart, helped in visualizing the trends over time. The chart was labeled as Chart 2.4.

---

The introduction of the CEP was pivotal in addressing the needs of the team. It provided a platform for brainstorming, ensuring that everyone understood their roles and responsibilities. The CEP was designed to be user-friendly, ensuring that all members of the team could adapt and contribute effectively.
<table>
<thead>
<tr>
<th>3 CPD</th>
<th>3.1 OPINIONS AFTER THE PILOT CPD</th>
<th>3.2 OPINIONS BEFORE THE PILOT CPD</th>
<th>3.3 OPINIONS ABOUT CPD IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yeah, after the course that it’s when I understood what what CPD was and how important it is for me.</td>
<td>before the training... before the training. Honestly, CPD was something I didn't like. For me I was just given a book when I was going to register. This is a CPD book, you will be filling in and you will bring it the next time for registration. But I didn't know what it was and the one who was given to me was an accountant who even didn't know. I was just instruction to say for someone who comes for registration give them this CPD book. So for me I thought it was like a requirement for me to register. Now if don't do anything with the CPD it means I will not be registered and if I don't register that means that my job it's also. So I did like this...</td>
<td>because of... first of all there wasn't any proper orientation on what CPD is and how important it is to have CPD. It just came in.</td>
</tr>
<tr>
<td>HCW1</td>
<td>...now the fact I have attended a training it means I have get knowledge or I'm reminded of something that I forgot so that how I feel with CPD!</td>
<td></td>
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<tr>
<td>HCW2</td>
<td>...after that training it was eye opener because when you are doing those things you sharpening your skills, you know more about your work so with that training now I am a changed person I take it positively that there is really need for any practice medical health person to at least undergo development training</td>
<td>Frankly speaking, as I said earlier on at first had negative attitude towards the CPD...</td>
<td>because of the way how the managers implemented it. It left a lot to be desired so to me at first I had that in mind it was just to find us and wanted to punish us in true sense</td>
</tr>
<tr>
<td>HCW3</td>
<td>I think it will assist me in my career and other health workers at least to give our patients quality work.</td>
<td>If you don't do this, then we are going to deregister you. So obviously, I mean, you study for some years and then you get deregistered simply because you haven't accomplished, I mean you haven’t done this CPD, I mean it's not so good.</td>
<td>They just came to accumulate a lot of points but how to accumulate those points was very difficult because when we talk about a seminar it's attached with a money issue. So in our registration the ... people are the one to attend because some people are from the rural area and they are working alone and no time to go, but they have to accumulate a lot of points, so what we were thinking was just a punishment for people.</td>
</tr>
<tr>
<td>HCW4</td>
<td>Right, I give you a picture which I have now. And that's after the training. Basically I've seen CPD as something which it's going to help me for me to develop my career and also improve my skill and knowledge. Yes in dealing with patients, staff and a lot other people around.</td>
<td></td>
<td>Yes, I think that the introduction of CPD itself is a very brilliant idea, but just too wrongly presented.</td>
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<tr>
<td>HCW5</td>
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<tr>
<td>HCW6</td>
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<td>HCW7</td>
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<td>HCW8</td>
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<td>HCW9</td>
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<td>HCW10</td>
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<td></td>
<td>Like the way I feel CPD... CPD are good... because they hope to equip knowledge to professionals. So the more you are getting knowledge the more you advance in you advance in your job. Yeah</td>
<td>CPD is very important. Any way as... we hated it, because no one want to be burden. You know Knowledge sometimes in this professional sometimes we feel like... sometimes knowledge is optional, nobody should force you to get knowledge.</td>
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</tr>
</tbody>
</table>
HOW 15. No, it's just the same thing (BAD IMPLEMENTATION). Because there was no CPD, no registration so it was given as a blackmail.

HOW 16. At the beginning when we were introduced to the CPD, when we first learned about CPD when we went to register at the nurses' council they shouted at us...

HOW 17. It was just looking like they wanted to punish us and this is why a lot of nurses they have diverted their career they have stopped being nurses and they have started other careers.

HOW 18. We can talk to them, that they should instruct us about CPD what is the real meaning of CPD because they seem they don't know, they don't know the CPD themselves at all.

