REPORT ON THE MIDTERM EVALUATION OF THE HEALTH LEADERSHIP, MANAGEMENT AND GOVERNANCE TRAINING PROJECT IN ZIMBABWE

Health Leadership, Management and Governance Project

2010-2016

University of Zimbabwe

Department of Community Medicine

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Abbreviations

ANC	Antenatal Care
DCM	Department of Community Medicine
DEHO	District Environmental Health Officer
DHE	District Health Executive
DHT	District Health Team
DMO	District Medical Officer
DNO	District Nursing Officer
CEO	Chief Executive Officer
CHS	College of Health Sciences
HMIS	Health Management Information System
HPA	Health Professional Authority
HR	Human Resources
HRH	Human Resources for Health
HRHD	Human Resources for Health Development
HRHIS	Human Resources for Health Information System
HRM	Human Resources Management
HSR	Health Services Regulations
HSB	Health Service Board
MDGs	Millennium Development Goals
MOHCC	Ministry of Health and Child Care
NGO	Non-Governmental Organization
NUST	National University of Science and Technology
PHC	Primary Health Care
PMD	Provincial Medical Director
PSC	Public Service Commission
PHE	Provincial health executive
PHT	Provincial Health Team
PMD	Provincial Medical Director
RHC	Rural Health Centre
UZ	University of Zimbabwe
WHO	World Health Organization

Evaluation Teams

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Executive Summary

Background:

The Leadership Management and Governance Project under DCM is a partnership among the MOHCC, HSB and the University of Zimbabwe that is assisting the MOHCC to strengthen manpower capacity through health leadership, management and governance training. The content of training is based on the roles and functions of the District Health Executives and these include management processes and procedures, good governance, use of health information for planning, application of health services regulations and accountability in use of health resources including the capacity to work with partners and the community in health care delivery.

Purpose

A midterm evaluation of the HLMG training was carried out. The main purpose of the mid-term evaluation was to assess the process and outcomes of implementing the health leadership, management and governance training programme in terms of efficiency, relevance, acceptability and sustainability.

Methods:

Kirkpatrick's model of evaluation *(reaction, learning, behaviour and impact*) was used to develop a framework for evaluating HLMG training.

Reaction

A onetime group series design was used for this level on each DHE group that went through training. A questionnaire was used to assess the *reaction of* participants' in terms of *how the delegates felt about the training* as a whole in terms of content, objectives, duration of training, competency of facilitators, venue and other logistics related to the training programme. Reaction was measured using Likert scales on parameters such as satisfaction, relevancy, adequacy, applicability and acceptability.

Learning

A Pre and posttest design was used to assess learning. A questionnaire based on the expected competencies was used to collect data from each group of participants before

and after training. The purpose was to assess *whether there was an increase in knowledge - before and after.*

Application /behavior

A cross sectional survey was used to evaluate this level. A questionnaire based on the competencies covered during training was used to assess application of knowledge gained during training into practice. Additionally the project developed 8 custom indicators to track the application of knowledge into practice. These indicators were developed in line with the content that was covered during the training as well as considering the expectations and responsibilities of the trained DHE members. Custom indicators were collected on a quarterly basis and results compared with the baseline to assess if there are any changes in terms of DHE performances after two and half years.

Results:

Reaction

A total of 237 DHE participants responded to this level of evaluation. The sample was made up of 39.7% females and 60.3% males. 95% of the participants indicated that the module on the National Health Care Strategy is relevant to their day to day duties and 87% agreed that the information provided to them on this module is adequate while 90% said they are able to apply what they have learnt during the training when performing their duties. Time given for each topic was thought of as inadequate since they preferred more time to grasp important information which was in most cases quite new for the participants. Over 90% of participants indicated that they were comfortable with the delivery methods used during training. Relevance was rated as very good by 98%. Usefulness was rated as excellent by 95% of participants.

Learning

Data was collected from 235 participants for assessing pre and post-test knowledge levels. The mean score for pretest was 38.1% (SD 13.3) and the median 38% IQR (30%-48%). Post training scores were mean=75.8 % (SD 10.0), median=76%, IQR (69%-86%)

Post test scores were significantly higher than pre-test scores ($p<0.001$). There was statistical significance between males (mean=36.6%, SD=13.3%) and females (mean=40.3%, SD=13.3%) on pretest scores $p = 0.037$. No statistical significance was

observed between males (mean=76.2% SD=10.2%) and females (mean=75.0%, SD=9.8%) at post testing implying an overall positive knowledge gain for the whole group from the training. Multiple comparison test indicates a significant difference in pre-test scores between Nurses (mean=44.6%, SD=11.9%) and Accountants (mean=34.5%, SD=10.3%) (p=0.018), between Nurses (mean=44.6%, SD=11.9%) and Medical doctors (mean=33.0%, SD=16.7%) (p=0.018) and between Nurses (mean=44.6%, SD=11.9%) and Pharmacy Managers (mean=34.4%, SD=11.1%) (p=0.017), with nurses scoring significantly higher. However, in the post-test scores there was no significant difference between professions. ANOVA test indicates a significant difference in pre-test scores by years in present position. Those with 6-10 years in present position scored significantly higher (mean=41.8%, SD=9.8%) than those with less than one year (mean=32.5%, SD=15.9%) (p=0.022), and those with more than 10 years scored significantly higher (mean=41.6%, SD=15.9%) than those with less than 1 year (mean=32.5%, SD=15.9%) (p=0.036).

Application of knowledge/behaviour

A total of 105 DHE members were interviewed in the cross sectional survey. Matabeleland South had the highest number of trained DHE members who were interviewed (17.1%) compared to Manicaland where only 7.6% were interviewed. A total of 60.8% were males, whilst 39.2% were females. Positive attitudes were also noted on procurement where responses disagreed with the statement that procurement should be done by one person to reduce confusion at 83.5%.

There is an obvious difference in scores for before and after training on all the assessed topics as indicated by statistically significance levels of $p > 0.001$ except for procurement which has a $p = 0.009$.

Conducting outbreak investigations showed a statistically significant difference as a result of training as seen by a $p = <0.001$.The scoring on this aspect increased two fold after training (2.8) against (4.4) indicating a clear improvement in conducting outbreak investigation in the DHE performance. There was a significant change in asset management and control after the training $p < 0.001$. Working as teams $p< 0.001$.There was significant improvement in DHE performance in all the areas trained in timely and accurate reporting p=0.002. DHE Coordination of activities was

statistically significant at p value 0.001. Attitudes for working as a team have shifted towards the positive. Positive rating of team work statements are ranging from a high of 89.4%, 81.0% Positive attitudes were also noted on procurement where responses disagreed with the statement that procurement should be done by one person to reduce confusion at 83.5%

Provincial Health Executive

A total of 18 PHE members were interviewed as part of the cross sectional survey in the six Provinces. The highest number being in Mashonaland East where 5 respondents were interviewed. Performance of DHEs was rated as significantly improved in all modules ($p<0.005$). PHEs noted that DHEs had improved in coordination of activities, asset management and outbreak investigation.

Regarding the PHEs opinion on the DHE training, (93%) of the participants agreed that the DHE training in HLMG has strengthened the performance of the DHE in all their roles and functions.

Provincial Hospital Management Teams

A total of 24 interviews were conducted at Provincial Hospitals as part of the cross sectional survey. A total of 24 Provincial Hospital Executives were interviewed from the 8 Provincial Hospitals and these were composed of 45.8% females and 54.2% males. The majority of the hospital executive teams were in the age group 25 -40 years.
The mean scores are highest on teamwork 3.96 and asset management 3.92 against the lowest mean score of 3.52 quality control. The hospitals had already received training on quality control hence the no difference in before and after mean scores.

Regarding the PHEs opinion on the DHE training, (93%) of the participants agreed that the DHE training by the HLMG has strengthened the performance of the DHE.

Conclusions

Relevance

The HLMG training curriculum was developed from the required competencies which are in turn linked to the day to day roles and functions of District, Provincial and Hospital Health Executives thus training was relevant to the needs of these managers.

Effectiveness

The immediate results from this evaluation of the training showed that the HLMG training provided the necessary leadership, management and governance knowledge

and skills to the District Health Executives, Provincial Health Executives and Provincial Hospital Teams. Scores for posttest show a definite increase in knowledge across all groups showing that learning did take place and was not influenced by the same factors at pre-testing level. There was an obvious increase in knowledge and skills for management and governance for health managers at district, provincial and provincial hospital teams as shown by the rating for before and after training.

Efficiency

The HLMG training has provided an essential function in terms of induction of health managers. Newly appointed health managers now understand the health services regulations and the understanding has strengthened their performance for quality health care service provision.

There was also evidence that health managers were now applying what they had learnt during HLMG training. Impact has been made in terms of working as teams, organizing and holding of planning meetings for better collaboration among programme managers. Impact has been observed in the improvement of accountability and planning for resources, budgeting procurement and submitting returns to the national level. Health managers are now aware that they have to use evidence for planning and evaluation of activities in order to account for any differences before and after public health activities. Our training provided much needed skills required by DHE for managing district public health activities.

Sustainability

a) Some districts have collaborated with partners after gaining skills for engaging partners from the HLMG training. The interaction with partners has provided additional resources which have in turn translated into improved quality in health care delivery and a sustained approach to health development in private partner participation.

a) The HLMG Project has trained teams of facilitators from HSB, MOHCC, UZ, ZIPAM and ZACH to conduct training National, Provincial and District level Managers. These facilitators are providing continuity in the HLMG training of newly appointed health managers at each level. The DHEs are using the skills obtained from the HLMG training to strengthen other programmes such as the RBF and /HTF these programmes are being supported by DHEs through

training of health center committees in leadership, management and governance as these group participate in the RBF and HTF initiatives. The DHEs have also extended training in HLMG among health workers at clinics and rural hospitals during District Health Team meetings, monthly meetings for nurses and EHTs.

b) The HLMG project has maintained an inbuilt mechanism for continuation of training through the provision of summer and winter schools as a way of continuity. Newly appointed health mangers can participate in these short courses so as to get an orientation on their roles and functions as health managers

Noted Good practice in the LMG project

a) Development of training curriculae for all levels of health managers

The HLMG project has developed a number of curricula for health executives for each level of National Health Care System within the MOHCC. These curricula have catered for the District Health Executives, Provincial Health Executives, Provincial Hospital Management Team and City Health Executives. This approach has been consider as good practice since these modules have been shared among all the organizations involved in leadership, management and governance training. All the Health Executives trained in this project were provided with CDs containing all the modules covered during training.

b) The HLMG project has formed a task force composed of the Ministry of Health and Child Care Health Services Board, Centers for Disease Control and Prevention, Management Sciences for Health and the University of Zimbabwe. The task force has facilitated the smooth implementation of all the training activities. Consensus through the task force committee has speeded up decision making and contributed towards success of the HLMG training.

c) The HLMG project provided partial support to trained districts in order to encourage the holding of quarterly DHT meetings. This support was considered as crucial in the development of coordination of health related activities at district level.

d) Partial support was provided to the Provincial Health Executive so as to enable them to provide supportive supervision, mentorship and on job training to the DHE members to ensure quality health care service delivery.

e) Partial support was provided to the provinces to enable them to conduct their Provincial Health Team(PHT) meetings which are crucial in coordinating district activities

f) The HLMG project trained health managers as teams. This approach was well appreciated by the participants since they realized that every public health manager has a lot to contribute towards the vision, missions and objectives of the MOHCC.

Recommendations

a) In-service training for health managers should continue to be competency based using the already developed modules so as to ensure success, relevance and usefulness in the strengthening of the health care systems.

b) Province hospitals and districts to have a an orientation programme that helps new health managers to understand the health system management processes and the health service regulations so that they can perform their duties in response to the MOHCC priorities

c) Methods such as group work and cases studies were found to be very conducive for learning in future such methods should be used in order to enhance adult learning

d) DCM in collaboration with MOHCC and HSB can work together to develop a pre-deployment training for health managers to prepare them for new appointments as health managers at provincial and district level

e) HLMG issues should be included in the training curricula of health workers since the participants considered the subject as essential for all health mangers as an important part that prepares them for their roles and functions.

f) There was concern that there should be a continued follow up and mentorship of trained managers on regular basis.

g) HLMG Training should be made a requirement for promotion to management positions.

h) The MOHCC to support the identification of further funding for HLMG training in Zimbabwe in collaboration with interested partners. HLMG should continue to be supported financially since this evaluation is indicating the need to for in- service training and pre-deployment training to cater for the high attrition in the MOHCC and also to cater for other partners that are involved in public health initiatives.

i) DCM LMGP to train trainers of trainers for each province in leadership management and governance as a sustainable strategy for ensuring quality in health care delivery and the training to emphasis the concept of working as teams since the participants rated this module very highly and field work follow up has also indicated that the module on working as teams was most favourable and the skills are being applied in the health teams day to day work

KEY WORDS: Kirkpatrick's model, Health Systems Strengthening, Competency based training and Evaluation

CHAPTER 1

1.1 Background

The Ministry of Health and Child Care remains committed to the vision of ensuring the highest possible level of health and quality of life for all citizens of Zimbabwe. This will be attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socio-economic development of the country. Over the last decade the government of Zimbabwe`s economy has declined due to various challenges. The declining economy has impacted negatively on the health sector and this has in turn reduced the ability of the MOHCC to deliver health care.

To achieve the attainment of the highest level of care provision, the Ministry of Health and Child Care has developed the National Health Strategy which has thirty three areas for action and implementation over the next five years (NHS 2009). One of the key aspects of the strategy is Health System Strengthening which requires adequate resources and an appropriate enabling environment as critical prerequisites for the successful scaling up of health care delivery. Health System Strengthening requires six pillars namely:

a) **Provision of adequate, skilled and well remunerated Human Resources for Health. (**Through halting and reversing brain drain, recruiting, training and retaining qualified health staff, Increase productivity and professionalism of health worker)

b) **) Continuous supply of medicines and medical supplies:**

c) **) Provision of functional Equipment:**

d) **) Provision of Transport:**

e) **) ensuring a sustainable and predictable Financial Base:**

f) **) There will also be need to address the issues of leadership and governance at all levels, disease surveillance and health information for decision making including strengthening coordination of health sector players.**

The areas identified in the NHS go beyond the boundaries of the health sector and are thus the Ministry of Health has actively pursued the opportunity to develop private and other public partnerships in order to response comprehensively to the health needs of the nation. The HLMGP under DCM is one of such partnerships that is assisting the MOHCC to strengthen the district health systems focusing on Pillar 1 and Pillar 6 specifically through the training of District Health Executives (DHE) as indicated in the National Health Strategy.: ***"Health management has weakened as a result of high attrition rates of experienced health service and programme managers. This has an impact on supervision and monitoring and is evidenced by reduced quality of service provision. "Page 9 NHS 2009 .The DCMLMGP has been running for a year and is now in its second year and has trained***

1.2 The overall Goal of the Project

To strengthen the public health manpower capacity that will contribute to quality patient care and to well-planned and managed public health programmes for total health improvement in the nation.

Long Term Objectives

1. Effective leadership in health planning, program implementation and patient care in public sector In Zimbabwe.
2. Implementation of the MOHCC National Human Resources for Health (HRH) policy at all levels of the public health sector delivery system.
3. Development and implementation of National Leadership training and mentorship program.

Short Term Objectives

1. To revise and implement a national leadership curriculum in the first year of the cooperative agreement.
2. To roll out the newly developed HRH policy document, at national and provincial levels. in the first year and rolled out to all 62 districts by the end of the fifth year of the cooperative agreement.
3. To train at least 500 health workers successfully in health leadership, management and governance.
4. To conduct at least 124 District strategic planning and review meetings and at least twenty provincial strategic planning and review meetings per year.

1.3 Introduction

The Leadership, Management and Governance Training programme now at its half-life stage carried out a midterm evaluation to self-introspect. Having trained all the DHE, PHMT in all provincial hospitals it was time to assess whether the programme was moving in line with its envisaged objectives and contributing to improved health care services.

1.3.1 Purpose of Evaluation

The main purpose of the mid-term evaluation was to assess the process and impact of implementation of the leadership management and governance training programme in terms of efficiency, relevance, acceptability and sustainability of the LMG training. The mid-term evaluation was based on the Kirkpatrick's model of training evaluation The model includes assessment of training based on four levels of training outcomes: knowledge gained, attitude change, and application of knowledge gained and impact on health. The evaluation only focused on the three levels since the fourth level requires a long time to realize.

1.3.2 Objectives of the evaluation

1. To assess the knowledge levels on the principles and frameworks on health leadership, management and governance provided during the training for DHE conducted between 01 October 2010 to August 2013
2. To assess the values and attitude on HLMG related to the application of principles covered in the DHE training.
3. To identify the practices of DHEs in place as a result of the HLMG training conducted between 01st October 2010 to August 2013
4. To assess on how the Health Services Regulations training conducted between 01 October to August 2013 has influenced the application of health services regulations in the workplace.
5. To compile success stories, best practices and challenges faced by DHEs in implementing what they have learnt.
6. To assess the progress made regarding district supervision and support by the PHE.

1.4 Framework for Evaluation

The midterm evaluation is in line with the project evaluation model adapted from Kirkpatrick training evaluation model. The evaluation focused mostly on the third level of assessing the application of theory into practice. The District Health Executives were trained in Health Leadership, Management and Governance in specific topics. The planned evaluation was based on the Kirkpatrick's model of training and evaluation outlined in table 1 below.

Table 1 level of measurement

Name	**Description**
Reaction Level	Measures the level of participant satisfaction with training
Learning level	Measures the degree to which the participants absorbed the material presented during training. On this level pre and post tests were conducted to assess the level of knowledge obtained by participants.
Behaviour Level	Measures the transfer of training concepts to applicable real world situations. This type of evaluation would measure the degree to which participants engage in the behaviours targeted during training
Results Level	Measures the actual cost effectiveness of the training and the return of investments produced by the training for the organization or training provider

1.5 Specific Evaluation Objectives

The specific objectives are related to the various stages of the Kirkpatrick's model of evaluation. In addition, specific programme process objectives were included since the evaluation was also focused on the process and outcomes of the HLMG training.

