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# **East, Central and Southern African Health Community**



## **The 1<sup>st</sup> Regional Forum on Best Practices in Health Care, and the 17th Directors Joint Consultative Committee Meeting (DJCC)**

**4-7 September 2007, Arusha, Tanzania**

## **PROGRAMME AND ABSTRACT BOOK**

**Theme:**

**Improving the Performance of Health Systems**

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## **Welcome**

It is a great honour and privilege for me to welcome you all to the Inaugural Regional Forum on Best Practices in Health Care and the Directors' Joint Consultative Committee meeting 2007. I extend a warm welcome to all friends and colleagues including the Directors of Health Services, Directors of Research Institutions, Deans of Medical School, Planners, Programme Managers, Chief Nursing Officers, Senior Health Officials, researchers and health professionals from both the public and private sectors. I wish to extend a special welcome to all our collaborating partners. We greatly appreciate your support.

This year we have decided to organize the Directors' Joint Consultative Committee in the form of a scientific forum. We believe the DJCC as the highest technical organ of the East, Central and Southern African Health Community (ECSA-HC) should focus on identification, documentation and dissemination of best practices. We envisage having an annual Regional Forum on Best Practices in Health Care.

The theme of this year's Regional Forum/DJCC is "Improving the Performance of Health Systems". This theme will enable us to share our experiences on how we can improve our health systems in order to reach the Millennium Development Goals. We believe the Forum will also provide a linkage between policymakers, directors of health, health experts, researchers and health professionals.

I would like to thank Family Care International (FCI), Africa 2010, USAID/EA, Population Reference Bureau (PRB), Clinton Foundation and other partners for their invaluable financial, technical and material support towards organizing the Forum/DJCC. I also thank all colleagues and friends who submitted abstracts on the sub-themes of the Conference. We look forward to stimulating discussions of your papers.

Finally I wish to thank all my colleagues at the ECSA Health Community for the hard work, diligence and dedication. I am very proud of the high level of teamwork and collaboration.

**Steven V. Shongwe**  
**Executive Secretary**

## **Acknowledgements**

This forum was made possible by the tireless efforts of a number of individuals working within different committees at the ECSA secretariat to plan and prepare all relevant documents, logistics and other aspects of the forum. We would like to recognize their collective and individual efforts in bringing to fruition this 1<sup>st</sup> regional forum on best practices in health care. The following individuals deserve specific mention:

### **Technical Committee and thematic teams**

Dr. Helen Lugina, Dr. Mark Bura, Dr. Melkizedeki Kimaro, Dr. Steven Shongwe, James Watiti, Jane Mashingia, Doreen Marandu, Mofota Shomari, Lilian Mwangi, Carol Tom, Allie Kibwika-Muyinda.

### **Venue, Logistics, transport & Accommodation committees**

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### ***Exhibitions, and Publicity committee***

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**FORUM SUPPORTERS**

The ECSA Health Community wishes to thank the following organizations, for their provision of financial, technical and moral support for the 1<sup>st</sup> Regional Forum on Best practices in Health Care



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**AFRICA'S HEALTH IN 2010**



# **EAST, CENTRAL AND SOUTHERN AFRICAN HEALTH COMMUNITY**

## **The 1<sup>st</sup> Regional Forum on Best Practices in Health Care and Directors' Joint Consultative Committee Meeting: 4-7 September 2007**

***Theme "Improving the performance of health systems for effective delivery of health interventions in ECSA"***

The East, Central and Southern African Health Community (ECSA-HC) in collaboration with its partners will launch the **1<sup>st</sup> Regional Forum on Best Practices in Health Care in Arusha, Tanzania from 4-7 September 2007**. This will be an annual scientific forum to review best practices in health care in East, Central and Southern Africa and will be organized by the East, Central and Southern African Health Community in Arusha, Tanzania. The purpose of the forum is to share best practices and experiences in health care in the East, Central and Southern African region. The annual forum will be attended by Directors of Health Services, Deans of Medical Schools, Directors of Research Institutions, Programme Managers, Senior Health Officials, Researchers and Health Professionals from the region. The Directors of Health Services, Directors of Research Institutions and Deans of Medical and Nursing Schools will participate fully in the Forum and will use the last two days (6 and 7 September 2007) to constitute the annual Directors Joint Consultative Committee (DJCC) which will meet to consider and adopt the recommendations of the Forum.

### **Why the Regional Forum on Best Practices?**

All countries in the East, Central and Southern African region have committed themselves to work towards reaching the Millennium Development Goals (MDGs) which were approved and adopted by Heads of State and Governments at the United Nations General Assembly in September 2000. Three of the eight MDGs are directly health-related (MDG 4: Reducing Child Mortality; MDG5: Improve Maternal Health; and MDG6: Combat HIV/AIDS, Malaria and other Diseases), the other five MDGs also indirectly address health issues. Ministries of Health in collaboration with regional and International organizations, universities, non-governmental organizations (NGOs) and the private sector continue to scale up and implement health care programmes and interventions that are aimed at improving the health status of the people in order to reach the MDGs.

Despite the commendable efforts of Governments of countries in East, Central and Southern Africa in scaling up their health programmes and interventions, available evidence indicates that progress towards the MDGs is slow and the MDGs may not be reached by 2015. The major challenges include weak, fragmented and under-funded health systems, lack of coordination, insufficient

human resources for health and managerial weaknesses. Clearly, there is an urgent need to build and strengthen effective, efficient and sustainable health systems that respond to the needs of the people of the region.

It is important, however, to point out that countries are at different stages of programme implementation and some have made more progress than others in addressing some of the MDGs. Sharing of experiences, information and expertise among countries could contribute towards finding solutions to common health problems.

Although every year numerous studies, evaluations, assessments and reviews of health care interventions and health systems issues are conducted by Governments, universities, regional and international organizations, individual researchers and health professionals, these are not disseminated widely and shared. This means that other experts, policy makers and programme managers do not get the opportunity to share and learn from others. Consequently, research findings are not used to inform decision-making and promote understanding of what works and what does not. Insufficient dissemination also results in unnecessary duplication of research work and waste of scarce resources.

The forum will therefore provide a permanent mechanism for policy makers, health experts, researchers and health professionals to disseminate and share best practices in health care. The identification, documentation and dissemination of best practices, and their utilization in decision making, policy formulation and implementation will contribute towards the attainment of the Millennium Development Goals (MDGs).

#### **How will the Regional Forum differ from other meetings?**

The scientific forum will provide an opportunity for participants from Governments, Universities, and Research Institutions, regional and international organizations to present results of relevant research work on health care.

The scientific forum will be unique in that it will provide opportunities for building of linkages between policymakers, directors of health, health experts, researchers and health professionals to interact, share best practices and agree on recommendations to improve health care in the region. The recommendations of the forum will be presented to technical and policy forums such as the Directors' Joint Consultative Committee (DJCC), the Conference of Health Ministers and other international meetings and conferences.

#### **Organization of the Regional Forum**

The Forum will be organized in the form of a scientific conference with plenary and parallel sessions. There will be presentations of papers based on abstracts submitted by researchers and health experts. There will also be poster exhibitions and display of relevant documents. On the last two days of the

Forum, the recommendations will be finalized and presented to the Directors' Joint Consultative Committee for consideration, action and follow up.

### **Inaugural Forum**

The inaugural forum will focus on the strengthening of health systems in order to scale up health interventions to reach the MDGs in the East, Central and Southern African region. The forum will review on-going programmes and review research work to identify some best practices, challenges and constraints.

### **Theme of the Regional Forum 2007**

The theme of this year's Forum is ***“Improving the performance of health systems for effective delivery of health interventions in ECSA”***

#### **Sub-themes:**

- Scaling up human resources for health
- Strengthening Disease Control: HIV/AIDS, TB, Malaria; and Non-Communicable Diseases
- Improving access to essential medicines and drugs.
- Health Care Financing: Equitable access to health care

#### **Objectives of the Regional Forum 2007:**

1. To provide a forum for participants to review the health systems challenges and to propose recommendations for addressing them.
2. To identify some best practices in health care in the region
3. To share experiences among participants on health care financing issues including equity in health care, budget allocation to the health sector.
4. To make recommendations on best practices in health care, in particular how these practices can be scaled up.

#### **Outputs of the Regional Forum 2007**

1. Best practices, challenges constraints in Health systems in East, Central and Southern Africa will be identified and actions to improve health systems will be agreed.
2. Best practices in health care will be disseminated
3. Recommendations on actions to improve the performance of health systems will be adopted for presentation to the Conference of Health Ministers and other international forums.

#### **Participants**

Participants will include, Directors of Medical Services, Deans of Medical schools, Directors of Research institutions, scientific experts, editors of the DCPD publications, managers of various programmes from ECSA member states,

Information Focal Persons, Directors of Disease Control programmes, epidemiologists, collaborating partners, agencies, and senior health journalists.

**Follow up**

The outcomes and recommendations of the Regional Forum on Best practices on Health Care will be presented to the DJCC in Arusha and subsequently to the 46<sup>th</sup> Conference of Health Ministers in February/March 2008 in Seychelles.

**REGIONAL FORUM ON BEST PRACTICES AND DJCC PROGRAMME**

<b>TIME</b>	<b>DAY ONE: MONDAY, 3 SEPTEMBER 2007 ARRIVAL, REGISTRATION, OPENING CEREMONY</b>
	<b>Arrival</b>
<b>1500-1700</b>	<b>Registration</b>
<b>1700-1830</b>	<b>Opening Ceremony</b> <ul style="list-style-type: none"> <li>• <b>Welcome Remarks</b> – <a href="#">Steven Shongwe, Executive Secretary</a></li> <li>• <b>Remarks</b> - <a href="#">WHO Representative</a></li> <li>• <b>Remarks</b> - <a href="#">Regional Director, USAID/EA</a></li> <li>• <b>Inauguration of Regional Forum/DJCC</b> by <a href="#">Guest of Honour</a></li> <li>• <b>Keynote Address</b> by <a href="#">Dr. Doyin Oluwole, Director, Africa 2010</a></li> </ul>
<b>1900-2000</b>	<b>Cocktail</b>
	<b>DAY TWO: TUESDAY, 4 SEPTEMBER 2007</b>
<b>0730-0830</b>	<b>Registration</b>
<b>0830-1000</b>	<ul style="list-style-type: none"> <li>▪ Introductions</li> <li>▪ Forum and DJCC Methodology</li> <li>▪ Remarks by FCI Vice President</li> </ul>
<b>1000-1030</b>	<b>TEA BREAK</b>
<b>1030-1300</b>	<b>Plenary: Increasing Skilled Care at Delivery: Dissemination</b> <a href="#">(FCI) (Abstract No. 1)</a> <ol style="list-style-type: none"> <li>1. <a href="#">Promoting Safe Motherhood in Africa: Skilled Care Model (FCI)</a></li> <li>2. <a href="#">Evaluation Findings of the Skilled Care Initiative (FCI)</a></li> </ol> <b>Discussion</b>
<b>1300-1400</b>	<b>LUNCH BREAK</b>
<b>1400-1530</b>	<b>Plenary: The Skilled Care Initiative Evaluation Results: Best practices in Improving Maternal Health</b> <a href="#">(FCI) (Abstract No. 1)</a> <ol style="list-style-type: none"> <li>3. <a href="#">Cost of the skilled Care initiative in Kenya and Tanzania (FCI)</a></li> <li>4. <a href="#">Scaling up attendance Strategies: The Way Forward (FCI)</a></li> </ol> <b>Discussion</b>
<b>1530-1600</b>	<b>TEA BREAK</b>
<b>1600-1700</b>	<b>Compilation of issues and recommendations from FCI presentations</b>

TIME	DAY THREE: WEDNESDAY, 5 SEPTEMBER 2007	
0830-1030	<b>Plenary Session 1</b> 1. Overview of Disease Control Priorities and Cost-Effective Interventions-- Fariyal Fikree (20 min) 2. Improving Disease Control: HIV/TB/Malaria (communicable diseases) Overview -Yahya Ipuge (20min) 3. Improving Disease Control (Non communicable diseases) Overview -Andrew Swai- (20min)  <b>Discussion (20 min)</b>	
1030-1100	<b>TEA BREAK &amp; /POSTER SESSIONS/EXHIBITION</b>	
1100-1300	<b>Plenary Session 2</b> 4. Scaling up Human Resources for Health: Overview (Dela Dovlo) (25min) 5. HRH Protocols, Strategies and Approaches in ECSA (15min) (Abs. No.5) 6. Use of non-financial incentives for health worker retention (15 min) (Abs. No.6) <b>Discussion (15 min)</b>  7. Panel: Africa Health Workforce Observatory-Country Experiences (40 min) (Abs. No. 4) <b>Discussion (10 min)</b>	
1300-1400	<b>LUNCH BREAK &amp; POSTER SESSIONS/EXHIBITION</b>	
	<b>PARALLEL SESSIONS</b>	
1400-1530	<b>Scaling up Human Resources for Health (A)</b>	<b>Improving Disease Control (A)</b>