HOW 19. Or maybe they just copied from somewhere and they didn't apply to us nicely, because it could have been better than... if they sort of the all year 'that maybe in 3-4 years come you have to do this... so this is what you are supposed to do, this is what you are supposed to do for maybe 2-3 yrs so that we were well oriented. But it looks like they just took it from somewhere and import that thing on us.

LC 3.4.3 3.5 HOWA

HOW 3. Yes, yes, so they introduced something for us without giving us the mechanism how they will ensure that everyone will have the opportunity to learn or to accumulate the CPD points.
APPENDIX 5

CONSENT TO PARTICIPATE IN RESEARCH STUDY

HEALTH WORKERS

Study Title: Capacity building for health education in Malawi

My name is Paola Gaddi and I am a student at Liverpool School of Tropical Medicine in the UK. As part of my MSc in Tropical and Infectious Diseases, I will be conducting a field-based research with plan in Lilongwe in Malawi. The aim of this research is to conduct an assessment of capacity building for health education in Malawi.

You participated in CPD course titled “Professional conduct and work ethics”.

I would like to invite you to participate in a research about health education in Malawi. I feel that your experience as a health worker in the Malawian Health System can contribute to my understanding and knowledge about health education in Malawi. I would also like to hear your views about the CPD course you have attended.

I would like to interview you in person and together with other participants in group (Focus Group Discussion). This will develop my understanding of the strengths and weaknesses of the health education in your country.

The interview will be held at a time and a location chosen by you and will last approximately 45 minutes. You might be asked to be interviewed a second time, some weeks after the initial interview; you are entitled to either accept or decline the offer. The FGD will be held at time and location chosen according to the needs of all the participants. It will last around 1 hour.

It is anticipated that this information will be used to generate suggestions and recommendations to develop a sustainable plan for action for next possible steps in a cooperation between Lighthouse Trust and other stakeholders involved in professional education and LSTM.
During the interview you may feel uncomfortable to talk about some topics, you can stop the interview at any time without any disadvantage and without anyone knowing you have withdrawn.

Although every attempt to guarantee total confidentiality and anonymity will be made, some information could identify you due to the relatively low number of participants involved in this study. All quotes taking from your interview will be shown to you before dissemination of the report for your approval.

All information provided will be treated with strict confidentiality. Digital recordings will be immediately uploaded onto a password-protected computer and coded in a form that only the researcher is able to decode. Once transcribed, the original recording will be deleted from the Dictaphone and comments will be anonymised. Information may later be used in the write-up of research. A copy of the study will be given to my course supervisor, the Liverpool School of Tropical Medicine, and a summary will be made available to any participant who requests it. The study may become published material. No person taking part in the study will be identified in any of these documents.

If you have any queries please contact me directly: paola.gaddi@yahoo.it

Participation in the study is entirely voluntary. Your decision whether or not to participate will not affect your future relations with Liverpool School of Tropical Medicine or with other institutions involved in the research. If you do decide to participate, you are free to decline from answering any questions and you may withdraw from the research at any time without giving a reason, up to the point when the researcher is no longer able to link information back to you.

................................................. .................................................. .................................................
Name of Participant Signature of participant Date signed

.................................................. ........................................................
Acknowledgement by researcher Date signed
STAKEHOLDER

Study Title: Capacity building for health education in Malawi

My name is Paola Gaddi and I am a student at Liverpool School of Tropical Medicine in the UK. As part of my MSc in Tropical and Infectious Diseases, I will be conducting a field-based research with plan in Lilongwe in Malawi. The aim of this research is to conduct an assessment of capacity building for health education in Malawi.

I would like to invite you to participate in this research because we feel that your experience as member of a relevant medical institution involved in training and health education can contribute largely to our understanding and knowledge about health education system in your country.

The research will involve in-depth in order to develop an understanding of the perception and ideas concerning strengths and weaknesses of the actual health educational system and general attitude towards health education system.

It is anticipated that this information will be used to generate suggestions and recommendations to develop a sustainable plan for action for next possible steps in a cooperation between Malawi Educational System and Liverpool School of Tropical Medicine.

Interviews will be held at time and location chosen by you and will last approximately 45 minutes. You might be asked to be interviewed a second time, some weeks after the initial interview; you are entitled to either accept or decline the offer.