1.5.1 Level 1: Satisfaction with Training

Objective: To assess the level of participant satisfaction with HLMG training.

1.5.2 Level 2: Measuring Transfer of Learning

Objective: To assess if the participant absorbed the information presented during HLMG training.

1.5.3 Level 3— Change of behaviour after training

Objective: To assess the level of application of HLMG ideas gained from the DHE training

- To assess if there are any changes in behaviour after the HLMG training.
- To assess the degree to which trained health managers are engaging in the behaviours targeted during HLMG training (e.g. holding meetings regularly working as a team utilizing health information for planning)
- To identify if the training is contributing towards an increase in discrete skills and techniques for leadership management and governance.
- To assess if there has been improved performance by DHEs and PHMTs that have undergone the HLMG training.

1.5.4 Level 4—Results

Objectives: To identify if the HLMG training have contributed to the overall organizational objective

Intermediate outcome of training may include the following aspects:

- Improved quality of work, higher productivity, reduction in turnover.
- reduction in scrap rate (i.e., less wasted resources), improved quality of work life, improved human relations (e.g., improved vertical and horizontal communication, Lower absenteeism, higher worker morale, greater job satisfaction

The evaluation did not include the fourth level of the Kirkpatrick's model which is an improvement in the community's quality of life and ultimately the reduction in morbidity and mortality.

1.6 Overview of Primary Stakeholders

The study sought to address the information needs of all the stakeholders involved in the LMGP that include CDC , , MOHCC, HSB , (MSH) and other UN organizations and

NGOs that have an interest in leadership, management and governance training of health workers. The stakeholders were to be engaged to contribute to the development of the evaluation process from the beginning to the finalization of findings of the evaluation.

1.7 Participatory Evaluation

The evaluation study incorporated the concept of participatory evaluation. This was done in order to empower the trained DHE members to analyze, appreciate and to solve any problems that may hinder the adoption of recommended management practices in a health care setting. (Jackson and Kassam 1999).The evaluation team comprised of all sectors HSB, MOHCC Human resource department all PMD offices, HSB and CDC. The participants from the training were given a chance to describe their experience in terms of knowledge gained and the practices they now engage in.

Table 2 Questions aligned to the three levels of Kirkpatrick's Training evaluation model

Level 1 **Reaction**	Did the content, mode of delivery and schedule of the course meet the training needs of participants? What are the participants' perceptions of opportunities to improve the course? Assess participants' reaction to the learning experience to inform improvements to the health HLMG training.	
Level 2 **Learning**	To what extend did the participants increase their knowledge of health leadership, management and governance. To what extend did the participants' attitudes regarding HLMG change as a result of the training?	Determine if the course was successful in increasing knowledge and improving attitudes about health HLMG issues
Level 3 **Behaviour**	How have participants applied knowledge gained from the training in their work settings?	Provide examples of application of knowledge through behavior change immediately following the health HLMG training
Level of evaluation	Evaluation questions	Value of measurement to stakeholders

Kirkpatrick's model for training evaluation 1959

CHAPTER 2

2.1 Methodology

2.1.1evaluation Design

The study designs were applied as appropriate for each level of outcome being evaluated as described under each section. A mixture of study designs were employed for this evaluation. Kirkpatrick's model of training and evaluation was used for this evaluation since the model formed the format of the training. Overall a cross sectional survey was used as an overall design. However other study designs were nested within the cross sectional survey framework in order to capture specific issues and to suit the level of evaluation and the specific outcomes accordingly in relationship to Kirkpatrick's model of training and evaluation as illustrated in table 3 below.

Table 3 Related study designs for each level of the model

Level of learning	**Study design**
Reaction Level	One time group series
Learning level	Pre and Posttest design Intervention study
Behaviour Level	Retrospective study design in randomly selected districts out of the trained Districts and provincial hospitals
Results Level	Cohort longitudinal study in future

2.1 .2 Target Population

The major stakeholders that participated in this evaluation were: the MOHCC specifically the DHE members, PHMTs, PHEs, MSH and the HSB, as well as other Developmental organisations who provide support to health related activities and other training institutions that had carried out similar training before.

All the PHEs, in the eight provinces were included into the study. The DHE members, the PHE and PHE who had successfully undergone LMG training for five days were included in the survey

The project targeted all DHE members in the 61 districts, facilitators in the DHE training, PMDs, programme managers in the MOHCC and those in the Private sector and Non-Governmental organization who have interacted and supported HLMG training over the three years.

2.2 Sampling Procedure

Manicaland, Mashonaland East, Mashonaland Central, Mashonaland West, Masvingo Matabeleland North and Matabeleland South were selected into the study. Convenience sampling was used to identify the respondents who are all members of the DHE and PHE who were found present on the day of the evaluation.

Development of the questionnaires

The questionnaires were developed using Kirkpatrick's model of training evaluation. The following questionnaires were developed:

a) Pre and posttest questionnaire
b) Workshop evaluation questionnaire
c) Custom indicator questionnaire field follow up
d) Midterm survey questionnaire based on the modules covered
e) Focus group discussion guide

Pretesting the Survey Instruments

The data collection instruments were designed for each of the three categories of respondents, namely DHE, PHE and PHMT members. The draft questionnaires were pre tested with the Seke DHE for user friendliness which was later not included in the survey. The technical content was pre-tested within the DCM to ensure that the questions were understandable and relevant to the study objectives.

2.2.1 Evaluation Questions

- Did the content, mode of delivery and schedule of the HLMG training meet the training needs of participants?
- What are participants` perceptions of opportunities to improve the course?
- To what extent did participants' increase their knowledge on health leadership, management and governance principles as a result of the training?
- To what extent did participant's attitudes towards health leadership, management and governance change as a result of the training?

- How have participants applied knowledge gained from the training in their work as DHEs

2.3 Data Collection

Reaction- Workshop Evaluation

Participants were given questionnaires to fill in at the end of each training session of five days. Questions in this level included how participant's felt about the learning process including aspects such as the organization of learning process, time allocated to the modules, ability of the facilitators ,relevance of subject covered, adequacy of time , , accommodation ,food and general ambiance of the venue.

Pre and Post test

Data collection involved the administration of pre and post test before participants began the training and post test upon completion of training. The pre test included demographic information to establish a baseline for knowledge and attitudes relevant to content in each of the moduels in the HLMG training. The post test included the same information on satisfaction with content mode of delivery and schedule as well as an opprtunity to provide examples of application of knowledge gained in a work setting.

Field Survey

The midterm evaluation survey involved carrying out interviews and focus group discussions with the selected respondents. Interviewer and self administered questionnaires were used to collect data. In cases where respondents were available the data collectors would administer the questionnaires but where the respondents were not available, the questionnaires were left for the respondents to complete . The evaluation teams would then come back on a later date to collect the completed questionnaires. Focus group discussions were held in each of the district visited.

Level 3— Change of behaviour after training

To assess if there are any changes in behaviour after the LMG training

- To assess the degree to which trained health managers are engaged in the behaviours targeted during HLMG training (**e.g. holding meetings regularly working as a team utilizing health information for planning**)

- To identify if the training is contributing towards an increase in discrete skills and techniques for health leadership, management and governance to assess if there has been improved performance by DHEs and PHMTs that have undergone the training

The information for level three objectives was collected as part of the field survey

Four tools were administered during the midterm evaluation field and these are:

1. Trained District Health Executive (DHE)
2. Provincial Health Executive (PHE)
3. Provincial Hospital
4. Focus group Discussion Guide

The number of tools administered for each category was as follows:

Table 4: Tools administered for the LMGP midterm evaluation

Tool	**Number of tools**
Trained District Health Executive (DHE)	205
Provincial Health Executive (PHE)	30
Provincial Hospital Management Teams	24
DHE focus group discussions	24

2.4 Location

The survey was carried out in the following 8 provinces:

Table 5: Study sites Provinces and Districts

#	Province	Districts
1	Manicaland	Chimanimani, Chipinge and Buhera
2	Mashonaland Central	Mt Darwin, Mazowe and Rushinga
3	Mashonaland East	Seke, Marondera and Chimhanda
4	Mashonaland West	Chegutu ,Makonde and Hurungwe
5	Masvingo	Masvingo, , Zaka, Chiredzi and Chivi
6	Matabeleland North	Lupane, Bubi and Umguza
7	Matabeleland South	Insiza, Bulilima, Mangwe ,Gwanda and Matobo,
8	Midlands	Gweru, Shurugwi and Kwekwe

In line with the objectives of the survey:

To assess the knowledge levels on the principles and frameworks on health leadership, management and governance provided during the training for DHE conducted between 1st October 2010 to August 2013.

Knowledge levels on principles and frameworks on health leadership, management and governance were measured on a Likert scale ranging from 1 (lowest) to 5 (highest).

Respondents were asked to rate their knowledge before and after training on 15 items. As follows: National Health Care Strategy ,Team building, Time management, Meeting management, Conflict management, Change management, Health Leadership, Human Resources management, Management of Financial Resources , Assets management, Analysis and management of DHS, Data analysis-Introduction to epidemiology, Operations research, Health ethics and governance and building partnerships

2.6 Data Management

Quality Control

A consultant biostatistician was engaged to provide technical guidance in the whole process of the evaluation survey design, sampling, developing of survey instruments data management and analysis. The consultant ensured that the study objectives were clear and the questions were developed to measure the stated objectives.

During the data collection process completion of the questionnaires was ensured through random checks of completed questionnaires. The completed questionnaires were collected at the end of each day by the team leaders and put in a secure place.

Data management commenced during field work. Data quality control took place during the data collection process. Questionnaires that were self-completed by the respondents were also checked for completeness and any incomplete questionnaires had to be completed by engaging the responsible respondents during rescheduled where necessary and possible.

Data entry

A data base was created in Epi Info 3.5.1 for each questionnaire to ensure that data would be captured immediately during and after the survey.

After the survey all questionnaires were sorted into the categories and were prepared ready for entry into the Epi Info data bases.

Two data entry clerks were trained to enter the data. After the training data entry commenced with each data entry clerk entering different questionnaires. Data entry quality checks were done randomly by selecting 10% of the entered questionnaires and verify accuracy and completeness.

After completing data entry, data was transferred from Epi Info to Stata 13 for cleaning and analysis in line with the objectives of the survey. The cleaned data was archived on USB and is stored securely by the project team.

EVALUATION (DHE)

FINDINGS

CHAPTER 3

3.0 Results of the Evaluation by Kirkpatrick's Levels of Evaluation

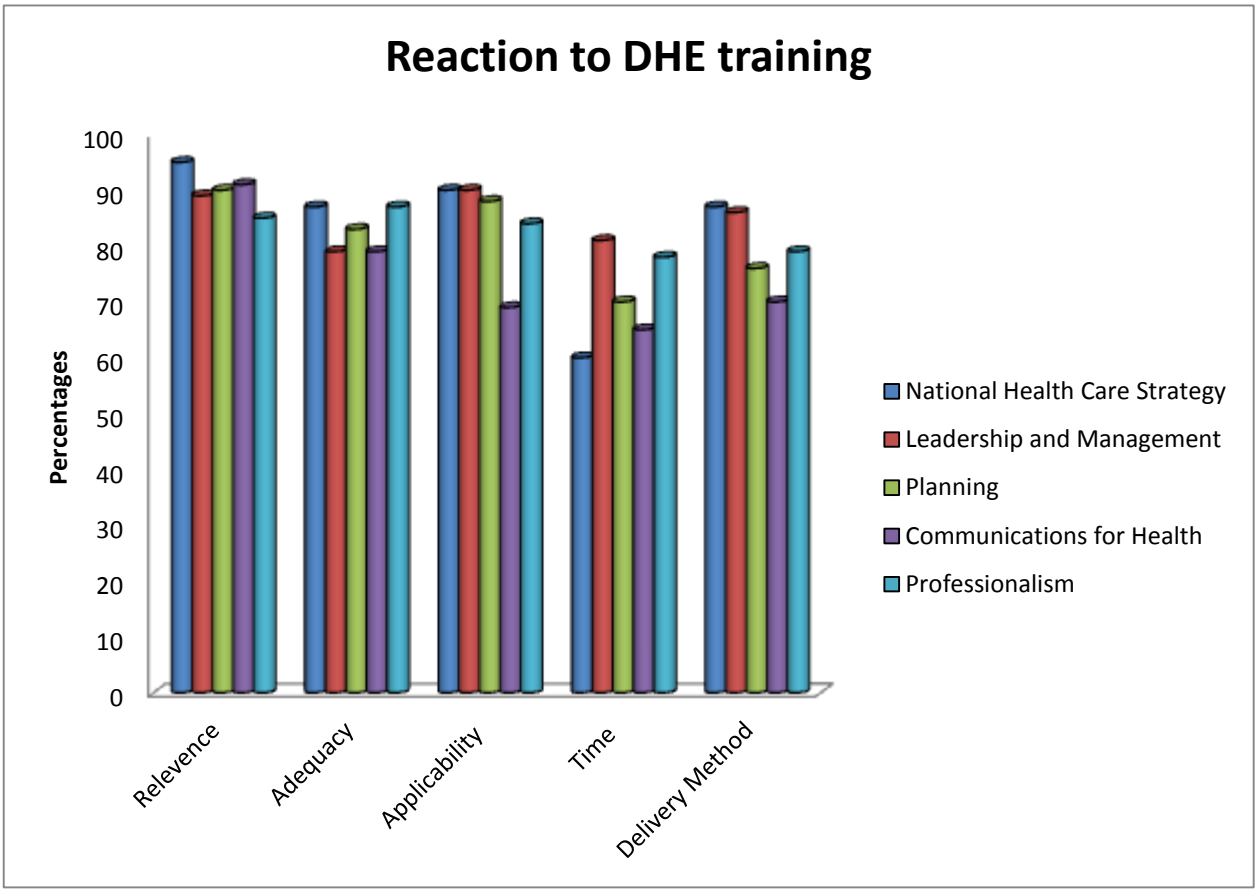
3.1 District Health Executive Findings

Level 1 Reaction

This first level of Kirkpatrick`s training evaluation model measures how the delegates felt about the training or learning experience.The purpose of these questions were to identify how the participants viewed the whole process and organization of the workshop, status of the venue, the adequacy of time allocated to each module ,workshop programming and the effectiveness of training delivered. The questionnaire consisted of questions on reaction evaluation on how the participants felt about the learning experience. Other aspects of the assessment included how the participants felt about the venue, meals and logistics arrangements and the overall coordination of the training. The reaction to the training was assessed at each of the training workshops held for the 61 DHEs. Data is based on 237 participants since this level of assessment was not done for the initial four workshops. The data presentation below provides information on the results of this assessment.

3.2 Reaction Per Five Modules

Figure 1:Reaction to DHE training national health strategy module



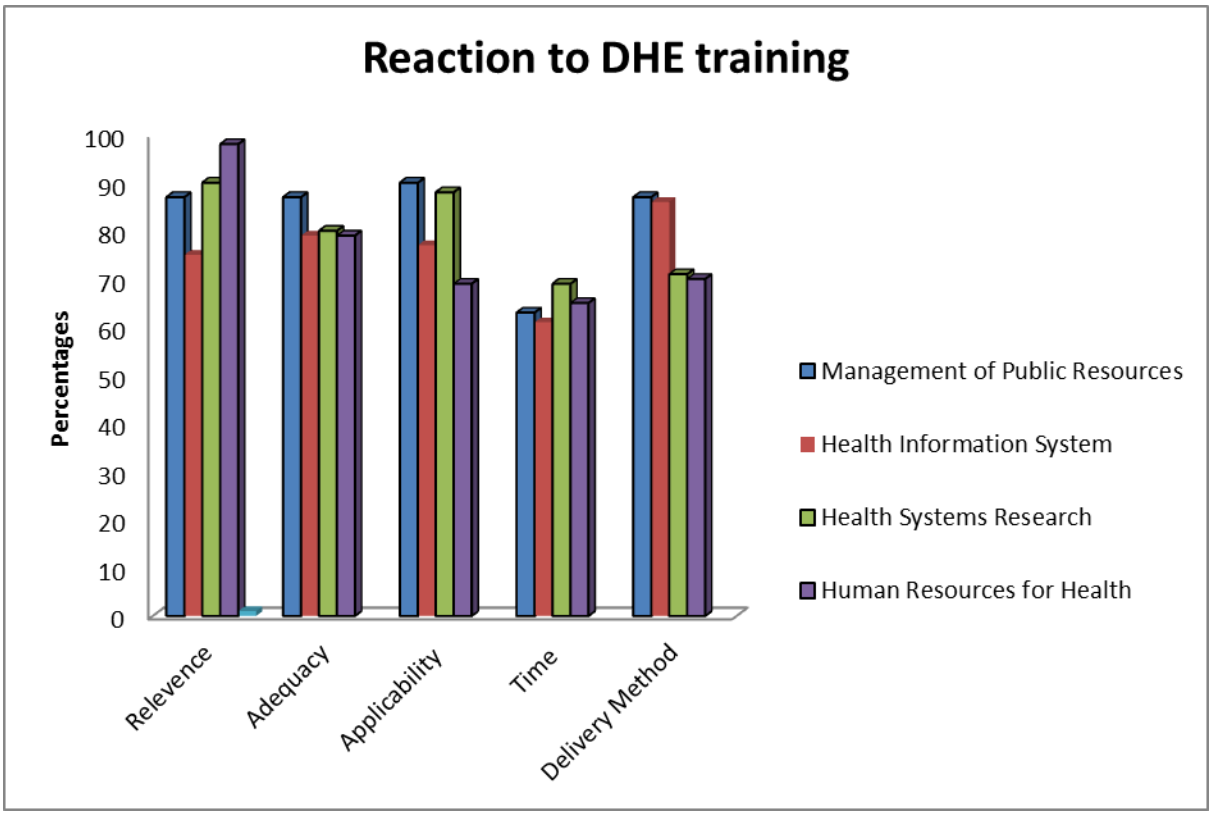
The development of the DHE curriculum was based on the DHE roles and functions. Competencies were then developed for each of the roles and functions. The whole curriculum was then developed as modules to respond to the learning needs of the District Health Executives.

