**ETATMBA Annual Conference**

**Malawi Institute of Management, Lilongwe**

**Saturday 26th May**

**MINUTES**

**Present:** Paul O’Hare (Chair), Godfrey Mbaruku, Chisale Mhango, Francis Kamwendo, Alan Davies, David Davies, Doug Simkiss, Siobhan Quenby, Ed Peile, Chicco Chiwandira, Anne-Marie Brennan

From midday: Staffan Bergström

**Apologies:** Senga Pemba, Fannie Kachale

**1. Welcome (PO’H)**

PO’H welcomed delegates and explained that the running order had been planned in order to take account of the later arrival of SB.

**2. Malawi BSc curriculum: overview, evaluation and development plans (EP)**

EP summarised the current situation regarding the curriculum. There are many interested parties with different views about the curriculum. Ideally 6 areas of interest would be approved simultaneously, but the Ministry of Health (MoH) was more interested in just surgery and non-surgery. The College of Medicine (CoM) and Dean were interested in increasing the basic clinical sciences, rather than a more training-focussed programme. Malawi Medical Council (MMC) emphasised that it would have to approve all training, even if it had been approved by the CoM.

To date: Warwick has approved a Level 4 Advanced Diploma. The COs’ current qualification equates to a Level 2 Diploma (from College of Health Sciences). Plan is to count this as prior learning, to which other modules can be added, making 2/3 of a degree. An additional 1/3 needs to be added to create a full degree. It is likely that the CoM will not approve the new courses in time, hence the proposal to give the current students a Warwick degree. However, this would still need approval from the MMC.

AD pointed out that the MMC have said they will approve the idea ‘in principle’.

EP said that Warwick has to produce a letter of explanation, a needs assessment, a curriculum and an apology.

CM commented that the MMC doesn’t need to approve a degree for existing COs – only to allow them to study. It is the MoH which promotes the COs, and they can do this without reference to the MMC.

PO’H said that the MMC’s approval would still be required for future qualifications.

EP said that with this in mind, he has designed one curriculum for Warwick and the CoM, but two syllabi – ie two different ways of delivering the same curriculum. To be delivered in 2 semesters per year, BOG1 (11 modules) BOG2 (8 modules), BOG3 (9 modules) producing 28 modules in total, making 360 credits. Warwick plans to APEL the first year, so EP has made Year 1 of the degree very basic so it is obvious there is no point in repeating it for the current COs.

Needs assessment is robust: early consultations, pilot study, amendments.

AD asked if the BSc surgery would be a separate syllabus or curriculum.

EP replied that a lot of teaching will be common to both. For example the curriculum lists ultrasound, but the syllabus will teach it differently for the obstetric and surgical courses. All the qualifications will be approved at the same time, producing a suite of ‘specialist CO’ qualifications. The curriculum for all specialties will be roughly the same, but the syllabi will differ.

PO’H reminded the group that the current COs will have distance learning to cover any basic science aspects required to satisfy the CoM.

EP said that one difficulty is inappropriate referral to hospitals.

Some discussion on this topic:

POH suggested a 2-month secondment; CM felt this was possible but there would be a cost for the project to bear.

SQ felt it would be more effective to send doctor trainers out to the DHs.

EP suggested refining this so that the doctors helped the COs in the district, and that the COs prepared specific lists of skill requirements so that they could have a highly-focussed 1-2 days of training at a large hospital.

GM said that the AMOs, while experienced, were often found to miss some basic principles when they were assessed, and emphasised that theory should be backed up with hands-on practice in the required area.

Agreed: one-month secondment, later on in the training period, and would aim to involve consultants visiting COs to do on-the-job training during the final year.

*Action:* PO’H will discuss with Ministry.

Coffee break

**Module 3: Advanced obstetrics** (SQ)

This is due to take place in November. SQ would like to focus on preterm labour (32-37 wks), covering pre-conceptual and antenatal care (diet, contraception, screening, anaemia), intrapartum (steroids, diagnosis), and post-partum (DS covering small for dates, infection, running special care nurseries). Ultrasound training to differentiate preterm from small for dates; scanners to be loaded from GE. Clarification on transfer issues: obstructed and preterm labour.