There is a possibility that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. Although every attempt to guarantee total confidentiality and anonymity will be make, due to the relatively low number of participants involved in this study you may be aware that some of the information you may decide to give, could identify you. However, we do not wish for this to happen. Thus, you do not have to answer any
question or take part in the discussion/interview if you feel the question(s) are too personal or if talking about them makes you uncomfortable. You may stop participating in the interview at any time that you wish.

All information provided will be treated with strict confidentiality. Digital recordings will be immediately uploaded onto a password-protected computer and coded in a form that only the researcher is able to decode. Once transcribed, the original recording will be deleted from the Dictaphone and comments will be anonymised. Information may later be used in the write-up of research. A copy of the study will be given to my course supervisor, the Liverpool School of Tropical Medicine, and a summary will be made available to any participant who request it. The study may become published material. No person taking part in the study will be identified in any of these documents.

If you have any queries please contact me directly: [address, email, telephone number]

Participation in the study is entirely voluntary. Your decision whether or not to participate will not affect your future relations with Liverpool School of Tropical Medicine or with other institutions involved in the research. If you do decide to participate, you are free to decline from answering any questions and you may withdraw from the research at any time without giving a reason, up to the point when the researcher is no longer able to link information back to you.

Name of Participant                     Signature of participant                     Date signed

Acknowledgement by researcher                     Date signed
APPENDIX 6

Paola Gaddi
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool
L3 5QA

Wednesday, 04 April 2012

Dear Paola

Re: Capacity building for health education in Malawi

I am pleased to inform you that the above protocol has formal ethical approval from the Chair of Masters Review Panel.

Approval is conditional upon:

- Notification of all amendments to the protocol for approval before implementation.
- Reporting of all severe unexpected Adverse Events to the Committee

Approval has been given subject to confirmation that when using direct quotes from interviews there will be no identifiers in the presentation of data and that all direct quotes are shown to participants to ensure they are comfortable with the way they are to be represented.

Additionally, the Panel would like confirmation that you have permission in writing from the Director of the Lighthouse Trust for this research to take place.

Failure to comply with these requirements will result in withdrawal of approval.

Yours sincerely

[Signature]

Dr Brian Faragher
Chair, Masters Review Panel
APPENDIX 7

Paola Gaddi
Liverpool School of Tropical Medicine

Dear Sir/Madam,

RE: Protocol # 1016: Capacity building for health education in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has reviewed and approved your application to conduct the above titled study.

- **APPROVAL NUMBER**: NHSRC # 1016
- **APPROVAL DATE**: 11/5/2012
- **EXPIRATION DATE**: This approval expires on 10/05/2013
- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789514, 08588957 or by e-mail on doccentre@malawi.net
- **Other**: Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

FOL CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: Dr C.Mwansamba (Chairman), Prof. Mlithe Benga (Vice Chairperson)
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)
## TRDR - Training Design Registration Form

### Version 1

<table>
<thead>
<tr>
<th>No.</th>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Form filled by</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Form filing date</td>
<td>(dd / mm / yy)</td>
</tr>
<tr>
<td>3.</td>
<td>Training Title</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Version Number</td>
<td></td>
</tr>
</tbody>
</table>

### Components

- Didactic (lecture, seminar)
- Skills Building Workshops
- Clinical Training (trainer's facility attachment)
- Consultation (trainee's facility-mentoring)
- Technical Assistance (Systems strengthening focus-supervision)
- Distance Learning

### Assessment methods

- Written pre-training test?
  - Yes (Y)
  - No (N)
- Written post-training test?
  - Yes (Y)
  - No (N)
- Post training practical test?
  - Yes (Y)
  - No (N)

### Certification

- Certification Issued?
  - None
  - Attendance
  - Pass

### Notes

- Enter the total time scheduled for each of the components using hours and minutes.
- Enter 00:00 if the component is not used.
#TRAINING FACILITATOR REGISTRATION FORM