95% of the participants indicated that the module on the National Health Care Strategy is relevant to their day to day duties and 87% agreed that the information provided to them on this module is adequate while 90% said they are able to apply what they have learnt during the training when performing their duties. The National Health Care Strategy module provides an overview of the policy, mission, vision and programme activities and the general direction for the MOHCC. The HLMG training was seen as relevant in terms of providing health workers (DHEs) with an orientation/induction which prepared them for their roles and functions as DHEs. This response is linked to the fact that the MOHCC was increasingly not being able to provide an orientation for newly employed DHEs personnel. All the modules were

relevant to the work being done by the DHE as highlighted by 90% of the participants. Time given for each topic was thought of as inadequate since participants preferred more time to grasp important information which was in most cases quite new for the them as shown by figure 1 above. The delivery methods used included lectures, plenary session, group discussions, group work, role plays and District projects. Most of the participants were comfortable with the delivery methods as indicated in the figure 1 above.

3.3 Reactions To Four Modules

Figure 2 Reaction to DHE training Management module



3.4 Evaluating Reaction

Level 2 to identify change in knowledge due to HLMG training

A questionnaire was developed on the basis the HLMG modules. Questionnaires were distributed before and at the end of each training workshop. The questionnaire was based on the nine modules of the DHE curriculum.

Assessing learning process pre and post

According to Kirkpatrick's model in order to assess learning acquisition, a comparison has to be made on how participants performed before and after the training and the difference between the two is the effect of the training. According to this process, it can be argued that the training was effective in equipping the participants with knowledge and information on Health Leadership, Management and Governance as shown in figure 3 below.

Figure 3 : The Relationship Between The Pre And Post Training Test

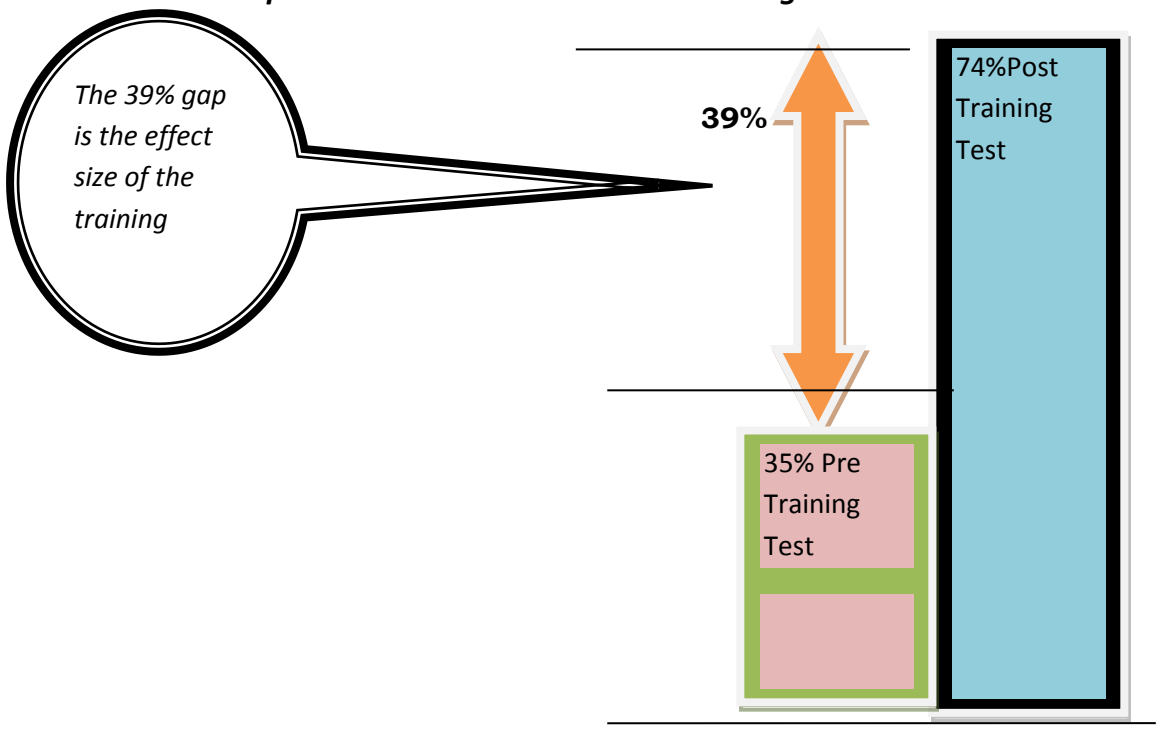


Figure 3 The diagram above shows the relationship between the pre and post training test and the level of learning achieved during one of the DHE training workshops as it shows an effect size of 39% which is the difference between the average mark for all participants in the pre training test and in the post training test.

The following section characterizes the acquisition of learning according to the demographic variables of the respondents

3.5 Characteristics /Reaction

Table 5 Respondents by designation

Designation	Frequency	Percent
ACCOUNTANT	32	13.6
DEHO	36	15.3
DHSA	39	16.6
DMO	33	14.0
DNO	34	14.5
HPO	2	0.9
MATRON	8	3.4
OTHER	15	6.4
PHAMARCY MANAGERS	36	15.3
Total	235	100
Highest level of education	**Frequency**	**Percent**
Diploma	123	52.34
Degree	95	40.43
Certificate	9	3.83
Master's Degree	8	3.4
Total	235	100

Table 5 above shows the demographics of participants who took part in the pre and posttest evaluation component of the programme. A total of 235 participants responded to reaction questions (93) 39.7% were females' whist (141) 60.3% were males. The highest level of education among the participants was a master's degree 8 (3.4%) basic degree 95(40.43%) with the majority having a diploma or certificate at 123 (52.34%) and 9(3.83%) respectively. There were an equal number of respondents for

most categories of the DHE team and a few in the categories of matron, nutritionists and health promotion officers since these are co-opted members of the DHEs in some districts.

Table 6 distribution of pretest/posttest scores by age gender and designation

Characteristic	Pretest score, mean(SD)	Posttest score, mean(SD)	p-value
Overall	38.1(13.3)	75.8(10.0)	<0.001
Age group (years)			
18-25	36.5(2.12)	78.5(13.44)	0.163
26-35	37.0(14.11)	75.6(9.94)	<0.001
36-45	38.8(13.02)	76.4(10.42)	<0.001
46+	39.0(12.75)	75.3(9.85)	<0.001
Gender			
Male	36.6(13.28)	76.2(10.16)	<0.001
Female	40.3(13.26)	75.2(9.81)	<0.001
Designation			
Accountant	35.1(9.77)	74.1(9.70)	<0.001
DEHO	40.9(14.75)	79.1(9.10)	<0.001
DHSA	41.5(11.14)	76.6(8.69)	<0.001
DMO	32.3(16.11)	74.8(11.53)	<0.001
DNO	45.6(11.79)	75.6(9.39)	<0.001
HPO	40.0(11.31)	70.5(2.12)	0.192
Matron	42.6(14.11)	71.0(8.49)	0.0002
Pharmacy manager	34.5(10.82)	75.1(12.54)	<0.001
Other	30.5(12.88)	75.9(10.98)	<0.001
Highest qualification			
Certificate	34.9(12.71)	73.6(14.00)	<0.001
Degree	38.6(15.15)	77.2(10.32)	<0.001
Diploma	37.3(11.75)	74.8(9.41)	<0.001
Master's Degree	47.3(12.44)	76.6(10.76)	0.002
Years in position			
<1	32.5(15.90)	76.1(11.33)	<0.001
1-2	37.4(13.81)	74.1(9.91)	<0.001
3-3	37.3(11.12)	75.5(9.12)	<0.001
6-10	41.9(9.76)	78.3(10.27)	<0.001
>10	41.6(15.86)	75.4(10.40)	<0.001

The distribution of test scores by demographic characteristics shows that that the young age group had higher post test scores compared to the older age groups 78.5% 18-25 years compared to 75.3% in the age group 46years plus . Interestingly the same younger age group scored lower in the baseline. This shows a higher knowledge acquisition and retention in the young age group. There was no significant difference

in pre-test scores by age (p=0.750), and also no significant difference in post-test scores by age (p=0.9001). Regarding designation the District Environmental Health Officers (DEHO) scored higher on posttest 79.2 highest against 71.0 for matrons and 70.5 % for HPOs although this group were also not fully represented as the other designations. ANOVA test shows a significant difference in pre-test scores by designation (p<0.001). Significant differences were noted between DNOs and Accountants (p=0.032), DNOs and DMOs (p=0.001), DNOs and Pharmacy managers (p=0.011) and DNOs and others (p=0.006). DNOs scored significantly higher than each of these groups. In the post test scores no significant differences were noted by designation.

Overall, Post-test scores were significantly higher compared to pre-test scores (p<0.001).Scores by gender, scores show that the male scored lower at baseline and subsequently scored higher on posttest after an educational input 76.2 for males against 75.2 for females. Females scored significantly higher than males in the pre-test (though the scores were all low), p=0.037. In the post test there was no significant difference between males and females (p=0.383)

There was no significant difference in pre-test and post-test scores by educational attainment. However the respondents with a master's degree scored higher at both pretest 47.3% compared to those with a certificate who scored 34.9%. Post test results show that those with a basic degree and master's degree scored higher than other groups 77.2% for degreed and 76.6% for master's degree

The mean scores according to work experience ANOVA test indicates a significant difference in pre-test scores by years in present position. Those with 6-10 years in present position scored significantly higher than those with less than one year (p=0.022), than those with more than 10 years scored significantly higher than those with less than 1 year (p=0.036). There was no significant difference by years of work experience. *There is no doubt that health professionals that are more experienced do acquire some background knowledge of how the health care system is run and the requirements thereof.*

A total of 355 DHEs from 61 districts responded to the pre and post-test questionnaires during the five day health leadership, management and governance training workshops. Data was collected from 235 participants. Kirkpatrick's model of evaluation ***(reaction, learning, behaviour and results***) was used to develop a framework for assessing training outcomes. A questionnaire based on the expected competencies was used to collect data from the participants before and after training. Measurement was based on ***whether there was an increase in knowledge - before and after.***

The sample was made up of 39.7% females and 60.3% males and these comprised of medical doctors, nurses, health services administrators, environmental health officers, health promotion officers, pharmacists, accountants and nutritionists. 92.77% of the sample had either obtained a diploma or degree as a basic qualification in their respective professions and 3.4% had undergone post graduate training. 75% had 3-6 years of work experience. 41.7 % were in the age group 26-35 years.

Learning focused on pre and post- test scores. The mean score for pretest was 38.1 (SD 13.3) .Post scores were 75.8 % (SD 10.0) Post test scores were significantly higher than pre-test scores ($p<0.001$). There was statistical significance between males and females on pretest scores p value 0.037.No statistical significance was observed between male and female at post testing implying an overall positive knowledge gain for the whole group from the training. Multiple comparison test indicates a significant difference in pre-test scores between Nurses and Accountants ($p=0.018$), between Nurses and medical doctors ($p=0.018$) and between Nurses and Pharmacy managers ($p=0.017$), with nurses scoring significantly higher. However, in the post-test scores there was no significant difference between Professions although the environmental health officers tended to score higher in their posttest scores. ANOVA test indicates a significant difference in pre-test scores by years in present position Those with 6-10 years in present position scored significantly higher than those with less than one year ($p=0.022$), than those with more than 10 years scored significantly higher than those with less than 1 year ($p=0.036$).

Conclusions for Level 2

Scores for posttest show a definite increase in knowledge across all groups showing that learning did take place and was not influenced by the same factors at pre-testing level. Overly the training had an effect size of 39% which is the difference between the average mark for all participants in the pre training test and in the post training test. The younger age group tended to score higher in their posttest scores showing that the younger health professionals may need to be provided with in-service training constantly so that they easily acquire relevant information to ensure professional practice. Being female was related to high pretest scores .This could be due to the fact that more female health professionals are in place and they also tend to have more experience in the same position. Educational level plays a significant role in the additional acquisition of knowledge as evidenced by the fact that those with a basic degree and master's degree scored higher than other groups. Respondent with more years of experience in the workplace had higher posttest scores indicating the influence of experience in the learning process. *There is no doubt that health professionals that are more experienced do acquire some background knowledge of how the health care system is run and what they need to know to better deliver quality services.* In service training should be competency based so as to ensure success, relevance and usefulness in the strengthening of the health care systems. Our training provided much needed skills required by DHE for managing district public health activities. The content of our training was based on the roles and functions of the DHEs thus making it very relevant to their day to day activities.

3.7 Change of behavior after training

This section presents results on the assessment of the knowledge and attitudes of DHEs in terms of the HLMG knowledge gained and the cognition of how DHEs perceive themselves to be applying the knowledge gained in their day to day functions. The assessment was based on the modules covered during HLMG training.

Level 3— Change of behavior after training

To assess if there are any changes in behavior after the HLMG training.

To assess the degree to which trained health managers are engaged in the behaviours targeted during HLMG training (e.g. holding meetings regularly working as a team utilizing health information for planning)

To identify if the training is contributing towards an increase in discrete skills and techniques for leadership management and governance

In order to assess the level 3 on the Kirkpatrick's model interviews were conducted with DHE members in the selected districts

Overall mean score for these 16 items was 30% (SD=7.3%). These questions were asked in the negative. The scores were reversed so that the scores are measured in the positive sense and the overall mean perception score was 90.5% (SD=7.3%).

The DHE tool was administered to trained District Health Executive team members in the 8 provinces

Table 7 distribution of districts visited during the survey

#	**Province**	**N of questionnaire**		**Districts**
1	**Manicaland**	8	7.6	Chimanimani, Chipinge, Buhera and Nyanga
2	**Mashonaland Central**	15	14.3	Mt Darwin, Mazowe and Rushinga
3	**Mashonaland East**	9	8.6	Seke, Marondera, Wedza Mutoko and Uzumba Maramba Pfungwe
4	**Mashonaland West**	10	9.5	Chegutu, Makonde and Hurungwe
5	**Masvingo**	17	16.2	Masvingo,, Zaka, Chiredzi and Chivi
6	**Matabeleland North**	15	14.3	Lupane, Bubi and Umguza
7	**Matabeleland South**	18	17.1	Insiza,Bulilima, Gwanda, Matobo and Umguza
8	**Midlands**	13	12.4	Gweru, Shurugwi and Kwekwe

A total of 105 DHE members were interviewed in the survey. Matabeleland South had the highest number of trained DHE members who were interviewed17.1% and Manicaland had the least number 7.6%.

Table 8 Education/profession/years of experience and age in years

educational attainment	frequency	percent	Profession	Freq.	Percent	Years in present position	Freq.	Percent
Certificate	8	7.9	Accounting	19	18.5	Less than 1	2	1.9
Degree	36	35.6	Administration	24	23.3	1-2	13	12.6
Diploma	49	48.5	Environmental Heath	15	14.6	3-5	25	24.3
Master's Degree	5	5	Health Promotion	2	1.9	6-10	39	37.9
Other	3	3.0	Medical Doctor	8	7.8	more than 10	24	23.3
Total	101	100	Nurse	21	20.4	Total	103	100
			Nutritionist	1	1.0			
			Pharmacy	13	12.6			
			Total	103	100			
						Age in years	Freq.	Percent
						26-35	24	23.3
						36-45	38	36.9
						46+	41	39.8
						Total	103	100

Table 8 above shows education attainment professional qualification years of experience and age in years. The highest qualification among DHE members was a diploma held by 48.5% whilst the least was a master's degree held by 5% with a degree held by 35.6% of the respondent's .*The status indicates that the DHEs members do have the required qualification for performing their duties. This situation is the norm in the MOHCC since each officer has to be qualified in their respective field such as medicine, nursing, environmental health and pharmacy*

The findings indicate that the majority of respondents were in administration 41.8% (23.3%, 18.5%) Two respondents did not specify their professions. 14.6% were environmental health officers

It is pleasing to note that more respondents have been in position for more than 3 years with the majority 37.9% having been in position for more than five years with more than ten years for a good 23.3% of the respondents. Two respondents did not specify their durations in their current positions. More years in one place is obviously of advantage for an organization since stability is in built where people have more experience .Institutional memory can be passed on and new cadres are reassured of mentorship and guidance.

The majority of respondents were in the age group 36-46+ years. *The older age group formed 77% in total .The older age group also indicates stability in an organization since the young age groups tend to be very mobile thus upsetting the status quo and functions of an organization*

LMG related activities participated in by the respondent

Table 9: HLMG activities by DHE members

DHE Training	101(96.2)
HSR Training	18(17.1)
DHT	61(59.1)
Summer School	5(4.8)

Table 9 above shows the capacity building /training activities the respondents had participated in the past year. The question was asked to determine if there were additional similar HLMG training activities taking place. The question was asked as a measure to determine the real effectiveness of HLMG training.

Respondents were asked to rate their knowledge of the subject before training and after the training Table 19 below shows the responses in terms of scores.