	<ol style="list-style-type: none"> <li>1. Building the capacity of Health Centre Management Committees in Homabay, Kenya (Abs. No. 2)</li> <li>2. Developing the leadership capacity of Swaziland MOHSW (Abs. No. 3)</li> <li>3. Promising practices to address HRH workforce issues (Abs. No. 16)</li> <li>4. Health workforce competence and workplace assessment for safe deliveries: Implications for training and performance improvement (Abs. No. 18)</li> </ol> <p><b>Discussion</b> <b>Recommendations</b></p>	<ol style="list-style-type: none"> <li>1. Integrated management of TB, HIV/AIDS at facility level: Experiences from Tanzania (Abs. No.24)</li> <li>2. Development of HIV/AIDS workplace policy Swaziland MOHSW (Abs. No. 25)</li> <li>3. The magnitude and factors responsible for delay in tuberculosis management in Dar es Salaam (Abs. No.31)</li> <li>4. 'Male Circumcision to Reduce HIV incidence: Outcome of the Kisumu Randomised Controlled Trial.'</li> <li>5. Factors associated with low condom use for HIV/AIDS/STIs and pregnancy prevention among adolescents in Dar es Salaam (Abs. No. 29)</li> <li>6. Update on AIDS vaccine trials in Kenya'</li> </ol> <p><b>Discussion</b> <b>Recommendations</b></p>
<b>1400-1530</b>	<b>Scaling up Human Resources for Health (B)</b>	<b>Improving Disease Control (B)</b>
<b>1400-1530</b>	<ol style="list-style-type: none"> <li>1. The Emergency Hiring Project in Tanzania (Ab. No.15)</li> <li>2. Scaling up HR development: the case study of several African mental health human resources (Abs. No. 17)</li> <li>3. The Mkapa Fellows Programme: Bringing hope to rural areas of Tanzania (Abs. No. 14)</li> <li>4. Use of private nurse/midwives to reach under-served populations (Abs. No.13)</li> </ol> <p><b>Discussion</b> <b>Recommendations</b></p>	<ol style="list-style-type: none"> <li>1. Institutionalization of injection safety into medical training school curriculum in Kenya (Abs. No.27)</li> <li>2. Implementing sustainable sharps disposal systems in Kenya (Abs. No. 28)</li> <li>3. Factors leading to rejection of free Insecticide Treated Nets in the coastal region of Kenya (Ab. No.26)</li> <li>4. Rift Valley Fever (RVF) outbreak in Kenya (<a href="#">Presenter</a>) (15min) (Abs. No. 30)</li> </ol> <p><b>Discussion</b> <b>Recommendations</b></p>
<b>1530-1600</b>	<b>TEA BREAK &amp; POSTER SESSIONS/EXHIBITION</b>	
	<b>PARALLEL SESSIONS</b>	
<b>1600-1730</b>	<b>Scaling up Human Resources for Health (B)</b>	<b>Improving Disease Control (B)</b>

	<ol style="list-style-type: none"> <li>1. Direct entry midwifery training (Abs. No.8)</li> <li>2. Electronic learning for nurses in Kenya (Abs. No. 9)</li> <li>3. Training support workers (Abs. No. 10)</li> <li>4. Scaling up tutor training in Zambia (Abs. No. 7)</li> <li>5. Empowering midwives: Saving lives (Abs. No. 19)</li> </ol> <p><b>Discussion Recommendations</b></p>	<ol style="list-style-type: none"> <li>1. Food based dietary guidelines for Swazi adults living with HIV/AIDS (Abs. No. 23)</li> <li>2. Seychelles Dietary Guidelines (<a href="#">Abs. No.22</a>)</li> <li>3. The Seychelles national School Nutrition Policy (Abs. No. 21)</li> <li>4. Assessment of the prevalence of diabetes mellitus, hypertension and Associatedrisk factors in Swaziland (Abs. No. 20)</li> <li>5. Management of Micronutrient malnutrition through fortification of staple foods</li> </ol> <p><b>Discussion Recommendations</b></p>
<b>1730-1800</b>	<b>Meeting of Rapporteurs and Moderators</b>	<b>Meeting of Rapporteurs and Moderators</b>

TIME	DAY FOUR: THURSDAY, 6 SEPTEMBER 2007	
0830-1100	<b>Plenary Session:</b> <ol style="list-style-type: none"> <li>1. Improving Access to essential medicines and drugs: Overview (<a href="#">Rosalind Kirika</a>) (25 min)</li> <li>2. Overview- Health Care Financing: Equitable Access to Health Care-<a href="#">Moses Mukuna</a> (25 min)</li> <li>3. Using evidence-based practice to enhance service delivery in family planning – <a href="#">FHI</a>- (40 min) (Abs. No. 34)</li> <li>4. Drug Access Initiative (<a href="#">Clinton Foundation</a>) (25min)</li> <li>5. Essential surgery at the district hospital: Experiences from Tanzania, Mozambique and Bangladesh-<a href="#">Colin McCord</a> (20 min)</li> <li>6. Diagonal programming: An alternative to vertical and horizontal programmes-<a href="#">Nina Pruyn</a> (20 min)</li> </ol> <p><b>Discussion (30min)</b></p>	
1030-1100	<b>TEA BREAK &amp; POSTER SESSIONS/EXHIBITION</b>	
	<b>PARALLEL SESSIONS</b>	
1100-1300	<b>Improving Access to Essential Medicines and Drugs</b>	<b>Health Care Financing: Equitable Access to Health Care</b>

	<ol style="list-style-type: none"> <li>1. Access to prescription drugs and practice patterns in health care systems: Implications for policy development in Zimbabwe (Abs. No 33)</li> <li>2. Reports from DRA Meeting –ECSA/Clinton Foundation</li> <li>3. Harmonising drug regulation and registration in the ECSA region (<a href="#">Clinton Foundation</a>)</li> <li>4. Using assessment data as a strategic tool to operationalize the Regional Pharmaceutical Forum and empower it to implement interventions to Scale – up Best Practices in Pharmaceutical Management in ECSA Member States.</li> <li>5. Implementing a Regional Strategy (pre-service Curriculum), as a partial measure to address human resource capacity, to strengthen pharmaceutical management in support of ART roll-out in Lesotho</li> </ol> <p><b>Discussion</b> <b>Recommendations</b></p>	<ol style="list-style-type: none"> <li>1. Use of institutionalization of NHA in ECSA (Abs. No. 35)</li> <li>2. Institutionalizing hospital efficiency costing to increase effectiveness (Abs. 36)</li> <li>3. Cost sharing programme in Tanzania: Lessons from experience (Abs. No. 38)</li> <li>4. The Tanzania Community Health Fund as a Best Practice Map for Universal coverage (Abs. No. 39)</li> <li>5. Costing the delivery of Minimum Essential Health Services in the Coast Province, Kenya (<a href="#">Abs. No. 35</a>)</li> <li>6. Home-based care commodity management practice-Can we challenge policies and practice? (Abs. No. 40)</li> </ol> <p><b>Discussion</b> <b>Recommendations</b></p>
1300-1400	<b>LUNCH BREAK &amp; POSTER SESSIONS/EXHIBITION</b>	
1400-1600	<p><b>Plenary Session:</b></p> <ol style="list-style-type: none"> <li>1. Welcome by DJCC Chairperson &amp; Election of DJCC Chairperson for 2007-2008 (30)</li> <li>2. Presentation of outgoing DJCC Chairpersons Report (20)</li> <li>3. Summary of recommendations of the forum – <a href="#">Sub-theme Rapporteurs</a> (30min)</li> </ol> <p><b>Discussion (40min)</b></p>	
1600-1630	<b>TEA BREAK</b>	
1630-1700	<b>Meeting of Rapporteurs and Moderators</b>	<b>Meeting of Rapporteurs and Moderators</b>

TIME	DAY FIVE: FRIDAY, 7 SEPTEMBER 2007
0830-1030	<p><b>Plenary Session 1</b></p> <ol style="list-style-type: none"> <li>1. Summary of recommendations of the forum by Chief <a href="#">Rapporteur- Charles Oyaya</a> (30min)</li> <li>2. Themes and sub-themes of the 46<sup>th</sup> Health Ministers Conference (20min)</li> <li>3. ECSA-HC HRH Strategy (30 min)</li> <li>4. ECSA Strategic Plan (30min)</li> </ol> <p><b>Discussion (30min)</b></p>
1030-1100	<b>TEA BREAK &amp; POSTER SESSIONS/EXHIBITION</b>
1100-1300	<b>OFFICIAL CLOSURE &amp; LUNCH</b>
	<b>DEPARTURE</b>

# **SCALING UP HUMAN RESOURCE FOR HEALTH**

## ABSTRACT NO. 1

### THE SKILLED CARE INITIATIVE EVALUATION RESULTS BEST PRACTICES IN IMPROVING MATERNAL HEALTH

**Background:** Approximately 529,000 women die each year from the complications of pregnancy and childbirth, almost all of them in the developing world; more than half of these maternal deaths take place in sub-Saharan Africa. Most maternal deaths could be prevented if all women received high-quality care before, during, and after childbirth. Increasing rates of skilled care during childbirth is widely recognised as a priority strategy for reducing maternal mortality. Indeed, rates of skilled attendance at childbirth are being used as the target indicator to measure progress toward the 5<sup>th</sup> Millennium Development Goal of improving maternal health. Globally, however, only 53% of deliveries are attended by skilled attendants, and in sub-Saharan Africa only 41% of births are attended by a health professional. Moreover, there has been little evidence-based guidance available on how to make skilled care available and accessible in low-resource settings.

In an effort to obtain such evidence, in 2000, Family Care International (FCI) in collaboration with ministries of health, with support from the Bill and Melinda Gates Foundation, launched the Skilled Care Initiative (SCI)—a five-year project in four rural, under-served districts in Burkina Faso, Kenya, and Tanzania where the majority of women give birth with unskilled providers. The SCI had a dual focus on health systems interventions to strengthen the availability and quality of skilled maternity care, as well as community-focused interventions promoting the utilisation of skilled maternity care throughout pregnancy, childbirth, and the postpartum period. The project had a particular emphasis on mid- and lower-level health facilities that are closest to women, but it also aimed to strengthen obstetric care at the first referral level. The project included a strong evaluation component designed to provide sound data on the feasibility and effectiveness of the approach. The evaluation showed that the package of interventions can lead to dramatic increases in skilled attendance rates—even in resource-constrained settings. In addition, the findings suggest that the skilled care approach and focus on mid- and lower-level health facilities can improve access to care, even among the poorest women. These and other results have great relevance as African states strive to achieve MDG 5, and develop national roadmaps and action plans towards this end.

#### Program

##### 1) Promoting Safe Motherhood in Africa: the Skilled Care Model

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The Skilled Care Initiative was launched in 2000 with the specific objective of increasing rates of skilled attendance in four districts in Burkina Faso, Kenya and Tanzania. Health systems interventions to improve maternal health care were implemented from 2003 to 2005 and included (1) Infrastructure strengthening such as the provision of solar

equipment and water tanks, extermination of bats, and repair of leaky roofs and damaged walls; (2) Addressing equipment and supply gaps; (3) Improving provider skills through trainings for more than 300 providers in routine and emergency obstetric skills; (4) Strengthening referral systems by purchasing ambulances and two-way radio call systems or cellular phones; and (5) Strengthening supervision and health service management including supportive supervision, record-keeping, and health planning and budgeting. To complement health systems interventions, FCI also launched intensive behaviour change and mobilisation efforts to encourage health-seeking behaviours and build community support for the use of skilled care. The activities targeted those with important roles as household decision-makers or community influentials and were carried out at the village level in almost every community.

## **2) Evaluation Findings of the Skilled Care Initiative**

Authors: Brahima Bassane, Ellen Brazier, Djeneba Diallo, Angela Mutunga, Tuntufye Mwakajonga, Olipa Ngobola, Margaret Perkins, Ellen Themmen

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The Skilled Care Initiative included a rigorous evaluation component to assess the availability and quality of skilled care in the intervention districts, its financial and cultural accessibility, and changes in use of skilled care over time. The pre-test, post-test, quasi-experimental design included (1) facility assessments covering 147 facilities in the project districts on the quality, availability, and utilisation of maternal health services and (2) household surveys covering a random sample of nearly 17,000 households to collect information on the use of skilled care at delivery, and knowledge, attitudes, and care-seeking behaviours during pregnancy and childbirth. Baseline data was collected between 2002 and 2003. Endline surveys were conducted in 2006—approximately three to six months after the end of project interventions—to measure changes in the availability and use of skilled care during pregnancy, delivery, and the postpartum period.

Some significant and dramatic increases in the use of skilled care during childbirth and the percentage of deliveries taking place in a facility were observed. The improvement was most impressive in Burkina Faso, where at endline, 56% of births took place with a skilled attendant, compared to only 25% at baseline. In Tanzania, skilled care-seeking during childbirth increased from a much higher baseline rate of 64% to 68% at the endline survey. In Kenya increases were more modest. In all three countries the overwhelming majority of increased institutional delivery caseload took place in mid- and lower-level health facilities. In addition, in both Burkina Faso and Tanzania, gaps between the richest and poorest women narrowed in terms of their use of skilled care during childbirth.

## **3) Cost of the Skilled Care Initiative in Kenya and Tanzania**

Authors: **Stephanie Boulenger** and Tania Dmytraczenko

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The objective of the costing study was to determine the cost of the skilled care package, including health systems components and community-focused behaviour change communication (BCC) components in one district in Tanzania and two districts in Kenya. All input and unit cost data were collected through a retrospective analysis of financial records, budgets, reports, and all available documents from FCI. To supplement and verify the data, interviews with FCI staff were conducted. The total implementation cost of the SCI from 2002 to 2006 in Igunga district, Tanzania, and Homabay and Migori districts in Kenya, are 559,095 US\$, 364,469US\$ and 277,140 US\$, respectively. The average annual cost of the SCI per delivery with a skilled birth attendant was 15.0 US\$ for Tanzania, and 10.6 US\$ for Kenya. The cost per capita was 1.7 US\$ for Tanzania, and 0.6 US\$ for Kenya. This study also estimates the maintenance costs of the intervention beyond the implementation phase, and the replication costs, i.e. what would be the cost for a government to replicate the SCI interventions to other districts, or additional facilities in Tanzania and Kenya.