<table>
<thead>
<tr>
<th>No.</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Form filling date (dd / mm / yy)</td>
</tr>
<tr>
<td>2</td>
<td>First name</td>
</tr>
<tr>
<td>3</td>
<td>Middle name</td>
</tr>
<tr>
<td>4</td>
<td>Last name</td>
</tr>
<tr>
<td>5</td>
<td>Sex (F/M)</td>
</tr>
<tr>
<td>6</td>
<td>Date of birth (dd / mm / yy)</td>
</tr>
<tr>
<td>7</td>
<td>Birth District</td>
</tr>
<tr>
<td>8</td>
<td>District of origin</td>
</tr>
<tr>
<td>9</td>
<td>Highest Level of Medical qualification: 1=Medical Doctor, 2=Clinical officer, 3=Medical assistant, 4=Nurse/Midwife, 5=HSA, 6=Patient attendant, 7=Lab Technician, 8=Pharmacy Tech, 9=Counsellor, 0=None</td>
</tr>
<tr>
<td>10</td>
<td>Highest level of education completed (Primary, JCE, MSCE, Tertiary)</td>
</tr>
<tr>
<td>11</td>
<td>Personal phone number</td>
</tr>
<tr>
<td>12</td>
<td>Workplace phone number</td>
</tr>
<tr>
<td>13</td>
<td>Current Position (title)</td>
</tr>
<tr>
<td>14</td>
<td>Employer</td>
</tr>
<tr>
<td>15</td>
<td>Name of facility</td>
</tr>
<tr>
<td>16</td>
<td>Name of department</td>
</tr>
<tr>
<td>17</td>
<td>Address</td>
</tr>
<tr>
<td>18</td>
<td>District</td>
</tr>
<tr>
<td></td>
<td>TRAINING PARTICIPANT REGISTRATION FORM</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>1.</td>
<td>Form filling date (Tsiku) (dd / mm / yy)</td>
</tr>
<tr>
<td>2.</td>
<td>First name (Dzina koyamba) Name</td>
</tr>
<tr>
<td>3.</td>
<td>Middle name (Dzina lina) Name</td>
</tr>
<tr>
<td>4.</td>
<td>Last name (Dzina la bambo) Name</td>
</tr>
<tr>
<td>5.</td>
<td>Sex (Wamkari/Wam'muna) F M</td>
</tr>
<tr>
<td>6.</td>
<td>Date of birth (Tsiku lobadwa) (dd / mm / yy) DOB</td>
</tr>
<tr>
<td>7.</td>
<td>Birth District (Boma lobadwira) DistB</td>
</tr>
<tr>
<td>8.</td>
<td>District of origin (Boma lochokera) DistC</td>
</tr>
<tr>
<td>9.</td>
<td>Highest Level of Medical qualification (Maphunziro a Pumwamba a zachipata) 1=Medical Doctor 2=Clinical officer 3=Medical assistant 4=Nurse/Midwife 5=HSA 6=Patient attendant 7=Lab Technician 8=Pharmacy Tech 9=Counsellor</td>
</tr>
<tr>
<td>10.</td>
<td>Highest level of education completed (Polekezera maphunziro) Primary JCE MSCE Tertiary P J M T</td>
</tr>
<tr>
<td>11.</td>
<td>Current Contact and Work Place Details Phone</td>
</tr>
<tr>
<td>12.</td>
<td>Workplace phone number (lanya yakuntchito) Phone</td>
</tr>
<tr>
<td>13.</td>
<td>Current Position (Mukugwira nthito yani (Udindo)) WinFr</td>
</tr>
<tr>
<td>14.</td>
<td>Employer (Mukugwira kuli) WinFr</td>
</tr>
<tr>
<td>15.</td>
<td>Name of facility (Malo a nthito) WinFr</td>
</tr>
<tr>
<td>16.</td>
<td>Name of department (Chigawo panchito) WinFr</td>
</tr>
<tr>
<td>17.</td>
<td>Address (Keyala) WinFr</td>
</tr>
<tr>
<td>18.</td>
<td>District (Boma) WinFr</td>
</tr>
</tbody>
</table>
## TR SR SESSION REGISTRATION FORM

1. Form filled by
2. Form filling date (dd/mm/yy)
3. Training Title + Version
4. Training Session number (record system generated ID)

### Session Schedule Time and Place

5. List of dates when the training will be conducted (dd/mm/yy)

### List of Facilitators

8. 
9. 
10. 
11. 
12. 

### Data office use

13. Checked by
14. Entry by