3.8 Knowledge Rating Before And After Training

Table 10: Self Evaluating of knowledge before and after training

Evaluate your knowledge level of understanding before and after training

1 = No knowledge or skills				3 = Some knowledge or skills		5 = A lot of knowledge or skills				
BEFORE TRAINING score(% number of people)					Modules covered during training	AFTER TRAINING score(% number of people)				
1(3.3)	2(13.0)	3(29.4)	4(40.2)	5(14.1)	*National health Care Strategy*	1(0)	2(2.1)	3(31.6)	4(49.5)	5(16.8)
1(0)	2(4.1)	3(25.5)	4(38.8)	5(31.6)	*Team Building*	1(1.0)	2(0)	3(19.4)	4(39.8)	5(38.8)
1(0)	2(4.1)	3(23.5)	4(40.8)	5(31.6)	*Time Management*	1(1.0)	292.9)	3(8.7)	4(49.0)	5(38.5)
1(1.0)	2(7.1)	3(25.5)	4(38.8)	5(27.6)	*Meeting Management*	1((0)	2(0)	3(14.6)	4(49.5)	5(35.9)
1(2.0)	2(12.2)	3(23.5)	4(37.8)	5(24.5)	*Conflict Management*	1(1.0)	2(4.9)	3(23.3)	4(36.9)	5(34.0)
1(1.0)	2(11.5)	3(21.9)	4(43.8)	5(21.9)	*Change Management*	1(0)	2(1.9)	3(23.1)	4(50.0)	5(25.0)
1(1.0)	2(4.1)	3(17.4)	4(52.0)	5(25.5)	*Leadership*	1(1.0)	2(0)	3(9.6)	4(50.0)	5(39.4)
1(4.1)	2(5.1)	3(33.7)	4(37.8)	5(19.4)	*Human Resources for Health*	1(1.0)	2(5.9)	3(21.8)	4(37.6)	5(33.7)
1(4.1)	2(11.2)	3(33.7)	4(31.6)	5(19.4)	*Finance Management*	1(1.00	2(7.7)	3(27.9)	4(36.5)	5(26.9)
1(3.2)	2(6.3)	3(29.5)	4(35.8)	5(25.3)	*Assets Management*	1(1.0)	2(5.9)	3(21.8)	4(37.6)	5(33.7)
196.6)	2(13.2)	3(34.1)	4(28.6)	5(17.6)	*Analysis & Management of DHS*	1(4.2)	2(5.2)	3(27.1)	4(39.6)	5(24.0)
1(1.1)	2(16.3)	3(31.5)	4(35.9)	5(15.2)	*Data analysis –Intro to epidemiology*	1(3.1)	2(11.3)	3(27.8)	4(39.2)	5(18.6)
1(5.4)	2(21.5)	3(34.4)	4(26.9)	5(11.8)	*Operations Research*	1(12.1)	2(13.1)	3(34.3)	4(27.3)	5(13.1)
1(1.1)	2(9.5)	3(28.4)	4(43.2)	5(17.9)	*Health Ethics and Governance*	1(1.0)	2(2.0)	3(30.7)	4(42.6)	5(23.8)
1(3.2)	2(8.4)	3(33.7)	4(36.8)	5(17.9)	*Building Partnership*	1(1.0)	2(4.9)	3(22.6)	4(38.2)	5(33.3)

There is an indication from the pre and post rating of knowledge in table 10 that respondents had some degree of knowledge about management since ratings at 4 and five are high compared to the lower scores. There was some knowledge of the national health strategy as indicated by a score of 52% at 4 rating before training compared to other scores. In terms of after training scores increased on scale 4 rating on the topics such as time management, meeting management, change management, team building leadership, health ethics and the national health strategy. Rating increased positively from negative rating before training to an increased positive rating.

Table 11: Summarizing self-rating scores on knowledge before and after training

Before training		**Module covered in training**	**After training**		**p-value**
Mean score	Std. Dev.		Mean score	Std. Dev.	
3.49	1.00	National health Care Strategy	3.81	0.73	0.016
3.98	0.86	Team Building	4.17	0.81	0.113
4.00	0.85	Time Management	4.21	0.80	0.076
3.85	0.95	Meeting Management	4.21	0.68	0.001
3.70	1.04	Conflict Management	3.98	0.93	0.049
3.74	0.97	Change Management	3.98	0.75	0.052
3.97	0.83	Leadership	4.27	0.71	0.011
3.63	0.99	Human Resources for Health	3.93	0.87	0.007
3.51	1.06	Finance Management	3.81	0.96	0.008
3.74	1.01	Assets Management	3.97	0.94	0.027
3.37	1.12	Analysis & Management of DHS	3.74	1.02	0.006
3.48	0.98	Data analysis –Intro to epidemiology	3.59	1.02	0.286
3.18	1.07	Operations Research	3.16	1.18	0.822
3.67	0.92	Health Ethics and Governance	3.86	0.84	0.072
3.58	0.98	Building Partnership	3.98	0.92	0.0008

Table 11 above shows the summarized scores on the knowledge before and after training

The mean scores are higher for 98% of the topics. Operations research remains scores even lower after training 3.18 SD 1.07 before training and 3.16 SD 1.18. The highest scores are on team building 3.98 SD 0.86 AND 4.17 SD 0.81 time management and meeting management 4.00 SD 0.85 AND 4.21 SD 0.80, meeting management and leadership issues. There is an indication that these areas are very relevant to the day to day functions of the health managers. The results indicate that the training did make a difference in knowledge levels among the DHEs. These results are

corroborated by our findings on the pre and post test scores. It is pleasing to note that the evaluation asked respondents to rate themselves close to a year after training whereas the pre and posttest took place during the HLMG training.

3.8.1 Application Of Knowledge And Skills From The LMG Training

A question was asked in which DHE members were asked to score the difference in performance in terms of before and after the training. The area of improvement was based on the modules covered during training from which the HLMP developed custom indicators for monitoring the training. The scores are presented below in table 21

Table 12 Mean DHE performance scores before and after training

Timely and accurately reporting	2.3(0.7)	3.5(0.9)	0.002
Procurement	2.3(0.3)	3.5(0.2)	0.009
Coordination of activities	2.1(0.7)	3.6(0.5)	<0.001
Outbreak detection	2.8(1.1)	4.4(0.5)	<0.001
Asset management and control	2.4(0.7)	3.6(0.7)	0.001
Teamwork	2.3(0.9)	4.0(0.6)	<0.001

Table 12 shows the mean scores for DHE performance before and after training. There is an obvious difference in scores for before and after training on all the assessed topics as indicated by statistically significance levels of p value > 0.001 except for procurement which has a p value of 0.009.The respondents had all attended the DHE training and their assessment as people that are directly involved in performing these functions gives evidence that the HLMG training has indeed made a significant contribution towards health system strengthening through capacity building which leads to quality improvement in health care delivery

3.9 Self-Evaluation Perception And Attitudes

Table 13 Perceptual Analysis (% response rate to each item given for each score)

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree

		Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
#	**Rate your feelings in relation to the statements**	**1**	**2**	**3**	**4**	**5**
19	Working as a team makes me feel bored	81.0	15.2	1.0	0	2.9
20	Working as a team wastes a lot of time	75.0	23.0	0	2.0	0
21	I cannot work in a team because I am more educated than the rest of the team	89.4	9.6	1.0	0	0
22	It is difficult to be ethical because of our poor salaries	55.8	27.9	12.5	1.0	2.9
23	Ethics are only on paper	61.9	24.8	9.5	2.9	1.0
24	Ethics should be practiced by people at higher levels	64.8	18.1	4.8	5.7	6.7
25	Applying Governance principles is impossible in the face of low salaries	53.9	30.8	10.6	3.9	1.0
26	I cannot wait for a group decision since I am the one in charge	57.3	37.9	3.9	1.0	0
27	Waiting for communities to give their input will delay our projects	50.0	37.5	7.7	4.8	0
28	We need to respond to partner needs since they have the funding for our projects	40.2	33.3	12.8	10.8	2.9
29	I do not need to be involved in ordering of drugs since I am not a pharmacist	60.4	33.7	4.0	1.0	1.0
30	I am trained as a pharmacist other members of the DHE cannot understand my work	50.0	39.1	10.9	0	0

31	Funding that is meant for EPI should be used only by the nursing department	58.3	32.0	4.9	2.9	1.9
32	Only one person should do the procurement to reduce confusion	83.5	14.6	1.9	0	0
33	The supervisor cannot discipline me since they also lack discipline	65.4	96.2	3.9	0	0
Q34	Funding for malaria must be strictly used by the environmental health department	60.0	30.5	6.3	2.1	1.1

Self-Assessment of knowledge and skills application (% response rate to each item given in brackets)

Perceptions and attitudes are often regarded as antecedence to behavior both negatively and positively. Table 13 above provide scores on self-rating for attitudes and perception of how DHEs currently feel about certain issues pertaining to their work and in relationship to what was covered during HLMG training. The statements were meant to identify whether attitudes had shifted from negative to positive. All the responses show a definite shift towards the positive since pre assessment indicated a poor state of working relationship among the DHE members .Attitudes assessed related to working as a team coordination of activities sharing of resources, ethical practice, procurement, working with communities and governance issues.

Attitudes for working as a team have shifted as seen by the first three statements which were all assessing the concept of teamwork. Responses on the issue of team work are highest ranging from a high of 89.4%, 81.0% and 75% this response shows that that attitudes have shifted towards the positive.

Positive attitudes were also noted on procurement where responses disagreed with the statement that procurement should be done by one person to reduce confusion at 83.5%. The results show that there is a small shift on ethical practice and governance issues since respondents still thought that it was not easy to apply governance issues are difficult to apply when they had low salaries and that the policy makers at higher

levels should apply ethical practices 55.8 % and 50% did not think that it was easy to work with communities

3.10 Application Of Knowledge To Routine Practice

This section asked questions to identify whether the HLMG training had made an impact on their day to day work as a result of the HLMG training conducted between October 2010 to August 2014.

Individual face to face interviews were conducted during the field survey. The questions were based on the custom indicators developed from the modules covered during training. Other questions included the custom indicators that the HLMG project developed for field follow up which in turn related to the competencies of the District health executives. Questions were based on ***teamwork, meeting management, conflict management, asset management financial management Diseases outbreak investigation, managing health information system partner coordination grooming and etiquette and carrying out operational research projects.*** The section below provides a description of these practices.

The table below provides an overall overview of the responses performance after LMG training.

Table 14 Frequency of Application and practice

Frequency of DHE meetings	
Weekly	28(28.0)
Fortnightly	56(56.0)
Monthly	16(16.0)
Evidence for meetings available	
Yes	103(99.0)
No	1(1.0)
Frequency of resolving conflicts among health personnel	
Monthly	34(41.0)
Quarterly	19(22.9)
Bi annually	6(7.2)
Annually	6(7.2)
Never	18(21.7)
Sources of conflict identified	

Yes	74(84.1)
No	14(15.9)
Carried research during period trained	
Yes	35(34.0)
No	68(66.0)
Managed any outbreaks in past year	
Yes	56(56.6)
No	43(43.4)
Handled community concerns in district	
Yes	79(96.3)
No	3(3.7)
Patients ever turned away because of inability to pay	
Yes	3(2.9)
No	99(97.1)

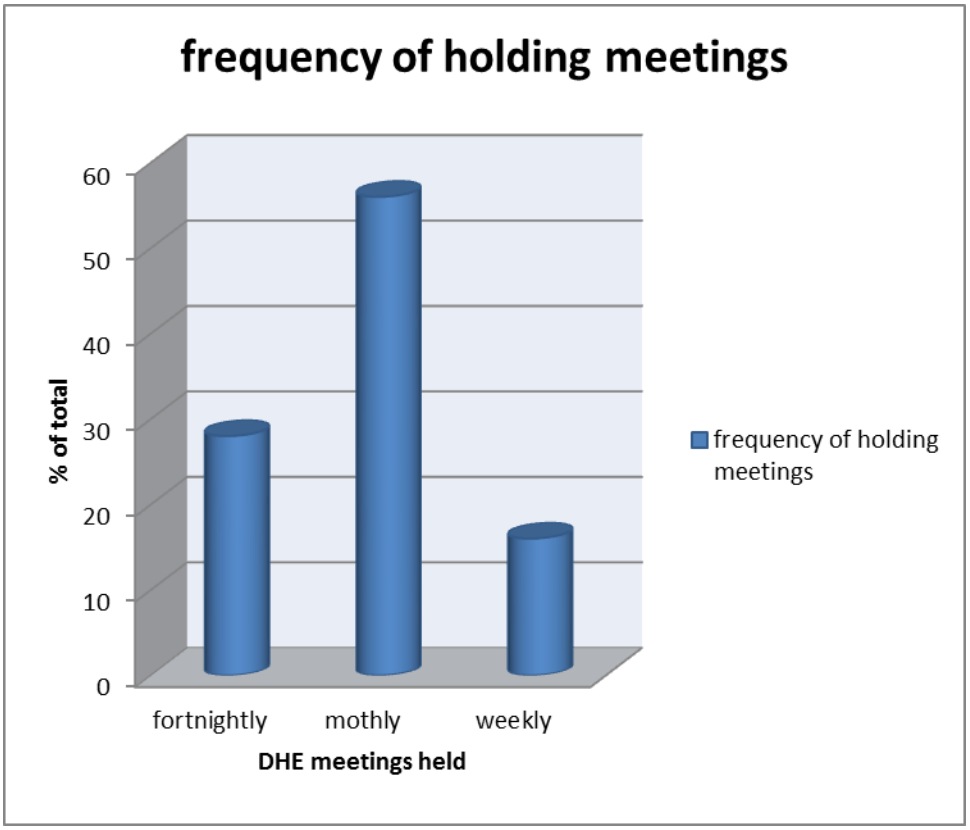
Table 15 Mean DHE performance scores before and after training

Timely and accurately reporting	2.3(0.7)	3.5(0.9)	0.002
Procurement	2.3(0.3)	3.5(0.2)	0.009
Coordination of activities	2.1(0.7)	3.6(0.5)	<0.001
Outbreak detection	2.8(1.1)	4.4(0.5)	<0.001
Asset management and control	2.4(0.7)	3.6(0.7)	0.001
Teamwork	2.3(0.9)	4.0(0.6)	<0.001

There was significant improvement in DHE performance in all the areas trained in timely and accurate reporting 0.002. DHE Coordination of activities was statistically significant at P value 0.001. The DHE represent the MOHCC at district level and are therefore crucial in providing policy and guidance to all the sectors involved in implementing public health activities at district level. These results indicate an improvement in this area. Conducting outbreak investigations showed a statistically significant difference as a result of training as seen by a p value of <0.001 .The scoring on this aspect increased two fold after training (2.8) against (4.4) indicating a clear

improvement in conducting outbreak investigation in the DHE performance. When outbreaks are managed on time and efficiently it improves the well-being of communities and reduced the spread of infection to the rest of the community. There was a significant change in asset management and control after the training 0.001. Working as teams < 0.001 lack of teamwork was seen as the biggest challenge in improving performance of DHE teams. It is obvious that the HLMG training has indeed made some remarkable improvement which in turn can improve general performance in other aspect of DHE work.

Figure 4: Frequency of holding DHE meetings



According to figure 4 above the MOHCC district health guidelines and procedures the DHE meetings are supposed to be held monthly. Prior to the LMG training most districts were not conducting DHE meetings due to inadequate manpower and poor team work. Figure 4 above shows the frequency at which these meetings are held. Of holding meetings 56% respondents indicated that such meetings are held monthly whilst 28% indicated the frequency as fortnightly a smaller number 16% indicated that the meetings are held weekly almost all respondents reported having evidence of these meetings. The team was able to view the record of meetings. All responses show that meetings are being held as required. Regular meetings are a feature of good

governance since meetings facilitate discussions on problems that may hinder success in the running of a district. It is pleasing to note that these meetings are now being frequently held as an indication of good management /governance

Figure 5 Frequency of resolving conflicts among DHEs

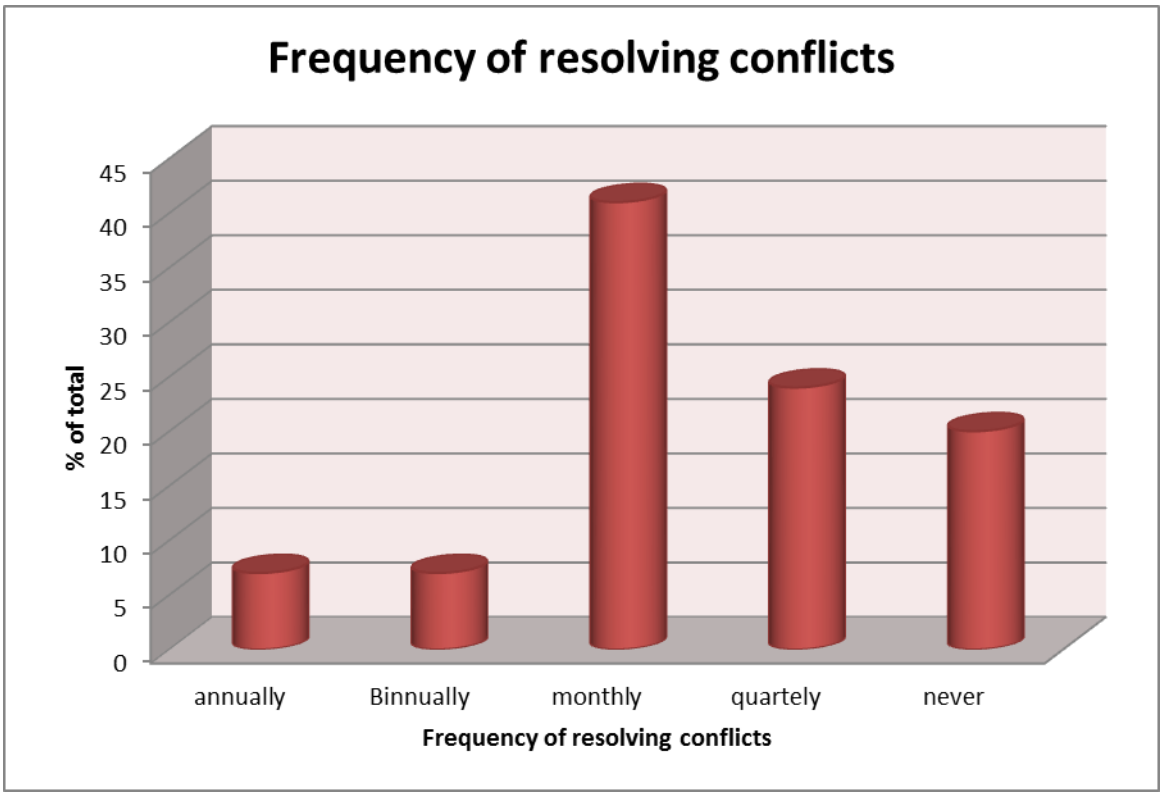


Figure 5: above shows the frequency at which conflicts are resolved in the surveyed districts Resolving conflicts on time is another indication of a well-functioning organization. The majority of respondents (41%) reported resolving conflicts among health personnel on a monthly basis with 23% indicating that they resolve conflicts on quarterly basis. A few are still resolving conflicts even though it is occasionally. The 20% who indicated never resolving conflicts were new members of the team that have not been involved in the process. Prior to the LMG training districts reported that they conflicts were not being resolved since the majority of DHE members were not aware on how to engage in this process. The training provided them with routine a framework of resolving conflicts as indicated in the health service regulations. It is pleasing to note that 41% are resolving conflicts on monthly basis and others are resolving conflicts albeit infrequently but never the less going through the process. The

types of conflicts being resolved include: **Absenteeism, accommodation conflicts, misappropriation of funds, social, staff disputes, insubordination, and teamwork conflicts. The sources of conflicts were indicated as**

Professional diversity, Drunkenness and lack of Respect, limited resources, Absenteeism, difference in knowledge levels, frustration due to working environment, frustration due to working environment, goal differences

Welfare of DHT members

This aspect of evaluation also focused on the improvement of the work environment since part of the LMG training covered aspects on how districts can improve their work environment in order to keep morale high for their teams as part of managing wellness in the workplace. The following were some ways DHE had improved their workplace environment for the benefit of all health workers working at district level There was a general indication that some DHEs had gone out of their way to cater for the welfare of their staff by putting in place recreational facilities such as soccer teams, netball facilities**,** and creating environments in which games such as volleyball, darts, snooker could be played in a relaxed environment. Other districts indicated that they had identified a room where staff can watch TV together and access the internet. Most importantly was the putting in place support mechanisms for, psycho-social support through group interaction. However, 54% of the surveyed districts had not put anything in place for their workmates.