#### **4) Scaling up Skilled Attendance Strategies: The Way Forward**

Authors: Brahim Bassane, Ellen Brazier, Djeneba Diallo, **Ann Starrs**, Ellen Themmen,  
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## ABSTRACT NO. 2

**Title: Building the Capacity of Health Centre Management Committees (HCMCs) in Homabay, Kenya**

**Author(s):** Ellen Brazier, **Angela Mutunga** [amutunga@fcimail.org](mailto:amutunga@fcimail.org)

**Institutional affiliation:** Family Care International,

In 2006 and 2007, Family Care International (FCI) in collaboration with the Ministry of Health implemented a unique initiative in Homabay district in Kenya aimed at strengthening the role of community members in health service delivery management. The objective was to improve the quality of maternity care by enhancing community participation in and contributions to the management of facilities.

FCI developed a self-assessment tool on key management areas related to the roles and responsibilities of the committees as articulated in the MOH guidelines. Results indicated a weak understanding among the members of their roles and responsibilities and limited skills/training for carrying out these functions. A training program was developed to address these specific skills gaps, and 58 members from six committees were trained in late 2006. During the training, each committee developed an action plan outlining how they would work to better fulfill their overall roles and responsibilities. Follow-up visits were conducted in April 2007 to evaluate progress in implementing action plans, and to provide additional on-site training and guidance. All six committees made significant progress and key outcomes included: (1) Increased knowledge and role in management of health facilities, (2) Increased recognition of organizational mission and values, (3) Demonstrated initiative in demanding financial accountability and development of financial tools, (4) Increased efforts towards resource mobilization, and (5) Active engagement in sensitizing communities about safe motherhood.

This initiative yielded important outcomes and results, particularly with regard to developing management assessment and training materials that are tailored to the roles and functions of health center management committees in Kenya. Evaluation results showed that the training and capacity-building activities did much to address the needs identified at the outset—an outcome that will make a significant difference for the provision of quality maternal health services and community participation in maternal health.

**Type of presentation: ORAL**

### **Abstract No. 3**

**Title:** Developing the Leadership Capacity of the Swaziland Ministry of Health and Social Welfare

**Author(s):** Chauke Ngoma

**Institutional Affiliation,** Institutional Affiliation: Southern African Human Development Capacity Coalition (SAHCD), P.O Box 1655, Pretoria, South Africa  
Tel: 27 124601118 Fax: 27 124600018, Email: [chauke@mkhangelingoma.co.za](mailto:chauke@mkhangelingoma.co.za)

#### **Objectives**

Share information for adaptation and application at the country level of innovative strategies to address health workforce performance and enhancing result oriented approach in the region.

#### **Description of the project**

The Leadership Development Program (LDP) is a unique hands-on and practical skills strengthening and development initiative that aims to assist managers to have a result oriented focus in their management approach. Through the LDP, the Southern African Human Capacity Development Coalition (SAHCD) is assisting the Swaziland government in improving the quality of health care in selected facilities through a series of workshops, coaching and mentoring activities spanning 6 months. Each of the facilities has identified a specific challenge to showcase how they are using their newly acquired leadership skills to achieve results with minimal resources.

#### **Lessons learned**

“LDP has taught us a shared vision, collaborative approach and enhanced team spirit. Team work has replaced the historical differences between the Hospital Administrator, the Matron and the Medical Superintendent and we all work to achieve results,” said Leonard Dlamini, RFM Hospital Administrator. At Good Shepherd Hospital they were able to reduce patients waiting time in OPD by 30 minutes within three months and their target is one hour. Hlatikulu Hospital improved their waste management.

#### **Policy and programme implications**

LDP can be more successful in an environment where local managers have some delegations that allow them to implement and manage their budgets without requesting approval to purchase everything. “This a multi-facet problem solving approach which I’ll use even in my congregation,” boasts Dlamini.

**Type of presentation: ORAL**

## ABSTRACT No. 4

### **African Health Workforce Observatories: National Approaches**

**Organizations:** East, Central, Southern Africa (ECSA) Health Community, World Health Organization, World Bank, Capacity Project.

Contact Person: Dr. Helen Lugina

Address: Plot 157 Oloirien, Njiro Road, P.O. Box 1009, Arusha, Tanzania;

[helugina@ecsa.or.tz](mailto:helugina@ecsa.or.tz)

### **Objectives:**

- 1) To introduce key features of the Africa Health Workforce Observatory (AHWO)
- 2) To discuss four country-level applications and lessons learned about implementing national observatories
- 3) To identify support needed for other countries in the region to implement a national observatory

### **Description of the Project:**

The Africa Health Workforce Observatory (AHWO) is a cooperative network among countries and partners to promote human resources for health policy development, information sharing and partnerships that will strengthen health workforce systems and policy dialogue in Africa. The first AHWO meeting was held in September 2006 at ECSA headquarters in Arusha, with participants from 14 African countries, to mobilize support for development of national observatories to deal with human resources for health issues at the country level. A panel of experts from four countries with national observatories will discuss their experience in developing national observatories; identifying human resources issues addressed; describing outcomes; sharing lessons learned; and suggesting ways to improve the observatories. This will be followed by a discussion period with participants from the region to identify how to develop national observatories in other countries; how to support country-to-country sharing and collaboration; and how to disseminate information across the region.

**Type of presentation: PANEL DISCUSSION**

## ABSTRACT NO. 5

**Title: Human Resources for Health Protocols, Strategies and Approaches in ECSA Countries: A Desk Review.**

Dambisya YM<sup>1</sup> ([yoswad@ul.ac.za](mailto:yoswad@ul.ac.za)), and Lugina H<sup>2</sup>

<sup>1</sup>Department of Pharmacy, School of Health Sciences, University of Limpopo, Polokwane, Republic of South Africa; <sup>2</sup>Human Resource Development and Capacity Building, East, Central and Southern African Health Community, Arusha, Tanzania.

**Background:** A desk review of HRH policies and practices in ECSA region and internationally was undertaken as part of the process for the development of a strategy that will enable ECSA-HC to work with and offer relevant support to member states on HRH issues.

**Objective:** To establish areas of progress and gaps to inform the focus of ECSA-HC HRH work in the medium term.

**Methodology:** A review of published and grey literature, with input from an ECSA workshop. The review took into account issues of financing, policy, education, partnerships, leadership, management systems, and equity, efficiency, effectiveness and quality of the health systems.

**Findings:** The region is largely characterised by low income, poor health indicators, high disease burden, low health sector spending and a small health workforce. The main HRH challenges are (a) Poor HRH development and management (b) Low production (c) Inefficient utilisation of available HRH (d) high attrition of staff, (e) limited resources for the health sector as a whole, and (f) lack of reliable data on HRH. ECSA countries have employed various financial and non-financial incentives for health worker retention, with varying degrees of success. There are a number of initiatives to optimise health service delivery, including decentralisation and the essential health package. There is political leadership on HRH issues, evident both nationally and at international forums such as SADC, AU and ECSA.

**Conclusion:** There are many innovative approaches to the HRH problem in the region, though these remain poorly documented and/or disseminated. Some best practices in tackling the problem in the region will be highlighted.

**Type of presentation: ORAL**

## ABSTRACT NO. 6

### **Title: Use of Non-Financial Incentives for Health Worker Retention in East and Southern Africa**

Dambisya YM<sup>1</sup> ([yoswad@ul.ac.za](mailto:yoswad@ul.ac.za)), lipinge S<sup>2</sup>, Lugina H<sup>3</sup>, Loewenson R<sup>4</sup>

<sup>1</sup>Department of Pharmacy, School of Health Sciences, University of Limpopo, Polokwane, Republic of South Africa; <sup>2</sup>Department of Nursing, University of Namibia, Windhoek, Namibia; <sup>3</sup>Human Resource Development and Capacity Building, East, Central and Southern African Health Community, Arusha, Tanzania; <sup>4</sup>Equinet Secretariat, The Regional Network for Equity in Health in east and southern Africa (Equinet), Harare, Zimbabwe.

**Background:** The east and southern Africa region (ESA) faces a critical shortage of health workers. EQUINET in co-operation with ECSA-HC have a programme supporting knowledge for retention of health workers in ESA. A review of available literature on use of non-financial incentives in ESA was commissioned, supplemented by input from a regional meeting on HRH.

**Objectives:** To establish which non-financial incentives are used in ESA countries.

**Methods:** A desk review of published and grey literature on use of non-financial incentives in 16 ESA countries, subject to further input from countries at a regional workshop.

**Findings:** A variety of non-financial incentives are used, including: (i) Training and career path-related incentives, e.g. continuing professional development, training and research opportunities, scholarships ± bonding agreements (ii) Incentives that address social needs, e.g. housing, staff transport, childcare facilities, free food, and employee support centres. (iii) Improvement in working conditions, e.g. better facilities and equipment and better security for workers (iv) Strengthened human resource management (HRM) and human resource information systems (HRIS) (v) Workplace programmes to care for health workers and their families: access to health care and anti-retroviral therapy (ART) and health worker medical aid schemes. There was, however, little information on the application, funding, sustainability and impact of the incentives. Health information and management systems do not always adequately monitor or report on the impact of the incentives.

**Conclusions:** Non financial incentives can be complex to manage, and call for strategic capacities and information systems, backed by clear guidelines to and consultation with health workers. There is need to document and disseminate the use and impact of non-financial incentives so that the "best practices" are shared among the ESA countries. Examples of successful use of non-financial incentives in the region have been cited.

**Type of presentation: ORAL**

## ABSTRACT NO. 7

### **Title : Scaling Up of Tutor Training In Zambia**

**Author(s):** Dr Miriam Libetwa, Mrs Dorica Mwewa and Mrs Patricia Kamanga

**Institution:** Ministry of Health /WHO, Ministry of Health, Ndeke House Box 30205  
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### **Objectives**

- To increase the production of nursing and midwifery tutors by the year 2011
- To identify the training sites for tutors
- To develop curriculum for training tutors
- To Mobilize resources to support tutor training

**Introduction and Description of the Project:** Zambia is one of the thirty six countries experiencing a critical shortage of skilled human resources in the health sector. According to Zambian human resources strategic plan 2006-2011 there are 2,273 midwives and 6, 096 nurses against an establishment of 22, 332. The public health sector is operating at 50% capacity for reasons that are both exogenous and endogenous. The critical shortage of staff which Zambia is facing has equally affected education and training of nurses and midwives. One of the objectives of the Zambian human resources strategic plan (2006-2011) is to increase the output of training institutions. To do this, there is need to increase the production of nurse tutors. Tutors are key to the production of nurses and midwives and are change agents in educational reforms. The Department of Post Basic Nursing which was established in 1976 at the School of Medicine, UNZA is the only institution which trains nurse tutors for thirty-five (35) public, mission and private health training institutions in the country. The output from the Department of Nursing is inadequate to the demand of staffing levels of teaching staff.

The General Nursing Council recommended teacher student ratio for the classroom is 1:20 and for the clinical area 1:10, however what is prevailing for the classroom 1:75 and 1:60 (a teacher may be supervising students in more than six (6) practicum areas). This is over stretching the available teachers and compromising teaching and learning. There is need to explore the possibility of reviewing the curriculum used for training nurses and midwives in order to provide teaching and learning methodology in a shorter period while maintaining quality.

**Lesson Learned:** Stakeholders' participation is an important concept in developing nurses and midwives training programme.

**Policy and Programme Implications:** The training concept will need to be accepted by all stakeholders before further activities can be undertaken. The implementation of this programme will depend on the input from all cooperating partners and other stakeholders.

**Type of presentation: Oral**

## ABSTRACT NO. 8

### **Title : Direct Entry Midwifery Training**

**Author(s):** Dr Miriam Libetwa and Mrs Dorica Mwewa, Ministry of Health of Zambia, Ndeke House Box 30205 Lusaka Zambia, [milibetwa@yahoo.co.uk](mailto:milibetwa@yahoo.co.uk):[doricamwewa@yahoo.com](mailto:doricamwewa@yahoo.com)

**Objective:** To increase the number of midwives who will be able to provide quality midwifery and reproductive services.

**Introduction and Description of the Project:** The Health Sector in Zambia has been experiencing shortage of human resources over a period of time. This situation has constrained the Ministry of Health in achieving its vision of providing Zambians with equity of access to cost effect quality health care as close to the family as possible.

Maternal mortality is recognized in the world as a serious problem and several conferences have addressed the issue. The statistics in Zambia show that more than 70% of the 10 million Zambians live below the poverty line; Women of childbearing age 15-49 years constitute 22% of the total population and 18% of them are HIV infected. The recent DHS (2001-2002) places the maternal mortality ratio at 729 deaths / 100,000 live births. Many health facilities especially in the rural areas do not have sufficient numbers of midwives. The Ministry of Health in response to this crisis has initiated a number of strategies to address these challenges. These include re-opening of the closed nursing schools, retention schemes for health workers, rehabilitation of infrastructure in health institutions and the introduction of direct entry midwifery training. There are various training options, short and long term. The implementations of these different options will be in phases. The first phase will address the Direct Entry Midwifery training programme which be undertaken by selected training institutions. The participants will be trained for one and half years followed by six months interns. Their salary will be as other nurses whose duration of training is two years. Career progression for graduates will be the existing nursing and midwifery.

**Lesson Learned:** Early involvement of stakeholders in the development of a new training programme made it easier in having the concept accepted.

**Policy and Programme Implications:** The training program will need to be costed and included in the overall Ministry of Health action plan. Evaluation of the training program will need to be done before scaling out to the rest of the nurses and midwives training institutions in the country. The implementation of this programme will pose many challenges which will demand the participation and sustained support of all cooperating partners and other stakeholders. It is envisaged that this programme will greatly contribute towards the achievement of MDG 5.