AD said effective decision-making is vital in this area. Is possible to have phone app with weekly text describing each week in pregnancy. May help to work with the main NGOs (Marie Stopes and Save the Children); suggested both a bottom-up and top-down approach, with the middle gradually squeezed out.

Module to take place in Blantyre

*Action:* CC to investigate the logistics (teaching rooms, accommodation).

 AMB to arrange planning meetings within a month of Module 2 finishing.

**Malawi: report of progress to date: feedback from Modules 1 and 2** (CM, DD)

CM summarised Module 1. COs are being monitored, they are cascading their training and producing audits.

CM reported that guidelines have been revised, but there has been a problem with this: another project was completing the same task and sent those revised protocols for printing. However, the guidelines contain flaws. The MoH accepts there are errors and will correct them in the light of our comments.

DD summarised Module 2. About half the students have completed the course. The values-based practice is a new concept but the students have found it helpful. There are 3 components to assessment: OSCEs (GM was an observer), completing the audit cycle with a re-audit, and using the clinical leadership competency framework with its self-assessment and action plan for improvement.

CM suggested that zonal officers, who are health managers, attend the training.

PO’H suggested that a professional project could include a large audit, operationalising the guidelines and creating a flow diagram.

DS said that D-Tree could put flow diagrams onto mobile phones as a training device (to overcome the problem caused by the protocols not being approved). DS plans to apply to D-tree for funding and to obtain MoH support, which could also feed into a professional project.

SB arrived at this point.

**Milestones and deliverables**

Reviewing targets for the first 12 months:

Website. This is done, but is basic. DD suggested it could be improved.

*Action:* DD to contact Catherine Fenn at Warwick about making improvements

 AMB to ask SB for some photos

 AMB to arrange a meeting with Kate Cox and DD about the website

 AMB to discuss with Communications regarding increasing publicity

Report for Advanced Leader model can comprise the course documents for Module 2.

Design of pilot professional support network. This is underway (discussed later).

Design of evaluation. This is underway (discussed later).

Guidelines. SB commented that while these are now completed for the EC, there is no strong follow-up for implementation as there are insufficient resources. There can be conflict, with non-specialists designing inappropriate guidelines. Ifakara course is producing and teaching good practice guidelines.

Initial training of research staff. In Malawi one PhD candidate has been selected and should be registered; the second has yet to be registered. In Tanzania, one PhD candidate, a paediatrician, has had some difficulties registering, (which are now resolving) and the second applicant (a DMO with a masters in public health) is in process registering at Nelson Mandela University.

Recruit NPCs. Completed.

Finalise design of curricula, guidelines, content and assessments of all training programmes. Completed (not including the recent discussions on developing a BSc for the Malawian COs)

Criterion-based audit. In progress for Malawi. In Tanzania they are using log books to go through cases to form benchmarks for audits. Post-course assessment is in place in Tanzania.

Lunch

**Tanzania: report of progress to date (SB)**

Each course comprises 5 AMOs and 5 nurse-midwives so 10 per batch. Post-course assessment has been completed on 30 of the 106 trainees and is continuing. Assessors are different from trainers. Misunderstandings and errors have been identified but main difficulty is poor resources, meaning that the newly-trained staff are unable to practice their skills fully.

GM reported that further training is underway and there will be 124 in total. AMOs complete a log book, and the leadership training has helped them in their development. They are able to question their seniors and follow up and resolve difficulties.

DD asked if the assessments could be shared.

SB said that the assessment that was developed by SP was too complex and needed further work. There is therefore scope for re-aligning with Warwick’s assessments.

*Action:* SP to provide a summary statement after the third post-course assessment, so that other colleagues can make suggestions for its improvement.

SB commented that the 4-month course in Tanzania is too short; there is similar feedback from the students. It would also help if the AMOs could have some experience in a hospital to avoid the problem of them becoming dormant due to insufficient resources at the health centres.

SB also said that there is a degree of hostility towards AMOs, and any deaths linked to AMO practice could jeopardise the success of the project.

**EC reporting requirements (AMB)**

The first report for the EC covers the period 1 February 2011 to 31 July 2012. The report is divided into a core report, in which beneficiaries are required to comment on progress in terms of the original project objectives and deliverables, and the financial reporting.