Asset Registers

One of the problems before training was the fact that most districts did not have asset registers in place and this was causing a lot of pilfering of Government property since the assets could not be monitored 88% of the respondents said their offices now kept an asset register that indicates all the assets that the district owns and this could be produced at any time when required. The asset register is now being regularly updated in accordance with any newly acquired assets. Ethical principles are being adhered to during procurement .All the DHE members are now participating in the procurement process

Operational Research

One of the key activities in the strengthening of health care systems is the need to use evidence in the planning of public health interventions and in developing indicators for

monitoring and evaluation. The LMG training included a component of carrying out operational research. The districts were encouraged to bring their T5 forms to the training for problem identification. The analysis of these forms a basis for conducting operational research .At the end of the workshop they presented a proposal on how they were going to carry out the research. The evaluation identified that very few districts were carrying out research. As planned after the workshop only 34% reported having carried out any research. Various reasons were given important of which were lack of time capacity and resources to conduct the operational research

Outbreak investigation/management

57% of the respondents reported carrying out outbreak investigation and successfully managing the outbreak. Malaria was the most common outbreak investigated and successfully managed. The malaria programme is funded through global funds. It is therefore apparent that the funding provided provides resources and maybe the motivation to carry out malaria outbreak investigation.

Community concerns Patients' ability to pay

96% of the respondents reported having responded to community concerns in the districts. Examples of Community concerns included cost of health care services, waiting time at the hospital and general attitudes of health care workers towards the community 3% of the respondents reported that some patients were being turned away because of inability to pay for services.

RBF and HTF beneficiaries

Thirty two (32) respondents reported that their districts were beneficiaries of RBF and 74 reported their districts being HTF beneficiaries. Three respondents from Bulilima and Chiredzi districts reported that their districts were benefiting from both Results based funding (RBF) and the Health Services Transmissions Fund (HTF).

Handling and sharing resources

The majority of the DHEs agreed that it was still difficult to pull resources together as DHE. They indicated that it was easy when the funding comes directly to the District through the DMO .Their concern was that the national level programme managers are still directing funding to an individual which then makes it difficult to work a as team. Other districts reported that they were sharing resources such as per-diems for

supervision .They said that in such cases they all went for supervision even when specific officers are listed as the only people to go as a result they were able to share resources.

The National health strategy, using health information and working with partners

Respondents agreed that they are now planning their programmes with reference to indicators outlined in the National Health strategy with reference to data obtained from the health information system since they learned how to translate data into information that is useful for planning. Knowledge of the NHS had also facilitated the DHEs to guide partners in terms of the requirements of the MHCC policy frame work. The DHEs indicated that they were now more confident to in interacting with other sectors as policy makers. Introduction of new issues is always a difficult process; however the training DHEs obtained from the LMP has helped them to introduce change using the consensus building process as part of teamwork.

DHE EVALUATION QUALITATIVE DATA

CHAPTER 4

4.1 Qualitative Evaluation For DHEs

Qualitative information was collected through focus group discussions and in some cases group discussions in the selected districts. The discussion focused on the knowledge gained per module covered during training and its application thereof. A total of four focus group discussions were conducted as part of the evaluation in four provinces.

Developing Focus group discussion guide

A focus group discussion guide was developed (see annex) based on the custom indicators developed for monitoring and evaluation of the LMG training. The following indicators were addressed in the FGD guide: conducting regular DHE meetings , concluding disciplinary cases, Recording disciplinary cases in the misconduct register, conducting coordination meetings with developmental partners detecting Outbreaks on time ,reporting outbreaks on the weekly diseases surveillance system controlling outbreaks on time , providing Clinics with supervision and support number of Pregnant women booked for ANC for the first visit. Members of the research team were trained on the conduct of Focus Group Discussions (FGD).

Selection of participants

Participants to the FGDs were selected into the FGD based on:

- Having participated in the LMG training in the past 3 years
- Being members of the DHE

4.2 Conducting FGDs

Communication was made to the Provincial Medical Director about the evaluation a month before the evaluation. The communication outlined the date and time for the visits so that arrangement could be done in advance and some members of the DHE could easily be found in place on the specific dates since the DHEs are usually very busy with programme activities. In each case the team passed through the Provincial Medical Director`s (PMD) office to discuss the purpose of the visit and obtain an endorsement from the PMDs office on the districts to be visited.

Four FGDs were conducted in four clusters between 18th and 31st March 2014. Thirty-One DHE members participated in the FGDs. The participants were conveniently selected to be interviewed as regions. Manicaland, Mash West, Midlands and Matabeleland North provinces were selected.

Procedurally the purpose of the FGD was explained to the participants and the rules for conducting the FGD were explained as outlined on the FGD guide. The discussions started by asking a general question on how health workers are managing health care services and the challenges they are encountering on day to day basis. This question was then followed by specific questions related to the roles and functions of the DHEs and how they are performing these roles after the LMG training. Focus group discussions were conducted in the board room that was kindly provided by the DHE. Participants were asked to describe their experiences before training and how they are now applying the knowledge gained from the training The discussions also included the challenges that are being faced by DHE in applying what they learned during the training as well as possible solutions to these challenges

The FGDs were conducted by three people. The facilitator was responsible for asking questions the second person was responsible for the recording the conversations on tape and the third person was observing as well as recording the discussions using pen and paper. This same procedure was used for the four FGDs. Each FGD lasted about an hour.

Data Management

After data collection the next step was the transcription of the discussions which were recorded in English. The completed transcriptions were compared with hand-written notes to fill in inaudible phrases or gaps in the tapes. The two common methods in content analysis are identification of themes, and incidence density. In theme identification, the research looked for particular patterns, themes, concerns or responses which were posed repeatedly by the focus-group respondents. The group (rather than the individual) was the unit of analysis

4.3 Transcription and Analysis

Phase 1: The field notes were labeled for venue, date of FGD and person who conducted the FGD. After data collection the next step was the transcription of the individual, pre-labeled tapes.

Phase 2: Each book was transcribed from the notes to a word document verbatim in English.

Phase 3: The completed transcriptions were compared with hand-written notes to authenticate had been typed.

Phase 5: Methods of Analysis

The two common methods were used: content analysis where identification of themes, and incidence density were identified. In theme identification, the analysis looked for particular patterns, themes, concerns or responses which were posed repeatedly by the focus-group respondents. The group (rather than the individual) was the unit of analysis.

below shows a summary of the characteristics of the sample.

Table 16 Description of the FGD Sample

Date	Participants		Venue	Clusters	Number	Age Range
	Males	Females				
11thMarch 2014	4 males	5 females	Manicaland Nyanga	1	7	25-50
5th March 2014	3males	4	Mashonaland West Chegutu	2	9	25-50+
18th March 2014	2 males	6 females	Midlands Shurugwi	3	8	25-50
25TH March 2014	3 males	5 females	Mat. North St. Luke's Lupane	4	8	25-50

The focus group participants ranged in age from 25 to 55 years. 20 were females and 12 were males. It was only possible to have at least seven people per district participating in the FGDs. The participants were selected from Chegutu, Nyanga Shurugwi and Lupane districts.

The results are presented according to the themes from modules covered during training.

4.5 Results Of FGDs

Working as DHE Teams

Team work was a serious problem in most districts because of vertical funding of programmes which resulted in each member of the DHE doing his or her own activities. The LMG training focused on highlighting the benefits of teamwork and the challenges that can arise in working as a team and how the team leader can resolve some of these challenges

The discussions revealed that the HLMG training has improved communication among team members and there is now integration of activities.All the districts mentioned learning about teamwork as having the most singular out of the whole training They said that the training had strengthened team work among the DHEs. All the districts mentioned learning about team work as having the most singular benefit of the LMG training.

Teamwork has resulted in the integration of activities through combining trips especially on outreach program has resulted in the effective and efficient utilization of scarce resources. The benefits of the training are also manifest in the improvement in service delivery as there is evidence that now DHE members understood the role of each member and their related activities.

There was also a revelation that most activities used to be departmentalized and each person was carrying out his/her individual programme duties. The DHEs having realized the importance of team work have revived meetings such as DHE General meeting, Staff meeting and HOD meetings so as to work together as teams and increase efficiency.

Eighty-five per cent of the districts visited indicated that DHE Meetings are now running smoothly because of the renewed team spirit among the members. There was lack of appreciation of programmes run by other members before the LMG training which resulted in house fighting for resources. After the training they came back, sat down as a team to chat the way forward to work together. The DHE training has taught them to work together and share resources and this is done through conducting DHE meetings regularly and share information pertaining to their specific programmatic areas.

A member of the DHE stressed that the module on team building was of significant importance as it fosters team spirit and DHE Cohesion. They also highlighted that as a result of regular meetings communication has improved and decisions are wholly owned by the DHE as indicated below:

Team spirit and cohesion is clearly described below:

"After the training we realized that there is need for consensus decision making .There is no longer a dictator here, no matter how small the decision is we take the inclusive approach since they are decisions for the whole district not for specific individuals'. Before the training EPI used to be managed by the DNO. It is true that DNO is the technical person there is need for inputs from other members. IRS program was specifically for the DEHO, now everyone is aware of what is happening in the district. Record keeping has improved as we learn from the training all the meetings are recorded accurately and agreed upon by the DHE. The DHE meetings are very crucial as they help in resource allocation especially vehicles. There are different programs and all members will participate when they are aware of other activities

Appreciation of each other work and sharing information

All the members now appreciate the importance of other departments and the decisions are made in the DHE meetings. It was mentioned that planning of activities is now being done as a team as well as support and supervision to the rural health centres. Teamwork has also created a conducive environment for sharing information as expressed below:

*`Soon after the training I shared the information with everyone during the nurse`s meetings, this has given everyone a chance to reflect on their day to day activities and incorporate Health leadership, Management and Governance principles``-**DNO Lupane***

The training emphasizes the importance of training as a team and this is very critical especially during this time of scarce resources, there is need for proper coordination of activities together to get maximum benefits. Conflict is inevitable in all organization and one of the causes is limited

"We hope that all new members of the district will be able to undergo the same training such that in the process of decision making everyone will be at the same level"

LMG Training as induction on the Health Service Regulations

The majority of respondents admitted that during their long stay in the system they did not attend any training about the health services regulations.. There was a realization among the respondents that currently the MOHCC was not providing any induction for newly appointed officers and the LMG training was seen as fulfilling this important role as indicated by a newly appointed GMO in a statement below:

"This is a very important training which serves as an induction training .When I was promoted into managerial position there was no induction and all of a sudden I was expected to perform and lead the district. I have been in the District for many years and have not gone for any training like this. It was really an eye opener, as I have gained knowledge in working as teams, improve my leadership skills, communicate and plan together such that our activities as the DHE are coordinated. GMO Chegutu. Mashonaland West Province.

This point was further supported by the DMO Nyanga who said:

"The health Services Regulations training was very useful to us as the district as we are now using the information to conduct training for nurses in conditions of services and health services regulations"

*"I have never attended any induction training since I joined the Public health system and it was very challenging in interpreting the Health Services Regulations. When I came back from the training, I gave the regulations to all the departments and conducted an orientation exercises on the Health Service Regulations. The workshop had adequate information and I am now confident of conducting disciplinary hearin*g.

Disciplinary and Grievance Procedures

DHE s indicated that many new officers had just been thrown into the deep end of leadership and management when their pre-service training had not prepared them for such tasks. The sentiments are expressed in the statement below:

"We were drafted into the DHE without any leadership induction and I was expected to lead experienced and older colleagues- DMO –Mat North West

Another participant from Matabeleland weighed in saying...*"if the training had been done earlier we could have averted a lot of court case that we are now saddled with. We can now manage disciplinary hearings better*

There was consensus for the FGD participants that resolving of conflicts and responding to grievances has improved as a result of LMG training .The improvement has been attributed to the fact that DHEs are now aware of the requirements and processes for conducting disciplinary procedures since the LMG training includes the health service regulations in the training. Misconducts were not finalized because of lack of proper knowledge on grievance handling and disciplinary procedures the following statement supports the appreciation for the health service regulation training The lack of training in discplinary procedures could be the major reason why there were many pending disciplinary cases prior to this training. They said that hrough applying what they had learnt from the LMG training, they had managed to resolve all the pending disciplinary cases and employ measures that deter indiscipline behaviours of staff members

Decision making process

The participants reported that there has been improvement in the decision making process after the LMG training, before the training decisions were made on an individual basis but now the DHE is taking a leading role in making important decisions. There has been great improvement in the decision making process as illustrated by the statement below:

"During the meetings we also discuss on how best to utilize the Health Service Fund, all the activities to be carried out are agreed upon and there is now transparency in terms of resource allocation. After the training we came to realize that in a team there are members with different personalities with their weaknesses and strength. It is the responsibility of the DHE to recognize that and maximize on individual strengths and minimize on weaknesses. DNO Mat North

Effect of partial support provided to DHEs by the LMGP

The DHE, s major role is to coordinate sectors that are involved in public health and health care delivery activities. Over the past 5 years it has been difficult for DHEs to conduct coordination meetings in form of District Health Team meetings due to lack of resources. Some districts had not held any DHT meetings since 2010.The LMG project has been providing partial support to districts (6000USD) to conduct such meetings. Districts have successfully District Team Meetings with successful outcomes. The appreciation of the support provided by the LMG project is expressed in the statement below:

We planned for a DHT meeting with the resources from the LMG project. The meeting was a success and we managed to host a total of 55 participants for three days. The participants were from the MOHCC, NGO, Local government, Ministry of Agriculture, private sector and mission hospitals. We were able to get a full picture of what is happening in the district and develop recommendations to this effect" DHE Shurugwi

Management and Coordination of activities among DHEs

There was an appreciation among the DHEs that decision making process has greatly improved and now decisions are made as a team and there is ownership of projects and programs. Communication has improved after the training, both internally and external.

Respondents expressed that as a result of the LMG training, sub committees have been formed in order to speed up the decision making process as well as to encourage ownership of decisions. Examples of some committees formed include TB, OI, PMTCT and Infection Control. There was also an affirmation that the consultation in decision making has helped in resource allocation and coordination of activities. Coordination between departments has improved communication. The issue on coordination is illustrated through the following statement*:*

"The major benefits as a result of the DHE training is the improvement in information sharing as a result of improved communication information is now shared between departments .This is evidenced by how projects are being managed, for example the EPI project was predominantly for the nurses, and IRS for the DEHO now all departments are included in planning and project management. The administration department takes

a leading role in logistics and the Accounts department in making payments, the HR also involved in recruitment of the personnel who do the spraying. Shurugwi DHE

Coordination- the DHE is a multi-disciplinary set up which needs skills and experience in coordination in order to produce desired deliverables

The participants were happy that the training emphasised the leading role of the DHE in all health related activities in the district. This proved to be very beneficial to the DHEs as they used to leave their partners coordinating health related activities without informing the DHE. The training imparted a renewed sense of ownership among the DHEs as indicated below:

… "Now we ask the partners to submit their plans which we study and approve unlike before"……..DMO

The DHEs reported that they are now confident of their coordinative and leading role with regards to other sectors. They are now able to redirect efforts towards the MOHCC priority areas as well as their district priorities. In turn partners now also understand the DHEs role health care delivery. Before training they said that it was common for one programme manager to conduct a meeting with the partners, now every DHE member is now involved in these meetings with partners.