**Type of presentation: ORAL**

## ABSTRACT NO. 9

**Title: Electronic Learning for Nurses in Kenya: Programme for Upgrading Nurses from Certificate to Diploma**

**Author(s):** Elizabeth Oywer<sup>1</sup>, Registrar, Nursing Council of Kenya  
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Email: [eooywer@nckkenya.org](mailto:eooywer@nckkenya.org), <sup>2</sup> *eLearning Programme Manager*, The African Medical and Research Foundation (AMREF), P.O. Box 27691-00506, Nairobi, Tel: +254-20-6993204, Fax: +254-20-609518  
Email: [adesuwaa@amrefhq.org](mailto:adesuwaa@amrefhq.org)

**Introduction and Description of Project:** The nurse is essential for health service provision. Enrolled Nurses (ENs) comprise 70% of nursing and 45% of the health workforce in Kenya. These nurses, who are the initial points of contact for communities and the backbone of the health system, do not have adequate skills to manage new and re-emerging diseases like HIV/AIDS. This has necessitated the upgrading of their skills to improve nursing standards, achieve the health related MDGs and enable them respond effectively to disease diversity and complexity. The Nursing Council of Kenya (NCK) decided to upgrade the skills of 22,000 ENs to registered level and in partnership with AMREF and Accenture, introduced electronic learning in September 2005. ELearning was the preferred mode due to its interactivity, cost effectiveness, ease of revision and ability to achieve the goal in less time and a fraction of the cost of the residential programme. It would also enable continued service provision, instant application of learning and improved quality of care.

**Lessons Learned:** Over 4,500 nurses are enrolled, with 442 computers installed in 101 eLearning centers across 8 provinces. An evaluation by NCK in August 2006 confirms improved nursing care in the clinical areas as students are able to instantly apply learning. Despite a few challenges, such as the need for additional clinical placements, the programme is satisfying the previously unmet need for upgrading.

**Policy and Programme Implications:** E-Learning is a good option for providing nursing education in Africa. Nurses have embraced it and are reaping the benefits. All African countries should adopt this innovative educational paradigm that will revolutionize health education and ultimately improve service provision.

**Type of presentation: ORAL**

## ABSTRACT NO. 10

### **Title: Training the Support Workers**

**Author(s):** Monica Servina RN, RM, Dip. In Medical Education, MSC in Nursing and Education, National Institute of Health and Social Studies

ADDRESS; PO BOX 48, Ministry of Education, Email [servina9mr@yahoo.com](mailto:servina9mr@yahoo.com)

### **Objectives:**

1. To integrate non-employed youth into a training programme
2. To offer an alternative mode of training of health workers
3. To contribute towards the improvement of quality patient care

**Description of the Project:** At the end of the selection exercise of the secondary 5 school leavers, around 10% of the students population do not obtain placement in a post secondary institution. These youth aged 16 -17 years with no trade skills find themselves unemployed. Institutions within the hospitality, building, maritime and agriculture disciplines, within the Technical and Further Education of Ministry of Education have been able to enroll some of these students on apprenticeship program. Health as such had not been involved in this training modality. The employment of care assistants in Ministry of Health and Social Development is the norm and this has resulted in them not accessing training at the start of employment. Many had to learn their role and acquire skills through "on the Job" training with the quality of training and level of support varying across wards and units. A group of 12 trainees was recruited to embark on an apprenticeship mode of training for care assistants. A competency based approach program was developed through a dual process of Job analysis of the Nurse. 9 competencies were identified and the curriculum was designed around these competencies within the Seychelles Qualification Framework. The implementation was conducted over a period of 18 months. Attrition rate was at 50% with 6 students completing the program. The quality of care given by the new breed of care assistants is valued by the Nurse in Charge.

### **Lessons Learned:**

1. The care assistant course is attractive to secondary 5 school leavers and should be institutionalized
2. The course should be included as an additional career choice and inclusive in the national career program
3. The older participants do better on the program, and second chances training opportunities should be promoted.

**Type of presentation: ORAL**

## ABSTRACT NO. 11

**Title: An Informatics System for Ensuring Scaling up Human Resources for Effective Delivery and Access to Health Interventions in ECSA**

**Author(s)** Agnes Waudu, HSC, RN, RM \*\*\*; Martha Rogers, MD\*; Patricia Riley CNM, MPH\*\*; MD, , Stephen Vindigni, MPH\*\*; Elizabeth Oywer, BN, DAN, RPN<sup>#</sup>; Chris Rakuom, BScN, RN, RM, ICUN, <sup>##</sup>; Japheth Ngoya BSc, MSc, MCSE, CCNA\*\*\*; Andrew Kamenju BA, PGDSc\*\*\*; John Arudo BScN, MPH, MSc\*\*\*; Eunice Masamo, KRHCN, #  
# Julia Thuo, DAN, MPH #.

\*\*\*Kenya Healthcare Workforce Project, \*Emory University, Atlanta, USA, \*\*Centers for Disease Control and Prevention, Atlanta, USA, <sup>#</sup>Nursing Council of Kenya, <sup>##</sup>Ministry of Health, Kenya, Tel: 254 – 20 2867000 Fax 2714745, [awaudu@ke.cdc.gov](mailto:awaudu@ke.cdc.gov)

### **Objectives:**

- Establish an informatics system for monitoring and analyzing health workforce capacity to provide healthcare.
- Provide technical assistance to Kenyan leaders in using data for human resource (HR) management, research and policy development

**Description of Project:** Many countries face healthcare workforce shortages, requiring healthcare managers to efficiently deploy their existing workforce. However, few developing countries have informatics systems that can assess and monitor the workforce. Such system is being developed by this Project in collaboration with the Ministry of Health (MOH) and professional regulatory bodies such as the Nursing Council of Kenya (NCK).

**Approach:** HR management requires data regarding supply and the deployment of workers. In Kenya, supply data come from the NCK. The deployment data come from the MOH and private healthcare systems. The Project began by organizing steering committee for decision-making and technical team for development of the informatics system. Once user specifications were determined, computer hardware, including satellite connection, was installed and software program was developed. To date, data are available on over 44,000 nurses. Deployment data, collected quarterly by the nurse in-charge at each facility, are compiled at district/provincial levels and forwarded to MOH headquarters. The software and computer workstations have been installed in 2 provinces. The Project plans to expand to all 8 provinces over the next 2 years.

**Lessons Learned:** Staff is using the system for report generation and other administrative needs. Capacity building at all levels to use data is critical. Logistics (e.g., power outages) need to be considered especially in rural institutions. Maintaining systems is costly and must be factored in institutional budgets for sustainability.

**Policy and Programme implications:** HRH policy for efficient training, recruitment, and deployment will be available, creating a comprehensive informatics system to inform policy. Kenya needs to share the outcome by publication, dissemination at various forums.

**Type of presentation: POSTER**

## ABSTRACT No. 12

### **Title: Use of Private Nurse Midwives to Reach Under-Served Populations**

**Author:** Pauline Muhuhu, Senior Advisor, Best Practices, Extending Service Delivery Project (ESD [muhuhu@esdproj.org](mailto:muhuhu@esdproj.org))

**Introduction:** The paper presents the work of nurse midwives operating private clinics in rural trading centers and densely populated peri-urban communities in Kenya. These nurse midwives are experienced MCH/FP service providers who retired from public sector because they had attained the government retirement age, yet they have several years of experience and command community respect and trust, and the communities need services. The nurse midwives expanded the scope of their work with technical assistance agencies and the ministry of health. They formed clinic networks for peer support and quality improvements to complement supervision from MOH. Available data shows that this group has potential to reach many women in these communities.

**Problem:** Nurses and midwives in Kenya are predominately women who retire at 55 years of age yet, the government of Kenya has acute shortage of staff. This group has demonstrated capability to continue quality service delivery among the under served and hard to reach communities at a nominal fee.

**Best/Promising Practice Documentation:** Through literature review, observational site visits and interviews with cluster members the USAID funded Extending Service Delivery Project documented two private nurse midwives clusters comprising of 47 clinics, Nursing and Maternity homes and their networking practices that enhance facility sustainability and service quality.

**Results:** These networks demonstrate effective in increasing the use of family planning services ranging from 50 to 500 clients within one cluster in 2005/2006; improving access to essential reproductive health services for women as evidenced by the range of reproductive health services offered and the number of women referred for PMTCT. Clinics start-up was financially challenging to the individuals.

**Conclusion:** This retired group is a resource of service providers that exist in the communities and that has a high potential for filling in the gaps currently being experienced in service delivery. Strategies to support the group to initiate services among the underserved should be put in place.

**Type of presentation: ORAL**

## ABSTRACT NO. 13

**Title: Where Does the Next Generation of Health Workers Want to Work? And Why? Qualitative Evidence from Tanzania.**

**Author(s):** Julie Riise Kolstad, University of Bergen, Norway, Department of Economics, Herman Fossgt. 6, N-5007 Norway, [julie.kolstad@econ.uib.no](mailto:julie.kolstad@econ.uib.no)

**Introduction and Objectives:** The geographical imbalance of the health workforce in Tanzania represents a serious problem when it comes to delivering crucial health services to a very large share of the Tanzanian population. In this article, qualitative information about what can be done in order to stimulate health personnel to work in rural districts is provided. What do health workers themselves perceive as the main reasons for the geographical imbalance that we see in Tanzania today? Why do health personnel move to central areas? Why do some stay in rural districts? Are there any means available that can make a job in a rural district more attractive? These questions are sought answered through the analysis of a series of in-depth interviews.

**Method:** 16 semi structured in depth interviews concentrating on the determinants of the availability of clinical officers in rural areas, were conducted in March 2007. Last year clinical officer students from two schools were interviewed; one in a relatively rural setting and one in a relatively urban setting. At each location 8 students were interviewed and an equal number of male and female respondents as well as a good balance between respondents with rural and urban background were ensured.

**Results:** Salary and allowances was mentioned by every respondent. The possibilities of further education, housing, the equipment situation at the health facility and the workload also frequently came up as important aspects of a job that the respondents would consider before making a decision. However, there was no common understanding of whether the workload was highest in rural or urban locations. The same goes for where the chance for allowances is highest. Another interesting thing that came up during the analysis of the interviews was the general perception of clinical officers that choose to work in rural districts. The prejudice (or fear of the prejudice from peers) that those health workers were lazy, incapable, and/or status minded seemed to be very common.

**Conclusions, Policy/programme Implications:** It seems like the salary will have to increase in order to make the rural jobs more attractive. Favourable packages that include opportunity for further education after a certain amount of time in service is another option. Attitude campaigns and better information about working conditions in different location may also help somewhat. However, it is difficult to give concrete recommendations based on qualitative research only, a quantitative follow-up study is thus conducted this autumn.

**Type of presentation: POSTER**

## ABSTRACT NO. 14

**Title:** The Mkapa Fellows Programme: Bringing Hope to Rural Areas of Tanzania

**Authors:** Mkondya-Senkoro E., Saguti Nyamwihura A., Mkuwa S. Ipuge, Y. et al

**Institutional Affiliation:** Benjamin W. Mkapa HIV/AIDS Foundation, Ministry of Health & Social Welfare, Presidents Office Regional Administration and Local Government, Clinton Foundation, P.O.Box 77277, Dar Es Salaam, Tanzania; Email: [asaguti@mkapahivfoundation.org](mailto:asaguti@mkapahivfoundation.org) or [info@mkapahivfoundation.org](mailto:info@mkapahivfoundation.org)

**Description of the project:** Considering the 68% shortage of human resource for health and slow enrollment and uptake of Anti retroviral therapy in the rural districts of Tanzania, the Mkapa Fellows Programme (MFP) was initiated in July 2005 by the Former Presidents, Benjamin William Mkapa and Bill Clinton.

The target is to recruit 90 Fellows and to date 69 Fellows have been recruited and are serving 23 hard to reach districts of Tanzania. The Fellows comprising of Clinicians

(Medical Officer, Assistant Medical Officer), Nurse and either a Laboratory Technicians or Pharmacists under three years contract with the Foundation, were deployed to districts in team of three and work under the supervision of the District Medical Officer.

As a retention strategy, the Fellows and Districts have been benefiting from an incentive package having both monetary and non-monetary aspects.

**Objectives:** To recruit, train, deploy and retain skilled professionals to support the aggressive implementation of Tanzania's response to HIV/AIDS, including but not limited to the National Care and Treatment Program.

**Lessons learned:**

Orientation of regional and district officials jointly with the Fellows resulted into Fellows being well integrated into the district health systems.

Improvement of HIV/AIDS services requires having skilled and motivated health workers as well as strengthening the operational and health delivery systems

Fellows not only improved HIV/AIDS services, but other health services as well such as dental, maternal and child and pharmaceutical services.

**Programme and Policy Implications:**

The programme is observed as a good practice attempting to address Human resource for Health crisis concurrently accelerating HIV/AIDS care and treatment in rural areas; as observed within 9 months whereby there is 100 percent increase of clients enrolled to Care and Treatment Clinics and starting ART.

The fast track hiring and retention mechanisms used by the Programme are approaches that provide further insight and can be applied by the Health sector at the National and District level.

**Type of Presentation:** Oral

## ABSTRACT No. 15

**Title: The Emergency Hiring Project in Tanzania**

**Authors:** Mliga G, Mkondya-Senkoro E., Saguti Nyamwihura E., Mkuwa S, Nanai A., Chando A et al

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**Description of the project:** The Ministry of Health and Social Welfare in its effort to tackle the shortage of Human Resource for Health it embarked in January 2007 on a short term initiative namely Emergency Hiring Project funded by the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria. The aim is to accelerate hiring, placement and retention of 176 health workers to serve 19 rural districts. The hires of 10 different cadres have been placed on three years contract between the Ministry, Local Government Authorities and the new hires. Based on the Benjamin W. Mkapa Foundations experience on Mkapa Fellows Programme, the Foundation is providing technical and management support to the project.

To strengthen the district HRH management systems for long term solutions to recruitment and retention challenges, the Capacity Project through USAID funding is supporting another component of the EHP.