AMB has appropriate contacts now for all the finance reporting. There is a potential difficulty with the MoH as there has been little communication with the accountant.

EP offered to read the report draft to ensure it is coherent.

*Action:* PO’H will emphasise importance of finance reporting to Fannie Kachale and accountants Dominica Chidiaudzu and Fatsa Ninthala at the MoH.
 Working group to be convened, lead by Work Package leaders.

**Reports from work package leaders**

Refer to sheet ‘Work Package Objectives” for this discussion.

WP1 Developing the workforce by training NPCs in more advanced obstetric care (PO’H)

Objectives:

1 – well underway

2 – training DMOs, consultants; Tanzania use a professional organisation of O&G staff and local consultants

3 – on course

4 – on course

5 – SQ has looked at this with Saliya

6 – on course

WP2 Developing improved clinical guidelines and pathways for local African context and evaluation (SB)

Objectives:

1 – have tried to improve (see other comments above)

2 – covered

3 – covered

4 – difficult. More developed in Malawi than Tanzania. SB commented that it is difficult to measure the effect of training in practice. Solution could be to explain the difficulties and why Tanzania is not carrying out intervention studies

5 – will be covered with the inclusion of PhD students

6 – will be covered with the inclusion of PhD students

WP3 Clinical education, leadership management training and creation of a professional support network (DD)

Objectives:

1 – training and audits underway to address this

2 – the 2 sets of COs in Malawi and Tanzania are not directly interlinked but resources are shared. A group of midwives was invited to Module 2 in Malawi; Tanzania trains both AMOs and nurse-midwives. DMOs and DHOs involved. Students have to produce action plan of how they will work in teams

3 – SB has done some preliminary work with Ericsson. DD has links with African NPC network. Representatives from Malawi (Charles Mulilima, College of Health Sciences) and Tanzania (Cosmas Chacha Maro). Meeting planned for Arusha, November 2012. Agreed that each beneficiary will pay travel costs for its own representative to attend the meeting.

PO’H pointed out this objective refers to the vision of using mobile phone technology to facilitate 24-hour communication. This currently is NOT happening. Tanzania has a memo of understanding with Ericsson and can provide mentorship on a weekly basis. SB is interested in testing the feasibility of being on call in a pilot study. PO’H suggested this could be developed following Module 3: it could be a tool to assist in ensuring referrals are appropriate, with senior clinical officers providing telephone advice.

4 – covered as inherent part of modules/AMO training

5 – difficult. See discussion above.

WP4 Dissemination and outreach

1 – during the next course Malawi students will have done re-audits; could present to MoH

2 – in progress

3 – in progress

WP5 Project Management

Objectives:

1 – in progress

2 – SCRF is now 2 p/t posts. One is FK.

**Assessment of ETATMBA project**

This agenda item related to the project’s own ethics committee requesting information on how assessment would be performed in both Malawi and Tanzania. A study is underway in Malawi. Tanzania has had difficulties relating to the practicalities of assessing outcomes (see above, in particular the comments about resource difficulties). However, the PhD students will contribute to the assessment of the outcomes.

**Sustainable and transferable? Legacy of ETATMBA**

This question has underpinned all the discussion at this conference.

PO’H said there are still gaps between knowledge and action.

SB commented that we need to think ahead, regarding whether countries could afford training and whether it was realistic to expect them to continue. There can be complications, for example in Tanzania there are insufficient jobs available for qualified doctors, who then resent AMOs for undertaking their work.

PO’H said that the problem in Malawi is slightly different: COs feel underpaid and underappreciated. Their focus on gaining a BSc qualification illustrates this issue.

GM commented that morale in Tanzania is rather low among AMOs. Doctors are sent to manage hospitals in remote areas but only stay for a couple of years. Meanwhile, the AMOs can be trapped for years in the same role in these remote areas with no representation or power, yet they are the ones who carry out the essential work.

PO’H suggested that next year we should consider a symposium exploring the role of clinical officers, or possibly ally ourselves to a related symposium organised by another group.

The conference closed with a reminder that the next teleconference is planned for Thursday 14th June.