Conducting meetings

The Meetings are now productive unlike what was happening in the past where there were a lot of conflicts and reduced output. Most districts reported that they had not been conducting DHEs regularly since they did not see the importance of having regular DHE meetings. After the training, the same districts are now meeting regularly to plan and discuss pertinent issues for the district. The DHE meetings were revived and other meetings such as the General meeting, Staff meeting and Head of Departments meetings were now scheduled for. Eighty-five per cent of the districts visited indicated that DHE Meetings are now running smoothly because of the renewed team spirit among the members. Other districts reported that most activities used to be departmentalized and each person was carrying out his/her individual programme duties. There was lack of appreciation of some projects by other members which resulted in disorganization and in-house fighting.

"*The DHE training has taught me to work together and share resources and this is done through conducting DHE meetings regularly and share information pertaining to each other's specific programmatic areas"-**DHE Lupane***.

DHEs highlighted that as a result of regular meetings communication has improved and decisions are wholly owned by the DHE. Data quality assessments were done through reviewing of meeting minutes. This review highlighted that there is an improvement in the quality of the meetings being held as shown by the availability of meeting agenda being circulated to all the members before the meetings, action points clearly defined and members assigned the roles to do after the meeting.

Strengthening health care programme implementation

When asked. "What did you benefit from the training you received", the participants mentioned several areas covered by the modules

Role Clarity*…The training also helped to clarify on the core DHE members as there was confusion on who should be part of the DHE. This has caused problems in terms of reporting and delegation of duties and responsibilities.*

Teamwork- the DHEs are functioning well because of improved team work

DHE the meetings are the backbone of district health functioning. The participants mentioned that the meetings provide a platform to discuss on how best to utilize the Health Service Fund; all the activities to be carried out are agreed upon. As a result of the training they indicated that there is now transparency in terms of resource allocation.

…."*After the training we came to realize that in a team there are members with different personalities with their weaknesses and strength. It is the responsibility of the DHE to recognize that and maximize on individual strengths and minimize on weaknesses*"- DNO

The training has strengthened team work among the DHEs. The DHEs reported that they had not been conducting DHE meetings regularly due to verticalization and lack of shared values. Since the training emphasized the need for shared vision and

collective decision making most districts are now holding executive meetings regularly and this has in turn greatly improved service delivery in the districts…

…. "*Now the clinical members are also involving us in their programmes and we are all contributing significantly in our districts" -….. DHSA Chegutu*

Procurement

Most of the districts were under the results based financing or the targeted approaches programme and were thus involved in a lot of procurement. However many have not been trained in proper procurement procedures. The FGD participants indicated that the module on Procurement opened their eyes especially to improper activities that had been taking place before. They can now understand the procurement procedure language as shown in the statement below:

"*The PTC would tell me that we have sole bidders some of which I could understand the procedures"… DMO-*

The benefits of the training are also manifest in the improvement in service delivery as there is evidence that participants understood the role of Central Buying Unit and Procurement and Tender

Asset management

The DHE manages the assets of the government health centres in the districts and are expected to keep up to date inventories and stock control documents.

The participants indicated that that asset management had been very poor due to lack of institutional memory as well as lack of knowledge in dealing with redundant and obsolete equipment which continued to gobble up valuable space in the institutions. The training helped participants helped the DHEs understand the process of disposing of such assets and maintain records of both government and donor funded equipment. According to the participants this also helps in curbing pilferage of assets. The finding on improved asset management is supported by the national level reports which now shoe that districts as well as provinces have improved in asset management

Finances

The DHE is responsible for managing district resources. The participants indicated that the rest of DHE members had no interest in finance matters except the accountants and vice versa. The training helped them to appreciate the collective role of the DHE in the mobilization of finances and accountability of whatever resources they have. The appreciation of being involved in finances is shown by the following statement

'Now we don't blame the accountant when the money falls short of our expectations, it's now a collective decision on where and how to deploy our financial resources".....DEHO

HRH

The DHE manages HRH matters at their local level. Most DHE members were not trained on handling HRH issues like recruitment, interviewing disciplinary hearings and boards of inquiry. The result was that most of the matters were poorly done and the ministry in turn lost several cases due to mishandling. The module on HRH was indicated as having been very helpful and has thus served as induction for DHEs which should have been done before assuming the management roles and this importance is reflected in the following statement

... The module on HRH should be a must on anyone getting into the DHE to reduce misunderstanding and appreciation of how sometimes there are limited resources DHSA-

The Health Services Regulations training was very useful to us as the district as we are nw using the information to conduct trainings for nurses in conditions of services and health services regulations"

"I have never attended any induction training since I joined the Public health system and it was very challenging in interpreting the Health Services Regulations. When I came back from the training in Mutare, I gave the regulations to all the departments and conduct an orientation exercises in trying to get a clear understanding of the regulations. The workshop had adequate information and I am now confident of conducting disciplinary hearing

Support and Supervision to Primary Health Centres

The DHE provides support and supervision to primary health centres within their respective districts. This is meant to strengthen the facilities through capacity building as well as appraising on the development of the facilities infrastructure. The participants indicated that this activity was being done mainly along programme lines like PMTCT, OI ART, TB or EPI. The training helped them organize this activity as DHE while taking advantage of programmes which have resources. …

"I can now join the team going for OI ART to go and attend to the maintenance of facilities"…. DHSA

Support for District Health Team (DHT) meetings

The LMG project has been financially supporting districts to hold DHT meetings.The DHT is a platform for the DHE to meet with staff from the facilities and discuss operational plans as well updating the staff on any new guidelines to be followed. It is also a forum to meet with all the key stakeholders in the district. It should be conducted quarterly. The participants in the FGDs indicated that they were very grateful to the Leadership project for having resuscitated the DHT meetings which had long been forgotten.

…I have been in the district for five years and have never attended a single DHT meeting now I have been able to due to the support provided by the LMGP…DMO

The DHT meetings have facilitated the coordination of sectors involved in health care delivery at district level. It can be seen that the trainings has made districts appreciate the importance of taking a leading role in all health related activities as the support has increased coordination meetings as supported by the statement below:

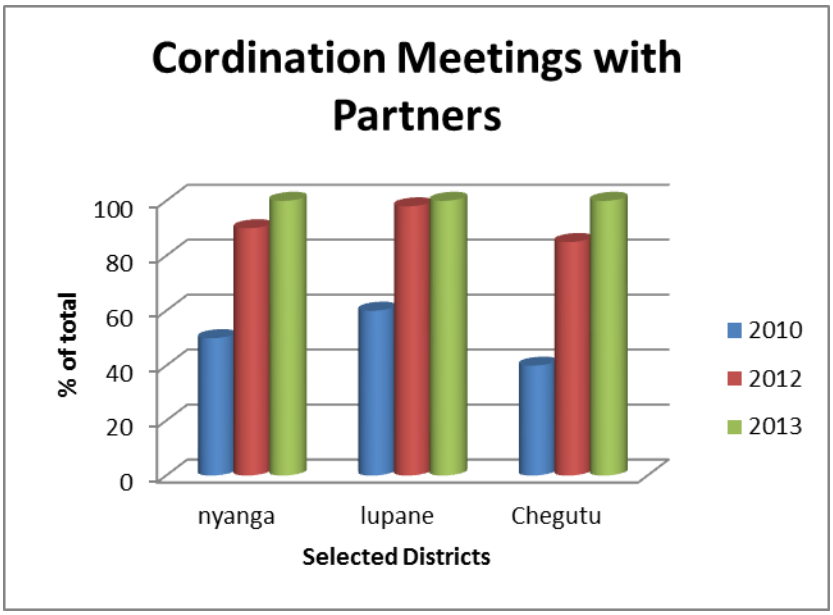
"***The financial support provided by the LMGP has made it possible to conduct DHE meetings with health workers from clinics and rural hospitals. This has made our supervision task much easier since we have also managed to disseminate the information from the DHE training to our entire health worker at district level." Chegutu DHE***

DHT meetings have also helped to coordinate other health related partners and this is seen as of paramount importance as the DHE should take a leading role in supervising all health activities regardless of the implementing partner. After the training they have managed conduct DHT meetings with all their partners.

Participants were asked to sum up their feelings about the DHE training and the following statements are self-explanatory:

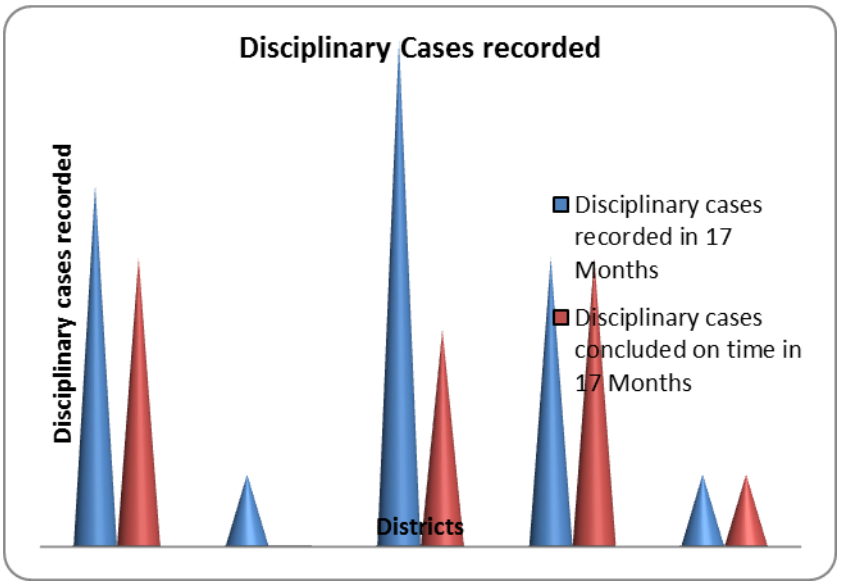
"We believe that the training was worthwhile and we came back as a complete new DHE team working together to serve the needs of our communities at district level."

Figure 6: Real Change has taken place



In resource limited settings where staff attrition is very high, it is necessary to put in place sustainable models for health systems strengthening like building internal capacity in the ministry of health.

Figure 7: Disciplinary Cases



PROVINCIAL HEALTH EXECUTIVES EVALUATION REPORT

5.1 Provincial Health Executive Level Evaluation

The Provincial Health Executive is responsible for translating and applying the Ministry of Health strategies, regulations and frameworks for the lower levels and generally to extent national level functions. The PHEs are also directly responsible for monitoring the performance of district health systems, training district-level staff, and conveying and translating and ensuring the operationalization of national health policies.

The evaluation was conducted before the PHEs were trained however the PHEs were aware of the training since the LMGP was partially supporting the provinces to carry out supervision in the trained districts. In addition, all the Provincial Medical Directors had undergone the trainer of trainer's workshops and were actively participating as facilitators in the DHE training workshops. The purpose of interviewing the PHEs was to identify their level of awareness about the LMGP and degree of support they were providing to the trained DHEs.

The overall response rate in this category was 56%. A total of 18 PHE members were interviewed in 6 provinces. The anticipated number of interviews was 24 PHE members. Manicaland, Mashonaland East and Midlands provinces had 100% highest response rate while Mashonaland Central and Mat North PHE were not able to complete any forms.

Provinces and sample

Table 17 : Provinces and Sample- PHE

Province	Freq.	Percent
Manicaland	4	22.2
Mashonaland East	5	27.8
Mashonaland West	2	11.1
Masvingo	1	5.6
Matabeleland South	2	11.1
Midlands	4	22.2
Total	18	100

A total of 18 PHE members were interviewed in the six provinces. The highest number being in Mashonaland East where 5 respondents were interviewed

Regarding gender, males constituted the larger percentage of respondents with 62.5% whilst 37.5% were females.

Age distribution

Table 18: Age Distribution- PHE

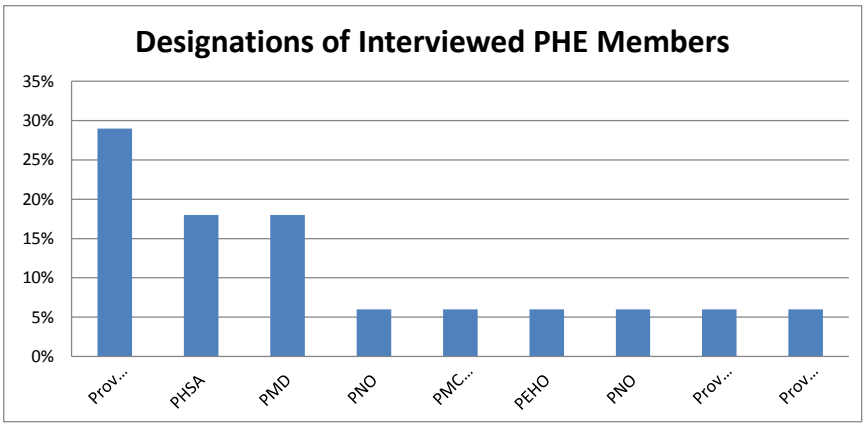
Age group in years	Frequency	Percent	Designation	Freq.	Percent
26-35	5	27.8	**ACCOUNTANT**	5	29.4
36-45	6	33.3	**PHSA**	3	17.7
46+	7	38.9	**PMD**	3	17.7
Total	18	100	**A/PNO**	1	5.9
			MOH-MCH	1	5.9
			PEHO	1	5.9
			PNO	1	5.9
			Provincial Nutritionist	1	5.9
			Prov. Pharmacist	1	5.9
			Total	17	100

Table 18 shows the age distribution of the sample. The highest number of the respondents was in younger age groups combined as the age group (26-45) age group totaling 61.1% of the sample. Younger people tend to move around looking for greener pastors. This finding confirms the initial concern of the MOHCC that health mangers in place were too young and in most cases inexperienced.

PHE members who were found at the PMD offices and responded to the questionnaires given to them The Provincial Health Executive is chaired by the PMD and comprises of the other key members such as the, PNO, PEHO, PHSA, PEDCO, PMCHO, Provincial Pharmacist and Provincial Accountant. Officers such the PHPO

and Nutritionist are in some provinces maybe co-opted members of the executive. Figure below further illustrates the designation of the sample

Figure 8: PHE Designations



5.3 Educational Qualifications

Figure 9: PHE Educational Qualifications

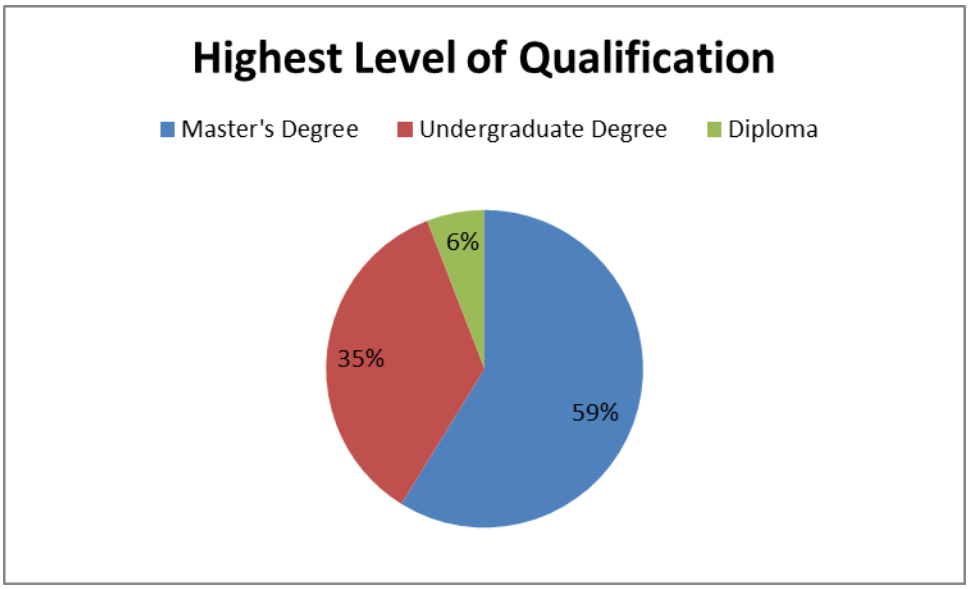


Figure 9 above shows the educational attainment of the sample. 59% at provincial level had attained a master's degree whilst 35% had attained a diploma level of education in their respective profession. A high level of professional qualification will facilitate understanding of managerial principles and frameworks.

Duration in present position

TABLE 19 : Duration in Present Position -PHE

Years in present position	Freq.	Percent
less than 1	1	5.9
1-2	4	23.5
3-5	3	17.7
6-10	5	29.4
more than 10	4	23.5
Total	17	100

Table 19 above shows years of experience in the current position. More than half of the respondents (52, 9%) have been in the Provincial Health Executive for more than six years. Institutional memory is maintained by long experienced managers who are

more likely to hand down managerial information to new recruits thus ensuring continuity of the management processes. In addition experience provides managers with a sharper the experienced managers with a more accurate appreciation of their roles and functions.

5.4 Provincial Health Executive Level Evaluation Results

Table 20 HLMG related activities participated in by respondent

DHE Training (facilitation)	6(33.3)
PHT	13(72.2)
PHE Curriculum Development	5(27.8)
PHMT Curriculum Development	3(16.7)
Summer School	0

The Health Leadership Project has involved the Provincial Health Executives in various activities of the project. This has been so as to build sustainability and enhancing project ownership by the MOHCC. A third of the PHE respondents (33.3%) had been involved in facilitation of the DHE training Programme. Table 21 below shows the various activities of the project that the PHE level has been involved in

Table 21 PHE respondents

Activity	**Number Of Respondents, N (%)**
DHE Training (facilitation)	6(33.3)
PHT	13(72.2)
PHE Curriculum Development	5(27.8)
PHMT Curriculum Development	3(16.7)
Summer School	0

Regarding the PHEs opinion on the DHE training, (93%) of the participants agreed that the DHE training by the HLMG has strengthened the performance of the DHE.