**Objective:** To accelerate recruitment, placement and retention of health workers in districts to support acceleration of HIV/AIDS services

**Lessons learnt:** Recruitment and placement of health workers to the districts can be implemented by the Government institutions in close collaboration with a Non governmental organization to reduce the cumbersome process of recruitment.

**Programme and Policy Implications:** The initiative is critically following up on the approach of hiring and placing health workers on three years contract followed by the new hires being mainstreamed in the Government system at the end of the contract. To improve retention of personnel, an attractive incentive package has been defined and used under the project; with aim of providing inputs to the Government into the upcoming process of defining attractive packages for hard to reach districts.

**Type of Presentation: Oral**

## ABSTRACT NO. 16

### **Title: Promising Practices to Address Human Resources for Health (HRH) Workforce Issues**

**Author(s):** Pamela McQuide, Graeme Frelick, Jim McCaffery, Bruno Benavides, Barbara Stilwell, The Capacity Project, 6340 Quadrangle Drive, Suite 200 Chapel Hill, NC 27517 USA, Tel. 919-313-9167, Fax 91-313-9108  
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**Objectives:** Disseminate and promote adaptation and application at the country level of innovative strategies to address health workforce shortages and other key HRH issues in the region.

**Description of the Project:** While recent reports have described general approaches to improve the HRH situation at the country level, we lack more detailed documentation describing public and private sector actions to address these problems. USAID's Africa Bureau commissioned a study to identify and document promising practices to serve as a practical and much needed resource for governments, partners and donors in promulgating policies and approaches that have successfully mitigated the negative effects of the health workforce crisis. The innovative strategies in Ghana, Uganda, Malawi, and Namibia focus on task shifting, improving retention, and increasing recruitment and rapid deployment. Guidelines were developed to replicate these promising practices at the country level.

**Lessons learned:** Complex, multifaceted issues can only be addressed effectively by partnerships among government, health professions, NGOs and others. When a new practice is considered, HRH leaders and practitioners should identify appropriate partners and engage in effective partnership building. Developing a shared vision and instilling values, managing complex programs and partnerships, and effective negotiation are some of the management and leadership skills that are also necessary. In addition, it is important to stress that effective HRM requires a broader approach, with coordinated HRH policies and interventions, rather than "one-off" responses.

**Policy and programme Implications:** Introducing or altering a practice can involve a major system-wide change and will have direct and indirect cost implications. One of the best uses of donor funding, or funding from public-private partnerships, is to allocate all or a certain percentage to designing, implementing and evaluating new practices that may address critical health workforce challenges. Health system leaders must be willing to advocate for funding in these areas, and donors need to be open to providing a certain level of support.

In ministries of health, HR units typically have little influence and low priority in terms of creating establishment positions and assigning qualified personnel to address workforce issues. Given the urgency of the HRH issues, it is important we build the capacity and professionalize the cadre of HR managers and leaders and give HR divisions the power and authority required to implement positive change.

**Type of presentation: ORAL**

## ABSTRACT NO. 17

### **Title: Scaling up Human Resource Development: The Case Study of Several African Mental Health Human Resources**

**Authro(s):** Prof. David M. Ndetei, MB ChB (Nairobi), DPM (Lond), M.R.C.Psych, FRCPsych, (UK), MD (Nairobi), Professor of Psychiatry, University of Nairobi & Director, Africa Mental Health Foundation (AMHF), Tel: (+254) -020-2716315, Mobile: (+254) -722 518365 / 720 957477, [dmndetei@mentalhealthafrica.com](mailto:dmndetei@mentalhealthafrica.com); [dmndetei@uonbi.ac.ke](mailto:dmndetei@uonbi.ac.ke)

**Objectives:** To study and compare the pattern and distribution of psychiatrists in Kenya, Uganda, Nigeria, Zimbabwe, South Africa and Egypt.

**Methods:** Email questionnaire to heads of academic departments.

**The Results:** South of Sahara and North of Limpopo there was gross deficiency of a psychiatrists. This was more marked in the rural areas giving a psychiatrist: population of one psychiatrist for 1-4 million populations. There was also gross deficiency in other mental health personnel. There was also massive loss of psychiatrists and other personnel through migration. Egypt and South Africa have done relatively better. Locally trained psychiatrists compared with foreign trained psychiatrists did much better on non-migration to other countries, working in rural rather the urban areas, working in public rather than private sector and in overall academic achievements.

**Conclusion:** In the fore-seeable future in Kenya and other similar countries, it will not be possible to achieve a psychiatrist: population ratio equivalent to what currently obtains in the Western countries, both in overall ratio for the country, and more importantly, in the average distribution within the country. For the needs of Kenya and other developing countries, local training of psychiatrists is superior to foreign training in several parameters. If Kenya and other similar developing countries in Africa are to achieve a realistic mental health service delivery in the foreseeable future, then other alternative training in mental health must be given more prominence than just training psychiatrists.

**Type of presentation: Oral**

## ABSTRACT No.18

**Title:** Health Workforce Competence and Workplace Assessment for Safe Deliveries: Implications for Training and Quality Improvement at the Workplace

**Authors:** Dr Alice Mutungi<sup>1</sup>, Dr Steven Harvey<sup>2</sup>, Dr Stephen Kinoti<sup>2</sup>, Thada Bornstein<sup>2</sup>, Dr Elizabeth Hizza<sup>2</sup>, Dr Josephine Kibaru<sup>3</sup> MOH/Kenya, Dr Helen Lugina<sup>4</sup>  
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**Objectives:** To determine the competency levels of the workforce attending to women during labor, delivery and early postpartum period; determine environmental and organizational factors that affect their productivity and performance; and assess implications for regional training and performance improvement at the workplace.

**Methods:** The study, conducted in 2 districts in each of 3 provinces, Nyanza, Coast, and Eastern, of Kenya, assessed competence of at least six hospital-based birth attendants and at least 12 health center-based attendants in each district, a total sample of 118 attendants and at least 19 health facilities (one hospital and at least one health center in each district).

Both knowledge and skills were included in the Competence assessment. A 50-question test related to the management of normal labor, delivery and immediate post-partum period for the mother and newborn measured clinical knowledge. Skills performance in active management of the third stage of labour, manual removal of the placenta, bimanual uterine compression, immediate newborn care, and neonatal resuscitation with an ambu bag, were assessed using anatomical models. Health facilities were assessed by completing a 90-item checklist to document human resource complement, infrastructure, processes of care, availability of supplies and equipment, and mortality data.

**Results:** Providers performed well in some areas, such as the knowledge test (63% of questions were answered correctly), proper use and disposal of gloves (84%), counseling mother on breast-feeding (94%), and checking the placenta for completeness (>90%). The key weak areas included the skills area where apart from active management of the third stage of labour (AMTSL), slightly fewer than 50% of the participants completed more than half of the necessary steps correctly; 43% correctly performed controlled cord traction, 15% invited patients to ask questions, 15% dried newborn thoroughly, and <10% ruled out presence of 2nd fetus before administering uterotonic. Nonetheless, providers appreciated feedback and performance improved immediately.

Regarding health systems, some key drugs such as antibiotics and uterotonic were available in most health facilities but organization and sustainability of referral and

counter-referral systems, algorithms for managing obstetric emergencies and use of maternal and neonatal health standards were wanting.

**Conclusions and policy/programme implications:** Generally, there were gaps with regard to competency of health personnel at performing basic life-saving skills, infrastructure and referral systems. However there were indications that some key problems can be resolved easily and at minimal cost and thus the potential for significant health improvements.

There is a need to conduct similar assessments in other ECSA member countries, and to work with stakeholders to improve provider competency, infrastructure, equipment, and supplies at basic levels as well as strengthen intra- and inter-facility referral and counter-referral systems to ensure continuum of care.

**Type of presentation: Oral**

## ABSTRACT NO. 19

### Title: 'Empowering Midwives: Saving Mothers' - Enhancing Midwifery Tutors Capacity in the ECSA Region

**Author(s):** Tina Lavender<sup>1</sup> Helen Lugina<sup>2</sup> On behalf of the ECSA project team<sup>3</sup>

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**Background:** It is estimated that 585,000 women die each year as result of pregnancy and childbirth. Almost all of these deaths (99 per cent) occur in developing countries, particularly Africa (WHO, 2006). Only 42 per cent of births in the African region are attended by skilled personnel. The majority of the developing countries have no midwifery educators' programmes to produce trainers to train the required skilled attendants. In sub-Saharan Africa midwifery educators are in short supply and those in post lack training, status and political awareness. Opportunities to pursue advanced education are severely restricted. Measures are needed to assist midwives to cope with scientific, technological and cultural developments and empower them to lead their profession.

**Aim:** The University of Central Lancashire, ECSACON, Health Section of the Commonwealth Secretariat, Higher Educational Institutions and ICM are developing a distance learning programme for midwives in the ECSA Region. This MSc in Midwifery and Women's Health aims to encourage critical thinking and strategic planning in midwifery education, practice, management and research.

**Method:** A needs assessment in Uganda and Tanzania (2006) identified the motivation for postgraduate education through distance learning; a need reinforced by the Commonwealth Secretariat, WHO and HEI's. Midwifery teachers were identified as an important cohort who, through advanced learning, has the ability to positively influence the profession and subsequent practice. We are developing a user-led distance learning programme by adopting a participatory approach to curriculum development. The course aims to produce critically evaluative practitioners, capable of developing maternity care in their own environment, promoting a humanising, safe experience for mothers and families. Thirty midwives from countries throughout ECSA participated in a curriculum planning and module development workshop. Brainstorming sessions, formal workshops and informal consensus methods were used to reach decisions regarding modules and subsequent content.

**Outcome:** This programme has engaged many midwifery partners to develop a postgraduate course which is flexible to the needs of individual countries and has shared ownership. This paper will not only present details of the curriculum but also an evaluation of participant's workshop experiences. The challenges of true partnership working will be discussed, as well as the mutual benefits to partners.

**Funding:** This current work is being funded by the England/African Partnership programme of the British Council and is a continuation of an initiative which started in Malawi in June 2006 (with major funding from Commonwealth Secretariat).

**TRENGTHENING DISEASE CONTROL: HIV/AIDS, TB,  
MALARIA AND NON-COMMUNICABLE DISEASES**

## ABSTRACT NO. 20

### **Title: An assessment of the Prevalence of Diabetes Mellitus, Hypertension and Associated Risk Factors in Swaziland**

**Author(s).** Tsabedze Lindiwe & Masango Sdumo, Non Communicable Diseases Programme – Ministry of Health & Social Welfare, Swaziland. P.O.Box 1246, Manzini, Swaziland., [Lindiwetsabedze@swazi.net](mailto:Lindiwetsabedze@swazi.net)

**Objectives:** To conduct a national prevalence survey for diabetes mellitus, hypertension and associated risk factor for coronary heart diseases and stroke.

**Methods:** A cross – sectional community based survey, on 1,584 persons aged 25+ years was conducted. The selection was by multi-stage cluster sampling. Subjects were recruited the day before and appointments were made for the following day. Subjects were requested to fast 10-12 hours since the last meal. Subjects were then visited the next morning at their individual homes. The following were then conducted per subject: Blood glucose, cholesterol, triglycerides, Glucose tolerance, Blood pressure, Body Mass Index was measured.

**Results:** Diabetes Mellitus highest in the age group 65-74 years 11%. Impaired glucose tolerance was highest in the age group above 75 years 26% group 65-74 years 20%. Impaired glucose tolerance was in females 17% and in males 16%. Hypertension was highest in the age group 75 36%. Obesity was highest in the 45-54 years old age 48%. Males were found to be more active 64% than females 36%. Cholesterol was present in the age groups 1.2% total cholesterol was present in the age group 25-34 years 4.4 %. Borderline triglycerides were most prevalent in the age group 45-54 years 6%.

**Conclusions:** The adult Swazi population is suffering from diet related non communicable diseases as demonstrated by the results presented.

**Policy/programme Implications:** There is need for more awareness creation on NCD's in the Swazi population. Preventative measures need to be availed at health facilities. Interventions are needed at facility as well as community level. NCD's need to be accorded more priority.

**Type of presentation: ORAL**

## ABSTRACT NO. 21

### **Title: The Seychelles National School Nutrition Policy- Improving the Nutritional Status of Seychellois Children**

**Author(s)** Sarah Romain,\_(BSc Nutrition/Dietetics, MSc Public Health Nutrition),Head, Nutrition Unit, Ministry of Health and Social Development, P.O. Box 52, Seychelles, E-mail: [dietitian@moh.gov.sc](mailto:dietitian@moh.gov.sc) , Tel: 388061, Fax: 225131

The Seychelles National School Nutrition Policy developed in 2007, represents efforts to utilize schools as sites for improving the nutritional well-being of all school children in Seychelles. The policy which has been jointly developed by the Ministries of Health and Education as well as all school communities in Seychelles, recognizes the importance of good nutrition and its impact on health. Over the past decade, the prevalence of obesity amongst children and adolescents has continued to rise at an alarming rate. Chronic diseases such as diabetes, high blood cholesterol and hypertension are now no longer restricted to the adult population, but increasingly becoming more apparent amongst our youth population. The policy capitalizes on the fact that schools are not only settings where nutrition education can be imparted, but simultaneously provide an excellent milieu for healthy eating to be practiced, ensuring the dissemination of strong and consistent messages for effective behaviour change. Through the development of this policy, a framework will be available to ensure that healthy eating is promoted in schools at all levels and that food service strategies become more integral to the educational role of schools. It will be used to coordinate all aspects of school nutrition including the curriculum, the school tuck shop, provision of school meals, training of school personnel as well as the nutritional psycho-social environment of the school. The Seychelles Dietary Guidelines launched in 2006 will form the basis of all nutrition education in schools and food provision will be centred on only foods of high to moderate nutritional value. An evaluation tool has been jointly developed to ensure that progress is monitored and that implementation is successful nationwide. Although still in its infancy, the policy had had wide acceptance by the community given that a bottom-up approach was taken in its development.