Areas that were mentioned as having improved include:

- Team work
- Coordination of activities
- Submission of programme acquittals
- Supervisory skills
- Consistence in DHE meetings

The majority of the respondents (81%) were aware that the HLMG project has been providing partial support for District Support and Supervision.

All the respondents have been involved in support and supervision of the districts supported by HLMG.

The frequency of support and supervision has been mostly quarterly.

Support and supervision is conducted by using a checklist and follow-up on the projects which the DHE came up with during training.

About 94% of the participants reported that all programme managers participate in district supervision.

Leadership Project Support

The majority of respondents (81%) were aware that the HLMG project has been providing partial support for District support and supervision. They also confirmed that they had participated in the supervision of the trained districts as part of their duties. And this has increased the collection of information to assess performance

The PHEs were asked to rate the performance of DHEs in relationship to the before and after LMG training

PHE Perception of DHE performance after LMG training

TABLE 22 : PHE Perception of DHE Performance after LMG training

Performance before training		**Modules covered during training**	**Performance before training**		**p-value**
Mean	SD		Mean	SD	
2.38	0.650	Timely and accurately reporting	3.38	0.961	0.002
2.55	0.820	Procurement	3.45	0.522	0.009
2.17	0.718	Coordination of activities	3.58	0.515	<0.001
2.92	1.084	Outbreak detection and control	4.25	0.622	<0.002
2.45	0.688	Asset management	3.42	0.793	0.001
3.08	0.793	Outbreak detection and control	4.08	0.900	<0.001
2.46	1.127	Team work	3.92	0.641	<0.002

Performance after training significantly improved in all modules ($p<0.005$).It is pleasing to note that the training has improved the performance of DHEs as observed by the PHEs Coordination of activities, asset management and outbreak investigation has greatly improved thus providing the basis for improving the delivery of health care services leading to the reduction of morbidity and mortality of the Zimbabwean population

Recommendations

The PHEs made the some recommendations to improve the functioning of DHEs. The majority of the respondents (82%) felt that the training programme needed to be an ongoing activity in the MOHCC rather than a onetime event. They also recommended that further training on resource mobilization was necessary since the economy is operating in resource constrained circumstances. The PHEs further recommended more support to provinces to be able to carry out support visits to the districts.

PROVINCIAL HOSPITAL RESULTS

CHAPTER 6

6.1 Provincial Hospitals Evaluation

Evaluation of PHMT in Health Leadership, Management and Governance Project

All the members of the Provincial Hospital Management Team (PHMT) interviewed said that the HLMG has strengthened the performance of the DHE.

Provincial hospitals were included in the LMG training at the request of the Ministry of Health and Child Care. All the provincial hospital teams were trained totaling 64. The teams trained were composed of matrons, hospital superintendent's s, matron's hospital administrators, accountants' pharmacists and tutors from provincial schools of nursing. It was seen as necessary to include this group in the evaluation

6.2 Designation Of Respondents- Provincial Hospitals Management Teams

A total of 24 interviews were conducted at the following Provincial Hospitals

TABLE 23: Designations for Provincial Hospitals Interviews

Provincial hospital	**Freq.**	**Percent**	**Profession**	**Freq.**	**Percent**
Bindura PH	3	13	Administration	5	20.8
Chinhoyi PH	2	8	Medical Doctor	5	20.8
Chipinge	1	4	Accounting	3	12.5
Gwanda PH	4	17	Nurse	3	12.5
Gweru PH	2	8	Pharmacy	3	12.5
Marondera PH	5	21	Nurse Educator	2	8.3
Masvingo PH	3	13	Physiotherapy	2	8.3
Mutare PH	4	17	EHO	1	4.2
Total	24	100	Total	24	100

The Provincial hospital respondents were composed of 45.8% females and 54.2% males. The majority of the hospital executive teams were in the age group 25-35 -40 + years at 75%. This shows that the hospital executives tend to be older since this is an institution there is less movement of health personnel. All the Provincial hospitals as they were trained were involved in the evaluation. A total of 24 provincial hospital executives were interviewed form the 8 provincial hospitals .Categories of health workers interviewed included accountants, administrators, pharmacists physiotherapist nurse educators Environmental health Officer human resource officers and medical superintendents. All grades of health workers were interviewed

Educational attainment **Work Experience**

TABLE 24: Educational attainment and Work Experience Provincial Hospitals Interviews

Highest qualification	Freq.	Percent	Years in present position	Freq.	Percent
Degree	13	54.2	<1	1	4.2
Diploma HND	7	29.1	1-2	5	20.8
Master's Degree	4	16.7	3-5	8	33.3
Total	24	100	> 10	5	20.8
			Total	24	100

The majority 83 % had diplomas and degrees as their highest level of qualification whilst only 16.7 had obtained a master's degree. Educational attainment can affect performance as health managers. In terms of work experience 53.3% had 3-10 years' experience at work. Work experience has an implication on the acquisition of the right knowledge and skill for improving leadership, management and governance practice.

HLMG related activities participated in by respondents

In terms of exposure to the LMG training only a small number 33.3% had been exposed to both the hospital curriculum development and the summer school

6.3 Provincial Hospitals Management Teams Results

Self-assessment of your knowledge and skills application

TABLE 25: Self-assessment of your knowledge and skills application ***Provincial Hospitals Interviews***

Current knowledge on HLM		**Modules covered during training**	**Application of knowledge at work**	
Mean	Std. Dev.		Mean	Std. Dev.
3.23	0.87	National Health care strategy	3.52	0.85
4.09	0.68	Team building	4.39	0.50
4.18	0.66	Time management	4.39	0.58
4.00	0.69	Meeting management	4.35	0.57
3.95	0.72	Conflict management	4.17	0.72
3.82	0.73	Change management	3.74	0.75
4.32	0.65	Leadership	4.22	0.52
3.86	0.64	Human resources for health	3.83	0.83
3.86	0.89	Finance management	3.78	0.80
3.91	0.92	Assets management	3.90	0.83
3.45	1.00	Analysis and management of DHS	3.86	0.71
3.32	1.09	Operations research	3.54	1.10
4.14	0.64	Health ethics and governance	4.29	0.55
3.67	0.97	Building partnership	3.83	1.03
3.68	0.99	corporate governance	3.88	0.74
3.71	1.10	Risk assessment and management	3.91	1.00
3.86	0.83	Quality improvement	3.96	0.75

Table 25 above shows self-assessment scores on knowledge level and the application level relationship to what was covered during the hospital LMG training

Modules covered during the PHMT training in Health Leadership, Management and Governance improved knowledge levels in participants. However, the knowledge change was not significant before and after training in the modules covered except for meeting management module where knowledge level after training was significantly

higher compared to before training (mean=4.3 (SD=0.6) versus mean=4.0 (SD=0.7), p=0.049).

Provincial Hospital Performance

Provincial hospital performance was good to excellent on the areas of quality control, procurement, asset management, risk management, team work and coordination of activities.

Current Provincial hospital performance was rated good by 53% of the participants and Very Good by 47% of the participants compared to prior training.

Rating of hospital performance based on modules covered during training

Table 26: Rating of hospital performance

Modules covered during training	**Percent number of respondents rating hospital performance**				
	Very Poor	Poor	Good	Very Good	Excellent
Quality control	0	4.35	43.48	47.83	4.35
Procurement	0	4.17	16.67	66.67	12.5
Asset management	0	0	20.83	66.67	12.5
Risk management	0	4.35	43.48	43.48	8.7
Team work	0	0	25	54.17	20.83
Coordination of activities	0	0	25	58.33	16.67

The question asked hospital team members to rate their performance according to the modules that were covered during LMG training. The ratings were spread along the categories ranging from very poor to excellent. The above table shows these rating/The highest scores are under the categories of good, very good and excellent ranging from 47.83% up to 66.67%.It does seem like a lot of application has taken place on procurement and asset management 66.6% on both respectively. The scores shifted dramatically from poor to excellent. There were no changes over quality control indicating that the hospitals are well advanced in this area even prior to LMG training .where as dramatic changes took place on procurement 4.17 up to 12.5 ,asset management up from 0 to 12.3 and on team work another dramatic increase from o

to 20,83. The results are again showing how the training on the importance of team work is resonating and strengthening the work of hospital managers

Table 26 : Rating of hospital performance

Modules covered during training	Rate your Hospital performance	
	Mean	Std. Dev.
Quality Control	3.52	0.67
Procurement	3.88	0.68
Asset Management	3.92	0.58
Risk Management	3.57	0.73
Team Work	3.96	0.69
Coordination of Activities	3.92	0.65

Additional rating in mean scores is shown in table above. The mean scores are highest on teamwork 3.96 and asset management 3.92 against the lowest mean score of 3.52 quality control. The hospitals had already received training on quality control hence the no difference in before and after mean scores.

Figure 10: Rating of hospital performance using modules covered during training

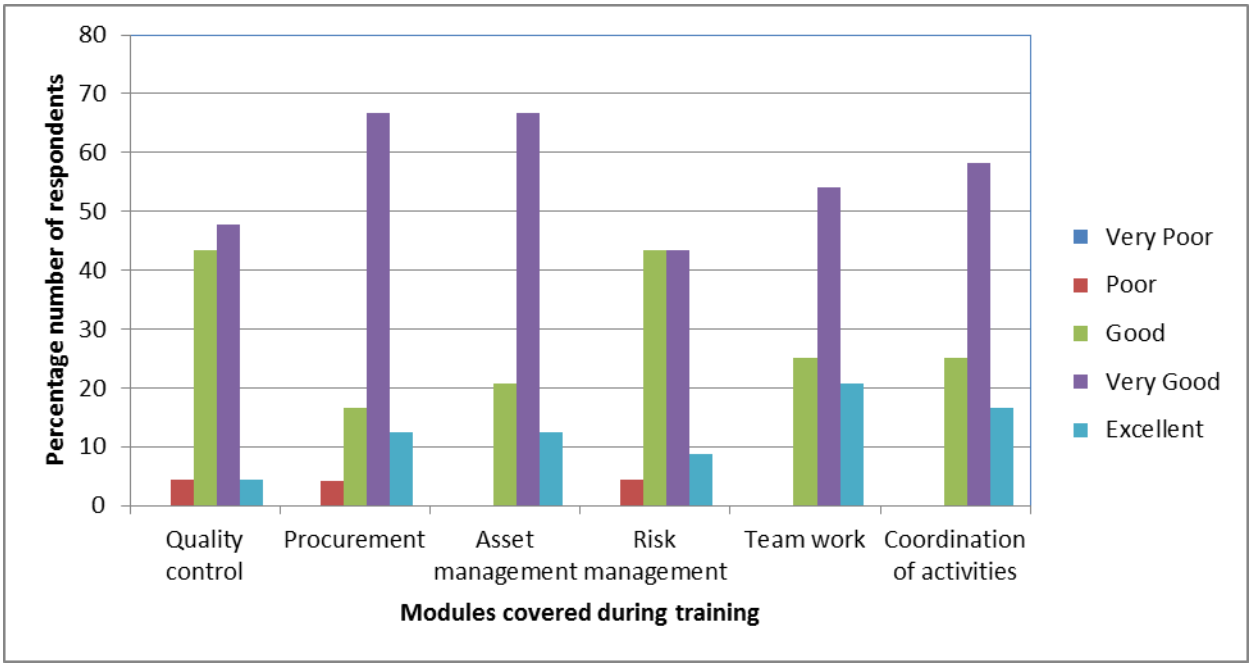


Figure 4 above shows a graphic presentation on the rating on performance against the modules covered. There is an obvious bias over the increase of positive rating in all the modules indicating an obvious increase on knowledge gain and performance of their roles and functions as PHT the positive rating is however the ratings are more pronounced and positive on coordination of activities procurement and asset management. Risk management and quality improvement are aspects that hospitals are already focusing on hence the low rating

CHAPTER 7

7.1 Stakeholder Perspectives

The main stakeholders in this project are the Ministry of Health and Child Care Health Provincial Medical Directors, District Medical Officers Services Board, Management Sciences for Health, Centers of Disease Contorl as the funding partner and the University of Zimbabwe Department of Community Medicine. The stakeholder perspectives are derived from this range of partners Harare, Bulawayo City Health Directorates

7.2 Dr L Mbengeranwa- Executive Chairman- Health Service Board

The HSB appreciates great work from CDC, MOHCC and UZDCM. HE said the constitution of Zimbabwe has provided for every citizen a right to access to basic health services and the HSB and MOHCC are in the process of realigning their respective statutes to comply with the constitution as well as the ZIMASSET blueprint which seeks to achievable sustainable development and social and equity. It is imperative for PMDs keep copies of ZIMASSET and the country's constitution which highlight the importance of responsive governance systems. It is in this regard that the HSB through HMGP in collaboration with UZDCM, MOHCC and CDC is already implementing ZIMASSET in health worker capacity building. The project is already bearing fruits and the boards is very pleased with the topics covered as it forms a critical executive knowledge so required of our public health managers. He appealed for continuous support for capacity building and pleaded with funding agencies to continue strengthening the health delivery system in Zimbabwe

7.3 Brigadier-General Dr G. Gwinji: Permanent Secretary MOHCC

The PS explained that the health sector has faced challenges in recent times which have made it difficult for young doctors and other health professionals to acquire and maintain the management skills necessary to function effectively at lower levels of the health system especially at district level. He said that it was important for the District Health Executive to acquire basic knowledge and skills of management if service delivery is to be fully restored and sustained over time.

We are happy that the Department of Community Medicine (DCM) of the University of Zimbabwe's (UZ) College of Health Sciences (CHS) in partnership with, the MOHCC, Health Services Board and the Management Sciences for Health (MSH), responded to an RFA from CDC Atlanta for a proposal to support effective leadership in health planning, program implementation and patient care in the public sector in Zimbabwe in response to the training needs of the MOHCC

The LMG project will address

The PS indicated that in order to achieve the health Millennium Development Goals (MDGs) and its stated desire to have the highest possible level of health and quality of life for all its citizens, the Republic of Zimbabwe needs to have a health workforce that

is well trained in technical areas as well as in leadership and management at all levels of the health delivery system this project will go a long way in strengthening health manpower skills for achieving positive health outcomes.

The PS indicated that the current health professionals work very hard and they remain dedicated to better health outcomes Despite their commendable efforts and dedication, the majority of health professionals now in leadership and managerial positions are young and lack the knowledge, skills and experience needed to play their role effectively because they have not benefited from mentorship of more experienced staff. The LMG project has come at the right time to address such shortcomings.

The PS also referred to previous manpower development an effort which was a contribution of various organizations. We see the LMG project as another effort to offer the necessary leadership and management training for health workers that take up positions of leadership at all levels of the health delivery system and will also enable senior managers to have opportunities for planning, reviewing service provision and supporting supervision. The PS ended up by appreciating CDC for funding the HLMG training

7.4 CDC Perspective- Dr P Kilmarx

The US: Centers for Disease Control and Prevention in Zimbabwe is very pleased working with MoHCC, and the HSB to support the UZDCM in training Zimbabwe's Public health manpower in leadership management and governance. This will ensure strong and effective leadership that is key to successful program implementation. If a country has strong governance and human resources management it will be possible to implement large scale programs like Art. The US: Centers for Disease Control and Prevention in Zimbabwe is happy with the collaborative efforts it has entered into with government of Zimbabwe to strengthen and sustain good leadership, management and governance in Zimbabwe's health care system.

7.5 Director Human Resources- Ms J Mudyara

The DHR stressed that people in leadership positions come from different backgrounds such as private and public. In some cases people are promoted to senior positions without requisite managerial and leadership skills. Managers at National Level are expected to run divisions in central hospitals/institutions and provinces effectively and efficiently, Induct, supervise, motivate and appraise team members. They are also expected to represent the Accounting Officers, handle grievances and

resolve conflicts and chair or be a member of an interviewing panel or disciplinary committee.

The Ministry has responded to the challenges faced through filling of vacant posts, conducting workshops and meetings in area of expertise and piecemeal training of members in various areas. However the challenge of inadequate resources is stifling progress. The presenter also highlighted areas which need training and they include *inter alia* team building, report writing and presentation skills, stress management, procurement/tender procedures and induction procedures. She suggested that as a way forward there is need for mandatory training for all health personnel in Health Service Regulations, Government protocol, Results Based Management including Performance management, chairing of meetings, committees, computer appreciation, finance for non-finance managers and time management. The director also indicated that training was required in department and professionalism in order to further strengthen the leadership skills of health managers. She indicated that the LMG project has come at an opportune time to support the MOHCC in its effort to rebuild the health care system

7.6 The Executive Director Health Services Board – Ms. R.R. Kaseke

The HSB places special emphasis on training of managers in leadership and management on a continuous basis. Succession planning to strengthen institutional memory and build leadership and management capacity amongst successors is also critical for continuity and preservation of institutional memory.

Efforts are being made to equip the health professionals with leadership and management skills and this entails the provision of the induction and the in service training for all health workers as well as the establishment of Manpower Planning and Development Department. The executive director end up appreciating the role the LMG project in addressing leadership management and governance knowledge and skills for health managers at all level. The appreciation is demonstrated by the statement below:

"The Board is cognisant that the health sector is labour intensive and that there is need to have the right number of workers possessing the right skills, knowledge and capacities"

7.7 Dr G. Sikipa, Technical Advisor from MSH

Dr. Sikipa explained that MSH has played a significant role at an international level in addressing the deficiencies and gaps in health leadership and management and it was happy to be associated with the current Leadership management and governance project It was noted that there are good doctors yet they are poor managers as evidenced by a weak health delivery system in terms of planning, budgeting and management. Inadequate capacity in human resources development, including training and personnel management has also worsened the plight. MSH therefore strives to strengthen administration, leadership and governance at all levels of the health sector and has leadership training programmes in various African countries. MSH has experience in leadership training as evidenced by its support for the current LMG project. MSH will thus continue to provide technical support during the project lifeline so as to improve the leadership management and government skills of health managers at all levels in Zimbabwe. He ended up by indicating that:

"Lack of leadership and managerial skills is prevalent in the newly promoted cadres who are in leadership positions"

7.8 National Level Perspectives/ Administration

Asset returns are designed to depict a summary of the state of assets at any given time. The summary indicates categories of items and their quantities and is born out of an inventory – register system. All provincial centres are expected to submit asset returns bi-annually, the first being at the end of June whilst the second would be submitted at the end of December of each year. The move would make it easy for the system to quickly reveal any deficiencies in terms of losses or damages. It was highlighted that in 2010 the Ministry of Health Head Office was not receiving not receiving 100% of returns. Below is a table illustrating those who have managed to submit their asset returns in 2010 and those who failed.