**Type of presentation: ORAL**

## ABSTRACT NO. 22

### **Title: The Seychelles Dietary Guidelines**

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**Author(s):** Miss Christina Esther (BSc), Ministry of Health and Social Development, [nutritionist@moh.gov.sc](mailto:nutritionist@moh.gov.sc), Tel. 00248 388062 / 00248 511448, Fax. 00248 225131

Aimed at guiding the Seychellois population to consume a diet that promotes nutritional well-being and prevent diet-related diseases, the Seychelles Dietary Guidelines (SDG) is a set of sixteen statements and a food guide (Seychelles Food Guide) produced and launched in June 2006 by the Nutrition Unit, Seychelles Health Department. The Seychelles Dietary Guidelines is directed at food intake and reasonable body weight in the general population from 2 years onwards, but nevertheless includes the specific recommendation on breastfeeding in the under twos. It is somewhat illustrated pictorially through the Seychelles Food Guide (SFG), a five food group model that directs attention on the importance of consuming a variety of foods to meet nutrient requirements. Besides being scientifically-based, SDG takes into account our leading causes of death (cardiovascular diseases followed by cancer) and our most prominent diet-related conditions. The results of the Seychelles Heart Study (2004) provides a clear rationale for using SDG as a means of improving our present diet which is highly refined, high in saturated fats and poor in fruit and vegetables. The Seychelles Dietary Guidelines is now an important tool for all educators including nurses, dietitians, doctors, teachers, social workers, the media, food caterers and manufacturers. So far, SDG and SFG posters have been produced and disseminated in schools, workplaces and amongst the general public during exhibitions, presentations and media programs. A resource pack is being printed for all Seychelles public and private schools. The Seychelles Dietary Guidelines now forms the basis of the School Nutrition Policy, the Food and Nutrition Policy for Health Institutions as well as the forthcoming National Food and Nutrition Policy.

**Type of presentation: ORAL**

## ABSTRACT NO. 23

**Title: Food Based Dietary Guidelines for Swazi Adults Living with HIV/AIDS.**

**Authors:** Tsabedze Lindiwe , Masango Sdumo, Love Penny, Non Communicable Diseases Programme – Ministry of Health & Social Welfare, Swaziland. P.O.Box 1246, Manzini, Swaziland.

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**Objectives:** Analyzing food consumption patterns of Swazi adults to identify macro and micro nutrients deficiencies\ excesses in order to formulate food based dietary guidelines for people living with HIV/AIDS.

**Methods:** A cross – sectional community based survey of 1,584 persons aged 25+ years was conducted. Nutritional analysis based on food frequency was carried. This study is an extension of the data analysis obtained from the Non Communicable Diseases Risk Factor Survey.

**Results:** An older rural population is evident, reflecting rural – urban migration. Body Mass Index was high in the urban area. Intakes of protein, fat and carbohydrates was higher in the urban area. The unemployed had lower intakes of protein, calcium and sodium. All males had a total kilo caloric intake of 1838, 46 – 2277, 70 Kcal per day. Overall fat intake was less than 30% of total energy but fat consumed was from saturated fat. Cholesterol was below 300mg\dy. Intakes of carbohydrate, dietary fiber and added sugar were low in all age groups. Intakes of calcium, iron, magnesium, zinc, vitamin A, vitamin B3, vitamin C, folate and sodium were low in all age groups.

**Conclusions:** Poverty is evident in food consumed by the rural population who are a majority. In the urban and industrialized area the emergence of a nutrition transition is evident.

**Policy/programme implications:** Develop food based dietary guidelines as nutrition support materials for dissemination to the public, and translate these into community based programmes for schools, the workplace, shops and supermarkets.

**Type of presentation: ORAL**

## ABSTRACT NO. 24

**Title: Integrated Management of TB and HIV/AIDS at Facility Level: Experience from Temeke, Tanzania**

**Author(s):** Bupamba M, Masika E, Kapalata, N., S, Wandwalo E, Egwaga, Swai, R., Cress S, and Ipuge Y,

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**Objective:** Increase access to TB and HIV/AIDS care and treatment services among co-infected patients to reduce TB and HIV related morbidity and mortality.

**Description of the Project:** Access to HIV/AIDS care and treatment services among TB patients as well as diagnosis and treatment of TB among PLHIV is limited due to a number of factors including few HCWs, limited space in clinics, unskilled personnel and big number of patients on both clinics.

In late 2005 the Clinton Foundation HIV/AIDS Initiative was invited by the Ministry of Health and Social Welfare to collaborate with Temeke Municipal Council in designing and implementing a model of providing HIV/AIDS care and treatment services in the setting of a TB clinic. The main objectives were to promote early diagnosis of HIV among TB patients, ensure continuity of treatment from TB to HIV, and improve the quality of life among co-infected patients. The intervention comprised of four major activities: Improvement of infrastructure to create adequate space for integrated services; increasing human resource capacity by recruiting additional staff and training on TB/HIV collaborative activities including HIV/AIDS diagnosis, counseling, care and treatment; improving monitoring and evaluation to ensure quality of care; improve referral networks to support services and linkage to community.

### Lessons Learned

- TB settings are ideal entry points to identify HIV-positive patients and provide HIV/AIDS care and treatment services.
- Comprehensive TB/HIV/AIDS care and treatment services provided under one roof promotes recovery to patients and enhances quality of life
- Linking facility-based services with community based activities promotes health seeking behavior and reduces HIV/AIDS-related stigma
- Human resource capacity, improved infrastructure and monitoring and evaluation facilitate quality health care delivery.

**Type of presentation: ORAL**

## ABSTRACT NO. 25

**Title:** Development of HIV/AIDS workplace Policy for Swaziland Ministry of Health and Social Welfare

**Author:** Jennifer K. Kaahwa

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**Objectives:** Disseminate and promote adaptation and application at the country level of innovative strategies to address the impact of HIV/AIDS on the health workforce in the region

**Project Description:** The Ministry of Health and Social Welfare (MOHSW) commissioned a study on the Impact of HIV/AIDS on the Health sector. The study undertaken by Health and Development Africa (HDA) revealed that there was high attrition due to illness and death, absenteeism, low morale, low levels of productivity, high costs of retraining, budgetary and managerial inadequacies. The MOHSW requested technical assistance from the Southern African Human Capacity Development Coalition (SAHCD) to facilitate the development of an HIV/AIDS workplace policy. The East, Central and Southern African Health Community (ECSA), a member of SAHCD facilitated the development of the policy. The process was led and fully owned by the MOHSW under the guidance of the Under Secretary Administration. It was participatory and involved wide consultations among stakeholders in order to build consensus on the final document. A number of workshops were conducted to draft and review the policy, and implementation plan. The final draft policy has been presented to the Permanent Secretary for subsequent approval.

**Lessons Learned:** Leadership of the process by the MOHSW creates a sense of ownership and enthusiasm for task accomplishment. Multi Sectoral approach and broad stakeholder involvement enhanced consensus building on the process and content of the policy. Some provisions of the policy that are not statutory are already being implemented.

**Policy/programme Implications:** The policy provides structural framework to support implementation. It also provides for increased access to prevention, treatment and care of careers and respect of human rights. More resources will be directed to service provision for career of careers, which will reduce attrition, increase morale hence improve access to and quality of health services.

**Type of:** ORAL

## ABSTRACT NO. 26

**Title: Factors Leading to Rejection of Free Insecticide Treated Nets (ITNs) in the Coastal Region of Kenya, 2006**

**Author(s):** Ayub Manya<sup>1</sup>, Doris Njomo<sup>2</sup>, Ruth Kihara<sup>1</sup>, Christine Pekeshe<sup>3</sup>, Eric Maitha<sup>4</sup>

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**Presenter:** Ayub Manya (M.B.Ch.B, MSc Epidemiology) email [ayubmanya@yahoo.com](mailto:ayubmanya@yahoo.com), cell phone +254 722221266, Division of Malaria control, Box 20750, Nairobi. Telephone/fax.+254-202716935

**Background:** With support from Global Funds, Kenya conducted a countrywide free mass distribution of insecticide treated nets to children below five years of age in 2006. However some communities in the coastal region rejected the nets. Many nets were therefore returned to health facilities and to local administrative centres within the district. A study was then conducted to establish the reasons for the rejection.

**Methodology:** A cross sectional study design was used. The study site was the affected administrative division of District X. Key informant interviews and focus group discussions were conducted. Four focus group discussions were held. Information was sought as to how they came to know about the distribution of the nets. A standardized guideline was used in the discussions. Qualitative data analysis was done.

**Results:** All key informant interviews confirmed that nets had been returned due to unconfirmed rumours, bad dreams and allergic reactions especially on the first day.

Radio, school children, dispensaries and sub-chiefs were mentioned as the sources of information. None of the participants was informed of airing the net for 24 hours before use. Over 95% of the participants were happy with subsidized nets but suspicious of the free nets. Some respondents associated the white nets and the rectangular shape, with coffins and ghosts. All women concurred that white nets were difficult to keep clean.

**Discussion:** Proper use of ITNs has been demonstrated to drastically reduce the burden of malaria. This study inferred that the nets were given out with inadequate social mobilization and education. The community disliked the colour, the shape and the free distribution of the nets. If not well mobilized, the community is always suspicious of free commodities. It is recommended that future campaigns should have adequate social mobilization and needs assessment to avoid community rejection.

**Type of presentation: ORAL**

## ABSTRACT NO. 27

**Title:** Institutionalization of Injection Safety into Medical Training School curriculum in Kenya

**Author(s):** \*Songa J, MD MPH, \*Lengewa C, \*\*Kanyotu M.

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**Location of Project:** Kenya, JSI MMIS Project

**Objectives:** To reduce medical transmission of blood borne pathogens like HIV, hepatitis B and C, the Making Medical Injections Safer (MMIS) project in Kenya provides training and educational materials to improve the quality of health care. To achieve this goal, Health care providers are trained on injection safety and waste management. To sustain safe injection practices, the involvement of medical training schools is vital.

**Methods:** Training institutions provide excellent environments for rapid roll-out of training activities on IS. Advocacy meetings were held with heads of the institutions, deans, academic boards, professional associations and regulatory bodies to build support. Lecturers from selected departments were identified as core trainers and trained. An integration framework was developed for key departments to fill the identified gaps. These departments include, Nursing, Clinical medicine, Medical laboratory and public health. The curricula review process begun. The core trainers are involved in strengthening the teaching of key concepts, support curriculum review and integration process and supervising students in clinical areas. The training institutions have been involved in the development of policy, standards and guidelines on IS.

**Results:** The review of curriculum to incorporate IS concept is ongoing. Selected departments are teaching IS. It is expected over 2000 nurses, 1500 Clinical officers, and 200 PHO and 300 Laboratory technologists to graduate annually. There is enhanced collaboration between training institutions, professional associations and regulatory bodies and other key partners.

Main challenges include slow curricula review process; a lot of resources are required. Involvement of other public, private and faith based medical training institutions.

### **Recommendations**

- 1) Continued support for the completion of the review process of curricula.
- 2) Mobilize all institutions to include IS in their training.
- 3) Mobilize additional resources for the process.

**Type of presentation:** ORAL

## ABSTRACT NO. 28

**Title: Implementing Sustainable Sharps Disposal Systems in Kenya**

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**Location of Project:** Kenya, JSI MMIS Project

**Objectives:** Injection safety is a process that involves several activities that include the safe disposal of used sharps. The key steps in the management of sharps are segregation, handling and storage, transport, treatment and disposal. In resource poor settings, treatment and disposal options are often limited. Therefore, incineration and use of protected sharps pits offer feasible options for treatment and disposal of sharps.

**Methods:** Injection providers in Bondo and Kiambu districts were trained on segregation. Safety boxes, needle removers and colour bins were provided to facilitate segregation of waste. Needle removers and safety boxes were procured through **PATH**. The **WHO** colour coding system for healthcare waste was adapted for Kenya. The existing deMontfort incinerators constructed by **MOH**, **UNICEF** and **WHO** were rehabilitated to improve combustion. Incinerator operators were trained by **JSI MMIS**. Protected sharps pits were constructed in facilities where needle removers were supplied. Waste management plans were developed. A transportation system for safety boxes put in place. The filled safety boxes were either disposed on site or transported to the nearest incinerator within the district.

**Results:** The disposal of sharps through incineration and use of protected pits has improved. Segregation of HCW as a best practice has been adopted in over 80 percent of health facilities. An assessment done in 2005 showed an improvement in sharps disposal in Bondo and Kiambu. There are indications of a reduction in incidences of needle stick injuries which can be attributed to the use of safety boxes.

### **Recommendations**

- 1). Explore alternative sharps disposal systems for the different health care settings;
- 2) Encourage partnerships with key stakeholders to ensure sustainability.

**Type of presentation: POSTER**

## ABSTRACT NO. 29

**Title:** Factors Associated with Low Condom Use for HIV/AIDS/STIS and Pregnancy Prevention Among Adolescents in Temeke, Dar es Salaam

**Author:** Amiri Rajabu Mmaka, Hubert Kairuki Memorial University, P.O. Box 65300, Dar es Salaam. Tanzania, [amirimmaka@hotmail.com](mailto:amirimmaka@hotmail.com), Mobile phone: +255 754 325694

**Objectives:**

1. To assess the knowledge related to condom use among adolescents.
2. To identify factors leading to low condom use among adolescents in the study area

**Methods:** A cross-sectional study involved 270 adolescents aged 13-24 (187 males and 83 females) living in the community from 24 streets of 8 wards in Temeke, Dar es Salaam selected by multistage cluster sampling technique were interviewed using a questionnaire.

**Results:** Results show that 63% had primary education, 90% were unmarried and 54% were Muslims. Other findings were that 98% of the adolescents had information about condoms and their functions. However, (62%) did not know the correct time to remove a male condom after use. Ninety percent did not know how to use a female condom and 92% did not know how to keep a condom for maximum efficiency. In addition, 60.7%(164) of the adolescents had penetrative sex, of whom, only 37.2%(61) had used condoms. Ninety percent (90%) of the adolescents who had used condoms reported less sensation, dislodging (loose) of condoms during sexual intercourse, itching on sex organs and painful sex when using condoms. Those adolescents who did not use condom at their first sexual intercourse reported to be afraid or shy to buy or ask for a condom from sources, did not know how to use condoms, not knowing the importance of using a condom, that condoms were not available and had no money to buy a condom as reasons for not using condoms. Other findings were that 88.5% (54) of the adolescents who had used a condom at their first sex reported to have used condoms at their last sexual intercourse. The opinions given by the respondents on how to enhance condom use behaviour among adolescents include: provision of more education on HIV/AIDS/STIs and early pregnancies prevention 59%(159), condoms should be provided to adolescents freely 25%(25), teach proper condom use in schools 14%(37), condoms should be distributed in homes, working areas and in schools 13%(35), condoms should be sold or distributed by adolescents/youths and provide condoms of different sizes.

**Conclusion:** Ignorance of adolescents on HIV/AIDS and sexually transmitted diseases were associated with the low use of condoms.

**Policy/programme Implications:** Programmes promoting condom use by adolescents should look into strategies for addressing the identified barriers to condom use first before pumping much resource into those programmes

**Type of presentation:** ORAL

## ABSTRACT NO. 30

**Title:** Rift Valley Fever (RVF) Outbreak in Kenya, December 2006-April 2007

**Author(s) & Presenter:** Dr. Joyce Kerubo Onsongo,

**Objective:** To share experiences learned from outbreak investigation and response on RVF

In mid-December 2006, several unexplained deaths in humans following acute onset of fever with bleeding were reported to the Kenya Ministry of Health from Garissa district in North Eastern Province (NEP). The area had experienced unusually heavy rainfall since mid-October 2006; rainfall for October through December. Eleven deaths were reported by December 20<sup>th</sup>. On 21 December, KEMRI confirmed RVF infection in 10 out of 16 patients tested by ELISA for IgM-specific antibody detection and by reverse transcriptase-polymerase chain reaction (RT-PCR) to detect the genome. These findings were confirmed later by isolation of the Rift Valley Fever virus (RVFV) itself from several clinical specimens. In response to this outbreak, an epidemiological investigation was launched on December 23<sup>rd</sup> by KMOH and Field Epidemiology Laboratory Training Program (FELTP), the Kenya Medical Research Institute (KEMRI), the Walter Reed Project of the US Army Medical Research Unit, the Global Disease Detection Division of the Kenya Office of the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) other partners including *Medecins Sans Frontieres* (MSF). Investigation teams conducted patient interviews and reviewed medical records retrospectively from December 1<sup>st</sup> in major health care facilities in the seven districts from which cases had been reported. A field laboratory was established by CDC, the Kenya Medical Research Institute (KEMRI), and the MOH at Garissa Provincial Hospital.

The index case was reported in Garissa district with symptom onset on December 4, 2006, suggesting possible exposure in late November 2006. From 30 November 2006 to 12 March 2007, a total of 684 cases of RVF were reported in Kenya, including 155 deaths, translating into a 23% case fatality proportion. Of the 684 reported cases, 234 (34%) were laboratory confirmed by the presence of IgM antibodies against RVF or by RT-PCR. Of the remaining 450, 221 were classified as probable. The last case was reported in the Rift Valley Province and died in Baringo district on 9 March 2007. WHO supported the Ministry of Health to institute effective coordination mechanisms at national, provincial and district levels. WHO mobilised over 15 international and local experts in support of outbreak response, and a facilitated multi-sectoral workshop to mobilise additional resources.

### **Lessons learnt:**

1. An effective disease surveillance system saves lives, by detecting promptly disease outbreaks and instituting effective response.
2. A well co-ordinated structure for disease outbreak response needs strong leadership at national level. This reduces duplication of efforts from local and international partners.

**List of people reporting (see Annex 1)**

**Type of presentation: ORAL**

## ABSTRACT NO. 31

**Title: The Magnitude and Factors Responsible for Delay in Tuberculosis Management in Dar-es-salaam, Tanzania.**

**Author(s):** <sup>1</sup>G.S. Mfinanga, <sup>1</sup>A. Kahwa, <sup>1</sup>B. Mutayoba<sup>\*</sup>, <sup>1</sup>G. Kimaro, <sup>1</sup>R. Mtandu, <sup>1</sup>E. Ngadaya and <sup>2</sup>S. Egwaga,

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**Objective and Methods:** Delays in the diagnosis and initiation of effective treatment of tuberculosis patients result in a prolonged period of infectivity in the community. This cross sectional survey assessed the magnitude and factors responsible for delay in TB management and it was conducted in all districts in Dar es Salaam region. Interviews were conducted involving 600 TB patients.

**Results:** The results showed that patient delay, defined as time interval between the onset of symptoms and the first doctor visit was more than 30 days in 35.1% of the study participants, with significantly ( $X^2 = 5.49$ , Df = 1,  $p = 0.019$ ) high proportion in females (41.0%) than in males (31.5%). The health system delay defined as a function of the time from of first consultation with a TB clinician to a time when diagnosis is made, was observed to be more than three days in 52.9% of the study participants, with significantly ( $X^2 = 10.1$ , Df = 1,  $p = 0.001$ ) high proportion in females (62.1%) than in males (47.0%). The factors that were associated with female patients delay included: not recognizing that the following could be symptoms of TB; night sweat (OR = 1.92, 95% CI 1.20, 3.05), having chest pain (OR=1.62, 95% CI 1.11, 2.37), weight loss (OR = 1.55, 95%CI 1.03, 2.32), and coughing blood (OR =1.47, 95%CI 1.01, 2.16). Likewise, living far from a health facility (distance  $\geq 5$  Km) visited at the time of interview (OR = 2.24, 95% CI 1.41, 3.55), having no primary education (OR = 1.74, 95% CI 1.01, 3.05) and having no employment (OR = 1.77, 95% CI 1.20, 2.60).

**Conclusion:** Findings from these study revealed a delay of management of tuberculosis patients which is a contributed by both patients and health facilities. The delays at both levels were more common in females than males.

**Type of presentation: ORAL**

## ABSTRACT NO. 32

### **Title: A Health Diary Approach to Reproductive Health Empowerment of Adolescent Young Women**

**Author(s):** Miyoko IIDA, Professor, Gunma Prefectural College of Health Sciences (Maebashi, Japan) , RN,MW,MS, [iida345@gchs.ac.jp](mailto:iida345@gchs.ac.jp)

**Introduction:** As a transitional stage of human development, adolescence is the period in which a child matures into an adult. For female adolescents it means the transition from the girlhood to the motherhood and the beginning of the reproduction. Adolescents face a wide range of issues everyday relating to their physiological, cultural and psychological concerns. One of the most important and complicated issues is teenage unintended pregnancy and AIDS/HIV infection. It becomes an obstacle to overcome for reproductive health promotion. Thus, it is the urgent challenge for WHO to strengthen adolescent young women's reproductive health.

**The Project:** The reproductive health of female adolescents is therefore a serious issue all over the world. A woman lives with a menstrual cycle, which is under the control of the hormone system and is necessary for reproduction. Knowing the menstrual cycles enables to promote the self-care for reproductive health. However, it is hard to keep in memory even of the previous menstruation without any action like writing a record about it.

**Policy and Programme Implications:** In this study we propose a specific-format health diary and design its draft version, in order for female adolescents in Africa to record about the information on menstruation. The design of the health diary is based on the author's nearly thirty years study and experience of using such a health diary in Japan. The use of such a health diary can certainly promote the empowerment of adolescent young women since it is able to help them manage their own self-care for the reproductive health in the long term. To enhance the style and format of the proposed health diary, it is important to take any advice from adolescent young women as well as health care experts.

**Type of presentation: POSTER**

**IMPROVING ACCESS TO ESSENTIAL  
MEDICINE AND DRUGS**

## ABSTRACT NO. 33

**Title: Access to Prescription Drugs and Practice Patterns in Health Care Systems: Implications for Policy Development in Zimbabwe.**

**Author(s):** Sebit, MB<sup>1</sup>, Chandiwana, SK<sup>2</sup>., Mtero-Munya, S<sup>3</sup>., Mapira, W<sup>4</sup>., Chandiwana, SD<sup>5</sup>., Nherera, L<sup>6</sup>., University of Zimbabwe<sup>1</sup>, Blair Research Institute, MoH & CW<sup>2-6</sup>, Harare, Zimbabwe

**Objectives:** To evaluate the drug provision and prescription patterns during health care interaction among prescribers, suppliers and patients; the characteristics and determinants of drug provision and prescribing patterns; the cost of drugs at the sales point of the different study sites; and recommendations to policy makers.

**Methods:** A cross-sectional study conducted in Harare and Mutare. Street corner interviews of community members coming out of pharmaceutical facilities; dummy patients visiting doctors' health care facilities; exit interviews on patient leaving facilities i.e., pharmacies/Surgeries/private clinics; and questionnaires for interviewing health providers/practitioners/ stakeholders were used. Data were analyzed using SPSS.

**Results:** About 138 subjects were enrolled. Of these, 62 (44.9%) were females, 47 (34.1%) subjects were aged 13-25 years, 98 (71%) had secondary education level, and 25 (18.1%) of them employed in private sector. A fifty nine (56.2%) subjects consulted doctors, 43 (41%) consulted nurses, pharmacists, 2 (1.9%), and only one (1%) did not know. Over half of the health providers were males, 54 (52.9%).

**Lessons learned:** Providers of health care systems do steal drugs from public sector facilities for utilisation in the private sector; prescribing of expensive brand name rather than generic drugs; unnecessary medications and injectable prescriptions, etc.

**Policy and Programme Implications:** Medical and economic effects due to misuse of drugs: adverse, possibly lethal effects; limited efficacy on account of under -therapeutic drug dosage; antibiotic resistance on account of over/under -therapeutic drug dosages; drug dependence; risk of infection due to improper use of drugs; effect on household and national budgets.

### **Recommendations**

- a) MoH & CW, Medical Aid Societies and health providers to collaboratively develop national policies that guide practice
- b) Better working conditions for practitioners/pay.
- c. Strict control /security measures and entrusting drug management to qualified personnel.
- d. Educating the public on drug issues

**Type of presentation: ORAL**

## ABSTRACT NO. 34

### **Title: Using Evidence-based Practices to Enhance Service Delivery in Family Planning**

**Author(s):** Dr Marsden Solomon, Family Health International, P O Box 38835-00623 Nairobi, Kenya, Tel 254-2-2713913-9, Fax: 27726130, Email: [msolomon@fhi.or.ke](mailto:msolomon@fhi.or.ke)

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**Description of the Project:** Improving the performance of health systems for effective delivery and access to health interventions remains a priority in East, Central and Southern Africa. To achieve this goal, health services need to ensure that evidence-based practices, based on experience and research, are incorporated into programs, especially in resource-constrained settings. Family Health International's CRTU Project has attempted to facilitate this process in the region by compiling Menu of Evidence-based Practices in Family Planning - a collection of evidence-based standards, norms, guidelines, tools and proven practices that can be used to address priority areas to improve access to contraceptives. FHI has also implemented two evidence-based best practices, to demonstrate the application of evidence to actual programs.

#### **Objective of the One-Hour Session:**

- To create awareness in participants, on use of evidence-based practices in Family Planning;
- To familiarize participants on documented processes of getting evidence into practice

#### **Methodology:**

PowerPoint presentations and hand-outs

A one-hour session to orient participants on the using evidence-based practices to strengthen health service delivery programs

#### **Lessons Learned in Applying Evidence to Practice**

- Leadership by the local Ministry of Health greatly facilitates the adoption of evidence-based practices
- Systematic provider training and attention to supply issues is essential to implement evidence-based practice
- Advocacy is needed, to build stakeholder consensus and secure support
- Continuous monitoring is essential to identify problems and address them

**HEALTH CARE FINANCING: EQUITABLE  
ACCESS TO HEALTH CARE**

## ABSTRACT NO. 35

### **Title: Use and Institutionalization of NHA in ECSA**

**Author(s):** Dr. Mark Bura, Health Systems Development Programme, ECSA NHA Network

In 2001 countries in ECSA started to produce and use NHA for policy decisions. To date the status of use and institutionalization of NHA in ECSA region can be divided into three main categories.

- Countries that have yet to undertake their first NHA
- Countries that have done only one NHA with minimal use
- And countries that have done more than one NHA and have used the result for policy decisions

The countries in the last but best category are six in ECSA. Some of these countries had some difficulties in getting resources initially but in general, later, they were able to get adequate resources, moderate technical expertise and maximized on NHA training programme by ECSA and international organizations conducted 6-8 years ago.

Over the past six years ECSA HC has been conducting NHA Regional Training courses that have contributed to the current core expertise in NHA in the region. A good example of the impact of NHA initiative by ECSA health community is the institutionalization of NHA in Mauritius, Zambia and Kenya.

The impact of NHA on policy decisions in ECSA can be summarized as follows:

- Kenya disseminated the results on 2nd NHA in 2005 and the Minister of Health was able to use NHA evidence to get an increase of 30% to the health budget. Although Kenya had initially been skeptical about the household health spending results the 2nd confirmed the validity of 1st NHA and indeed contributed to this significant budget support.
- Tanzania used NHA results to reinforce coordination of external resources and increased its attention to the private sector.
- Mauritius has seen that despite good quality health services fully funded through public Funds the households still spent highly on private sector and alternative medicine. As a result Mauritius is using NHA for development of SHI. The private sector is also using it for “medical hub”.
- Zambia has used NHA to focus resource to the rural communities through better resource allocation criteria.
- Uganda used the NHA results for public private partnership
- Malawi is going to use the 2<sup>nd</sup> NHA for Performance Based Financing and review resource allocation formula to be used for donor resources and drugs allocation.

The old problems of trained NHA experts leaving the ministry or placed into positions that do not support NHA still continues. There is still a need to train more NHA experts and consequently ECSA Health Community is establishing a regional course for this purpose at institutions in the region. There is a need for international effort to support NHA champions; training them for example to advocate better for NHA and similar innovations that need adoption and scaling up.

**Type of presentation: ORAL**

## ABSTRACT NO. 36

### **Title: Costing the Delivery of Minimum Essential Health Services Package in the Coast Province of Kenya**

**Author(s):** Joseph K Wang'ombe, PhD, University of Nairobi, Department of Community Health, Email: [jwangombe@mail.uonbi.ac.ke](mailto:jwangombe@mail.uonbi.ac.ke), Mercy G Mugo, PhD, University of Nairobi, School of Economics, Email: [mmugo@mail.uonbi.ac.ke](mailto:mmugo@mail.uonbi.ac.ke)

Three of the eight Millennium Development Goals (MDG's) focus on health improvement. Health systems in poor countries are not able to meet the MDG's due to resource constraints in the face of declining donor support. This calls for a limited package of essential health services as a top priority for government finance. A locally defined and costed Minimum Essential Health Services Package (MEHSP) for Kenya has not been compiled to date. Such a package could facilitate planning and decision making regarding financial resource requirements for efficient service delivery.

The study set out to define and cost the actual and the essential minimum package of health services in Coast Province of Kenya. Conceptualisation of the package essentially includes the ability to provide curative services to treat the ten leading causes of morbidity and effective promotive and preventive services at the district level. Sophistication of the system increases as service delivery moves up from dispensary to the health centre and the district hospital and vice versa. The costing methodology uses volume of services being offered at the health facility. The study departs from the traditional methodology by costing the operations of the facility and allocating the costs to defined health services, as opposed to cost centres.

Cost analysis shows that the higher the level of services the higher the aggregate costs. Individual facilities have unique cost experiences with the dominant inputs (buildings, equipment, personnel, drugs and non-pharmaceuticals). Resource gaps analysis shows that service provision is sensitive to dominant inputs at all levels of care. Targeting of the resources was found to be poor at all levels as demonstrated by the wide range of excess and shortages of inputs. A deliberate policy for targeting of resources for the important inputs to ensure optimisation of resource use is recommended.

## ABSTRACT NO. 37

### **Title: Institutionalizing Hospital Efficiency Costing to Increase Effectiveness**

**Author(s):** Dr. Mark Bura, ECSA Health Community; Dr. Takson Lambart, University Teaching Hospital, Lusaka, Zambia<sup>1</sup>, Prof. Harun arap Mengech, Moi Teaching and Referral Hospital, Eldoret<sup>2</sup>, Kenya, Dr. Hadija Shikely, Cost Provincial General Hospital, Mombasa, Kenya; Mr. Matthews Birgen<sup>2</sup>, Mr. David Kirui<sup>2</sup>, Mr. F. Mponella<sup>1</sup>, Mr. R. Tumeo<sup>1</sup>

### **Best Practice Model**

The objective of this presentation is to introduce team-based Hospital Efficiency Costing (HEC) model the use of which can improve effectiveness, efficiency and quality of hospitals services in the region.

**Background:** Hospitals consume 40-70% of Total Health Expenditure but are under funded. Most expenditure is spent on personnel (60-70%), drugs (9%) and medical supplies (10%). These resources are poorly managed. Staff shortages are rife; equipment last a third of lifespan; physical plants poorly maintained and dilapidating. Shortages and wastages of medicines and supplies are common adversely effecting client services.

Hospitals in ECSA operate at low effectiveness and efficiency; budgets are historically set rather than on unit costs. Decisions to improve effectiveness and performance lack adequate financial or workload information support.

To address these problems, in 2002, ECSA initiated a team-based Hospital Efficiency Costing.

**Objectives:** The major objective of this intervention is to increase efficiency and effectiveness of hospitals

**Methodology:** This 2-3 week operation, strictly team-based and lead by Chief Executive Officers (CEO) is being institutionalized. Groups of 5-6 peer hospitals are trained by certified trainers. Quarterly costing reports are analysed and shared with all service providers, health ministries, and stakeholders.

**Impact of HEC intervention:** Ten tertiary and secondary level hospitals have completed the costing. Two training centres for rolling out HEC to country hospitals have been established. Using costing information, managers have improved performance: analyses of inputs and activity monitoring is better, wastages are reduced, *work output and quality outcomes are improved*. Hospitals are able to adjust user-fees and allocate revenues rationally subsidizing the low cost services. Recruitment, training and distribution of staff is better. Contracting out services (catering, laundry and cleaning) has significantly improved effectiveness and efficiency of hospitals.

**Type of presentation: ORAL**

## ABSTRACT NO.38

### **Title: Cost Sharing Programme in Tanzania; Lesson from Experience**

**Author(s):** Neema Jamu, Senior Economist, Policy and Planning Department, Ministry of Health and Social Welfare, Tanzania

**Introduction and Objectives:** Cost sharing in Tanzania was introduced in July 1993 as a complementary health financing option. The objectives of cost sharing are to (i) generate additional revenues to bridge the gap in government allocation, (ii) improve availability and quality of health services, (iii) strengthen the referral system, (iv) rationalize utilization of health care services, (v) improve equity and access to health services by pooling financial risk and cross-subsidizing costs and (vi) strengthen community voice towards improving service quality and provider's accountability.

**Description of the Project:** The introduction of cost sharing in government health facilities was implemented in four phases; first phase included grade I and II services for referral and regional hospitals, the second phase covered grade III Services in referral and regional hospitals, the third phase in District hospitals and the fourth phase, in health centers and dispensaries via CHF approach. So far the implementation of CHF scheme has gone to 72 councils.

To ensure equity and access, issues of exemption and waivers have been considered to all government facility basing on particular services, age group, diseases and income. The need for exemption and waivers was to ensure that every body has equal rights to access health services especially for vulnerable and poor.

**Achievements and Lessons Learned:** A Number of achievements have been recorded since the introduction of cost sharing including drug availability, procurement of equipment and supplies, rehabilitation of hospitals, some changes of health providers' attitude and behavior, change of community attitude on the utilization of health care services and management of funds.

However, some challenges have been encountered such as exemptions for those who can not afford to pay have not been working effectively. At the same time, revenues are not collected and recorded accordingly. Capacity to manage funds and budget is still limited.

To the large extent, the Ministry achieved its objective of cost sharing policy, though there is a need to call for improvement in exemption and waivers mechanism to ensure equal utilization of health services, also to set strategies of revenue targeting to all health facilities.

**Type of presentation: ORAL**

## ABSTRACT NO.39

**Title: The Tanzania Community Health Fund as Best Road Map for Universal Coverage.**

**Author(s):** Ludovick James Nduhiye, Principal Economist, CHF/TIKA Coordinating Unit, Department of Policy and Planning, Ministry Of Health and Social Welfare, Tanzania.

**Introduction and Objectives:** The Tanzania Community Health Fund (CHF) is a model that aims to promote a sound partnership between the community and their government. This Fund is a potential means of ensuring greater security of access to health care services for the community from rural setting and urban informal sector. It is also empowering households and communities in health care decision.

**Description:** The Community Health Fund provides residents of typical rural district with the opportunity to contribute a household annual prepayment premium and receive a health card and be entitled to the specified health care service package. CHF is operating in 72 District Councils out of 98 targeted. But, 92 Councils had been sensitized and passed a By Law since December 2005.

**Achievements and Lessons:** The lessons from experience demonstrate convincing contribution on health care resources envelope at local level. For example, the last financial year (2006/07) matching fund application that indicates household contributions shows: Kigoma has managed to raise 95million which is 27% enrolment rate. Others are Igunga 32.3million; 15%, Mwanga 21million; 18%, Geita 96.9Million; 10%, Rungwe 80million; 14% and the least submitted matching claim is 13 million from Kasulu DC, about 4%. This amount has been spent on various activities targeted towards improvement of health services in respective health facilities. The Client perceived needs is a driving force on priorities setting. Drug, medical equipment, minor rehabilitation and construction of health facilities are the most common aspects in CHF Fund utilization.

Despite these achievements of CHF in the implementing districts, there are still some concerns and challenges. These include low enrollment of members and inadequate managerial skills, broader exemption policy and lack of effective promotion and marketing.

**Policy/programme Implications:** The success implementation of CHF, which targets more than 80% of all Tanzania, will provide a better road map for universal coverage.

**Type of presentation: ORAL**

## ABSTRACT NO. 40

### **Title: Home Based Care Commodity Management Practice – Can we Challenge Policies and Practice?**

**Authors:** Mavere Tukai<sup>1</sup>; Veronica Mkusa<sup>1</sup>; Michael Machaku<sup>2</sup>.

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**Objective:** To analyze and document the commodity management practice in home based care project in Kinondoni district. The study also aimed at monitoring and reviewing HBC kits supply management from supplier to the users.

#### **Description of the study**

*Approach/Methodology:* The team mapped the HBC commodity supply chain and documented HBC kit supply system management. Demands were matched with actually supplies and usage in order to address actual patients' requirements and other supply systems within the covered area.

*Target:* The analysis targeted health Facilities [Magomeni health centre and Mwananyamala hospital], HBC supervisors and Community Health Workers in Kinondoni district wards; patients and family members in Kinondoni district wards.

**Findings and Lessons Learnt:** Supply chain of HBC commodities strengths, potentials and gaps were identified. There is a possibility of integrating HBC commodities supply and other supply systems into the health facility. In addition, there was significant variation in products demand depending on various factors surrounding the set up.

Training on rational use of HBC commodities and flexibility in planning HBC support is important. Critically, adherence to government policies such as handling prescription medicines, quality assurance of products and risks associated with medicines would still need further scrutiny.

Supply management of HBC commodities is vital in monitoring effectiveness of the projects.

#### **Policy and Programme Implication**

Translation of policies and guidelines into guidelines is important for successful implementation of quality and robust HBC projects. This process is dynamic and need not to be fixed. Furthermore, linkage of HBC with other care and treatment component is necessary.

**Type of Presentation:** ORAL

## ABSTRACT NO. 41

**Title:** Implementing a Regional Strategy (pre-service Curriculum), as a partial measure to address human resource capacity, to strengthen pharmaceutical management in support of ART roll-out in Lesotho.

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**Objectives:** The objectives were to:

- Equip pre-service pharmacy and nursing students with skills required to manage all aspects of pharmaceutical and ART commodities.
- Find innovative ways of delivering the ART curriculum to graduating students in all health institutions in Lesotho;

### **Description of the project**

There are 183 clinics and 93 ART centers with 41,104 clients enrolled on the HIV chronic registers. Due to staff shortages, some of these clinics are run by nurses and pharmacy technicians. Therefore, there is need for an all-rounded health professional. With support from MSH, the Department of Pharmacy of the National University of Lesotho devised a program to hold training workshops for all final year students in health training institutions. For this purpose, the Department adopted, adapted, and implemented the "Pre-Service Curriculum for Pharmaceutical Management in Support of ART", developed by the Regional Pharmaceutical Forum for East Central and Southern Africa member states.

### **Lessons Learnt**

The pre-service Curriculum has the content to expedite skill building in commodity management in graduating students. The problem-based approach employed for the delivery of the Curriculum was found to be very effective in consolidating the knowledge and understanding of challenges facing ART programs of which the students had insight.

### **Policy and program implications**

As governments prepare to roll out ART to lower levels of health care, there is need to re-allocate resources to pro-actively build capacity and equip pre-service graduates for management of pharmaceuticals, as a more sustainable approach to address human resource constraints.

## ABSTRACT NO. 42

**Title: Using assessment data as a strategic tool to operationalize the Regional Pharmaceutical Forum and empower it to implement interventions to Scale –up Best Practices in Pharmaceutical Management in ECSA Member States. (Oral & Poster)**

**Authors:**

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**Objectives**

The RPF was established to provide technical leadership and support to ECSA countries to achieve:

- An enabling environment for a well governed, efficient and effective pharmaceutical sector in member states;
- Strengthened pharmaceutical management systems for improved access to quality essential medicines and health supplies;
- Improved and rationalized use of medicines by health professionals and the public.

**Description of the Project**

Countries in the ECSA region are re-strategizing in order to continue providing quality health care in the face of increasingly constrained resources, (policy, financial, information and human), an expanding HIV/AIDS epidemic and other emerging and re-emerging diseases.

The RPF network was launched in 2003 to address some of these constraints and is one of the Expert Committees of the DJCC. It's a collaborative mechanism of ECSA HC and MSH, funded by USAID/EA. Its primary mandate is to identify and develop strategies and better practices in pharmaceutical management at regional level and to then to advocate for their implementation by member states. The RPF's activities are implemented through four Technical Working Groups comprising experts in health/pharmaceutical management from the member states.

**Lessons Learned**

Member states can expedite implementation of interventions to improve pharmaceutical management systems by adopting better practices developed by the RPF.

**Policy and Program Implications**

As member states strategize on ways to increase access to essential medicines, they should consider adopting and integrating the better practices developed by the RPF into their health policies and operational plans.

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<sup>1</sup> Management Sciences for Health/ Rational Pharmaceutical Management Plus

<sup>2</sup> Management Sciences for Health/ Rational Pharmaceutical Management Plus

<sup>3</sup> East, Central and Southern Africa Health Community

<sup>4</sup> Management Sciences for Health/ Rational Pharmaceutical Management Plus