Table:27 : Ministry of Health and Child Care Vehicle Returns of 2010

NAME OF INSTITUTION	**SUBMISSION**	
	Yes	No
Mpilo Central Hospital	-----	No
Parirenyatwa Group of Hospitals	-----	No
Harare Hospital	Yes	-----
Chitungwiza Hospital	------	No
U.B.H Hospital		No
Ingutsheni Hospital		No
PMD Manicaland PMD		No
Mash Central	Yes	------
PMD Mash East		No
PMD Mash West	Yes	----
PMD Midlands	Yes	-----
PMD Mat North	------	No
PMD Mat South	Yes	

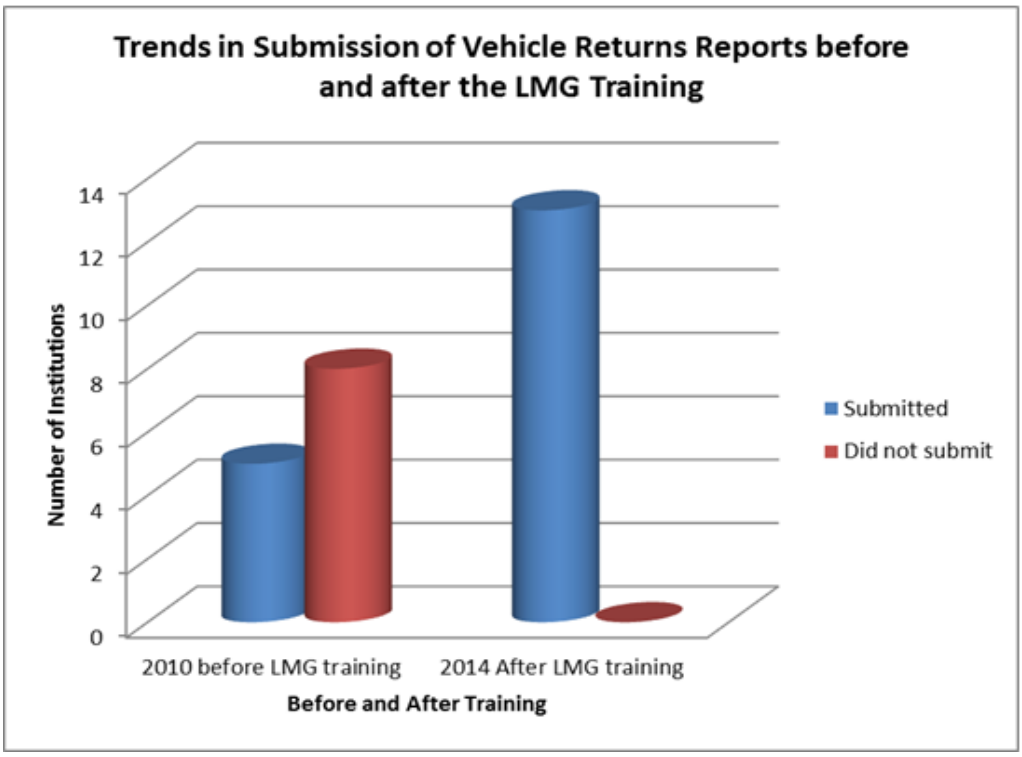
Table 27 above shows that in 2010 before the Leadership management and Governance training fewer institutions (Central hospitals and PMD offices) were remitting their vehicle return reports to the national level as indicated by the low remissions of only 43% of the total institutions.

Table 28 below shows that there is now increased awareness about the importance of remitting vehicle registers to the national level. This shows a clear indication of the differences that has been caused by the Leadership Management and governance training which covers a module on asset management and good managerial practices to improve good governance.

Table 28 : Ministry of Health and Child Care Vehicle Returns of 2014

NAME OF INSTITUTION	SUBMISSION	
	Yes	**No**
Mpilo Central Hospital	Yes	----------
Parirenyatwa Group of Hospitals	Yes	----------
Harare Hospital	Yes	----------
Chitungwiza Hospital	Yes	----------
U.B.H Hospital	Yes	----------
Ingutsheni Hospital	Yes	----------
PMD Manicaland PMD	Yes	----------
Mash Central	Yes	----------
PMD Mash East	Yes	----------
PMD Mash West	Yes	----------
PMD Midlands	Yes	----------
PMD Mat North	Yes	---------
PMD Mat South	Yes	----------

Figure 11 Trends in the submission of vehicle returns reports to national level



In 2011-2012 the health leadership, management and Governance training of the District health executives started which comprises a module on asset management and procurement procedures. The combined diagram clearly shows that the LMG training has contributed immensely the management of assets at all levels of the National Health care system as shown by figure11 above which shows that all institutions where all institutions managed to submit their asset returns. This assertion is supported by the fact that during the implementation of the LMG training no other similar programmes were running hence the conclusions about improvement in performance. It is also very clear that the training of DHE in LMG strengthened the overall performance of the health care system. The aggregate of remittances of reports at national is in a way a reflection of the performance of DHEs at lower level

7.9 Provincial Medical Directors Perspectives

PMD MIDLANDS- Dr. M Chemhuru

The PMD mentioned that there is a great improvement in the district performances and this can be attributed to the Health Leadership, Management and Governance. An assessment which was done in the province before the training under the MPH program by Doctor M Muchekeza revealed that there were many problems especially in coordination of activities, communication and team work. After the districts were trained she is noticing a change on how the districts are performing. Areas of Notable Improvements in DHE performance, Meeting Management, Outbreak detection and control, Management of disciplinary cases and Health outcomes .Below is a case study of Gokwe North District in Midlands.

7.10 Case Studies- Districts

Case study of Gokwe North District

Gokwe North district is in Midlands Province and it was trained in January 2013.A total of 5 DHE members were trained in Health leadership, management and governance. The District medical Officer was trained separately with Gokwe South Province in July 2011. The district has 19 Health Centres (6 Government clinics, 7 Rural District Council, 4 Mission Clinics, 1 mission hospital and 1 District Hospital). The curriculum at the medical school did not cover health leadership, management and governance at district level. It is difficult for the new DMO who just assume leadership position in the district to lead and provide guidance to the team without management and leadership skills. The training was very useful to the team especially issues to do with human resources, procurement and management of public financial resources.

Despite the DHE being remote the training has managed to build and strengthen team work within the members. Team spirit has been strengthened by the fact that everyone appreciates the role of the DHE members and this will enable the team to achieve more. The DHE decides what to buy and give authority this shows that the whole DHE is now taking part in deciding what to buy and when. They reported that before the LMG training buying was solely done by the accountant and the administrator without consulting other members. Improved performance is also being manifest in how the DHE schedule and conduct its meetings. They have managed to hold most of the

planned meetings and the meetings are well organized, with a clear agenda and action items specified.

Provincial Medical Director Masvingo: Dr. R Mudyiradima

The Provincial Medical Director(PMD) Dr. R Mudyiradima mentioned that the major thrust of the District system strengthening initiative through training of District health Executive members in Health Leadership, Management and Governance was to build strong and effective team's which can deliver quality health care to the clients. As a result of high attrition of experienced personnel due to political and economic crisis, junior staff was accelerated into leadership and management positions. There was need to build effective team which comprises of both the new and junior members and most experience cadres specifically the District Nursing Officers to work together towards a common goal. The PMD acknowledged that the training has managed to build strong teams in the Province. Team work is seen by the increase in the number of District Health Executive (DHE) meetings conducted. After the training the DHE meetings were revived and other meetings such as the General meeting, Staff meeting and Head of OD meetings were now scheduled for.

Team spirit has been strengthened by the fact that everyone appreciates the role of the DHE members and this will enable the team to achieve more. There is evidence of team work and improved performance in the province as said by the PMD. Improved performance is also being manifest in how the DHE schedule and conduct its meetings. They have managed to hold most of the planned meetings and the meetings are well organized, with a clear agenda and action items specified.

Other Provincial Health Executive members also mentioned that before the training there was lack of appreciation of some projects by other members which resulted in in-house fighting. After the training they came back, sat down as a team to chat the way forward. The DHE training has taught them to work together and share resources and this is done through conducting DHE meetings regularly and share information pertaining to their specific programmatic areas. They also highlighted that as a result of regular meetings communication has improved and decisions are wholly owned by the DHE .The DHE training serves as induction training to most of the members who did not have induction training and now DHE members now appreciate their roles and functions.

Success Stories

Mutare District

The training has managed to bring a new thinking in the district. It was an eye opener as team work was really emphasized. Soon after the LMG training, Mutare district discussed on how best they could cascade the LMG training to the other key members of the district who were not included out in the DHE initial training. The module on building effective partnership was very useful since it provided negotiating skills to the DHE members who then used the skills to discuss with their partners with regards to resources needed for cascading the LMG training to their wards and rural health centres. A partner (Plan International)1 who has an interest in capacity building at community level was identified and was willing to provide support for this training.

Plan International is working in the district under the project of women and children`s rights. The district was able to take advantage of the work being done by the organization. A short proposal for our Health, Leadership, management and Governance was prepared and funding was availed. The funding provided was complemented by the partial funding from the LMGP for supporting DHT meetings. The training modules received from the DHE training in form of a CD were used for cascading training. Key topics were selected since the funding was only for three days. A three days training was conducted for 12 participant's .The 5 DHE members that had been trained in the DHE LMG training facilitated in the lower level training.

Mutare district found that cascading the training was very useful as all members now have the same understanding. This has facilitated good working relationships and a good working environment has been created for the benefits of all health team members and clients at community level. Mutare district managed to solicit for financial support from their partners and they cascaded the training to other heads of departments as well as SIC clinics. This was a very positive development as capacity was built throughout the district health systems

Centenary District

Centenary district health executive used the information learnt during the training to document all their activities in a manner that attracted a lot of support from donors in Italy. The DHE agreed that the training equipped them with skills to communicate,

document and package their work and sell their ideas to potential funding partners. They have since sent a proposal for funding to their Italian partners and a grant for maternal and child health has been provided towards renovations for the waiting mother's shelters

Successful stories

This quarter with the support from the project we have managed to conduct our first District Health Team Meeting since 2010.The meeting was a success and we manage to with the resources that you provided. A total of 55 participants attended a three day meeting at Chaminuka training Centre. This provides a good platform for the DHE to get a full picture of what is happening in the district. As emphasized during the training the DHE should take a leading role in coordinating health related activities. Sometimes due to limited resources it is difficult to visit all the clinics in the district so the DHT meeting we conducted, it enable us to share experiences with all clinics and partners in the district as well as getting their success and challenges they are facing

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Successful Stories Mutare DHE

The training has managed to bring a new thinking in the district. It was an eye opener as team work was really emphasised. Soon after the training we discussed on how best we can cascade the training to the other key members of the district who were let out in the initial training. The module on building effective partnership was very useful to us as it enables us to look at our partners and identify one who can support us in cascading the training. Plan International is working in the district under the project of women and children`s rights, so we prepare a short proposal for our Health, Leadership, management and Governance training using the materials that we

received from the DHE training .We were fortunate enough to receive the funding and we selected key topics that can be covered in three days and conducted the 3 day training for 12participants. The 5 DHE members who were trained facilitated in our training and we also included the GMO, Matron, HRO and the RDC in the training. Cascading the training is very useful as all members have the same understanding and when we discuss health related issues pertaining to the district everyone will be at the same page.

Lupane District

The discussion reviled that there is a great improvement in communication between the members .The DHE is based at St Luke's Mission hospital and communication has improved between the DHE members and the Mission hospital staff .The issue of team work which was emphasised during the training has enabled planning together of all health related activities. The module on Human resources was a refresher and helped them to appoint 18 student nurses in the district. This has also led to the decline of disciplinary cases during the fourth quarter. There was no misconduct cases reported from the period July to September 2012.

Management of meetings has greatly improved as the members highlighted that the meetings are now coordinated with each member effectively contributing to the success of the district. An invitation is circulated in advance to all the participants.

There is a remarkable improvement in the operation of the trained districts .The health Leadership, Management and Governance training has contributed to some extend towards the strengthening of health manpower skills for improved delivery of services and towards improving quality of care. There has been reported improved team work, proper management of time, improved running of meetings, reduced conflicts, correct handling of grievances, protection and efficient utilization of financial and material resources, improved handling of patients and other health care users through good ethical practice, coordination with other sectors and partners. The LMGT includes some aspects of the rules regulations and operational procedures for DHE members. The inclusion of this subject has helped to introduce new members of staff to the processes of health care delivery system. This component has been well appreciated by the participants who indicated that some of the DHE members did not undergo induction training so these trainings are providing them with requisite information on how they should perform their day to day duties. If resources are

available all the DHE teams should be trained at the same time so that they can efficiently work together

Bikita District Before

Bikita District After

Bikita District

Another successful story can be told for Bikita district. The Bikita district had for over 15 years been operating in wooden offices make shifts at Nyika Growth Point. The district was not in a position to change their situation due to lack of resources. Bikita

district was trained in LMG principles in 2014. Immediately after the LMG training they realized that they could change their situation through working with partners. The training in LMG gave them the confidence knowledge skills and confidence to analyze their partners in terms of their objectives and the partner's objectives. They identified a partner that had been operating at the same center and were paying an exorbitant amount of rentals to the local authority. They approached this partner with a proposal to assist them to build an office block. The partner obliged since the DHE included a proviso that they would use these offices under a special arrangement. In the end the partner gained office space and Bikita district became owners of brand new offices which gave them motivation and a high morale which the LMG team witnessed during the evaluation exercise.

CHAPTER 8

8.1 Discussions

The evaluation findings indicate that the leadership project that has demonstrated real change in the functioning of DHEs across all the provinces as illustrated by the responses and the statements coming from the DHEs themselves. The project started training the lower levels district health executives since the MOHCC indicated that this was the level that serves the community and improvement at this level would benefit all levels. It seems that the MOHC was correct as the evaluation has indicated improved performance at this crucial level.

There is a remarkable improvement in the operation of the trained districts .The health Leadership, Management and Governance training has contributed to some extend towards the strengthening of health manpower skills for improved delivery of services and towards improving quality of care. There has been reported improved team work, proper management of time, improved running of meetings, reduced conflicts, correct handling of grievances, protection and efficient utilization of financial and material resources, improved handling of patients and other health care users through good ethical practice, coordination with other sectors and partners. The LMGT includes some aspects of the rules regulations and operational procedures for DHE members. The inclusion of this subject has helped to introduce new members of staff to the processes of health care delivery system. This component has been well appreciated by the participants who indicated that some of the DHE members did not undergo induction training so the LMG training has provided the newly deployed with requisite information on how they should perform their day to day duties. If resources are available all the DHE teams should be trained at the same time so that they can efficiently work together. All newly deployed health managers should undergo this training so as to continuously improve health care delivery

8.2 Recommendations

Recommendations

a) In-service training for health managers should continue to be competency based using the already developed modules so as to ensure success, relevance and usefulness in the strengthening of the health care systems.

b) Province hospitals and districts to have a an orientation programme that helps new health managers to understand the health system management processes and the health service regulations so that they can perform their duties in response to the MOHCC priorities

c) Methods such as group work and cases studies were found to be very conducive for learning in future such methods should be used in order to enhance adult learning

d) DCM in collaboration with MOHCC and HSB can work together to develop a pre-deployment training for health managers to prepare them for new appointments as health managers at provincial and district level

e) HLMG issues should be included in the training curricula of health workers since the participants considered the subject as essential for all health mangers as an important part that prepares them for their roles and functions.

f) There was concern that there should be a continued follow up and mentorship of trained managers on regular basis.

g) HLMG Training should be made a requirement for promotion to management positions.

h) The MOHCC to support the identification of further funding for HLMG training in Zimbabwe in collaboration with interested partners. HLMG should continue to be supported financially since this evaluation is indicating the need to for in- service training and pre-deployment training to cater for the high attrition in the MOHCC and also to cater for other partners that are involved in public health initiatives.

i) DCM LMGP to train trainers of trainers for each province in leadership management and governance as a sustainable strategy for ensuring quality in health care delivery and the training to emphasis the concept of working as teams since the participants rated this module very highly and field work follow up has also indicated that the module on working as teams was most favourable and the skills are being applied in the health teams day to day work

Conclusion

Success Stories

This quarter with the support from the project we have managed to conduct our first District Health Team Meeting since 2010.The meeting was a success and we manage to with the resources that you provided. A total of 55 participants attended a three day meeting at Chaminuka training Centre. This provides a good platform for the DHE to get a full picture of what is happening in the district. As emphasized during the training the DHE should take a leading role in coordinating health related activities. Sometimes due to limited resources it is difficult to visit all the clinics in the district so the DHT meeting we conducted, it enable us to share experiences with all clinics and partners in the district as well as getting their success and challenges they are facing

8.3 Lessons Learnt

The institution of a task force is of great importance in the management of a project since it provides a conducive environment for project development implementation and evaluation. The task force especially when chaired by policy makers makes access to institutions and decision makers much easier.

Proving this leadership, management and governance training has come at a time when it is most needed and appreciated and this has provided a constant source of motivation for continuation for the project staff as well for other members of the task force.

The LMGP has been able to work with facilitators from the MOHCW specialty departments and this has enhanced the quality of content that is given since these facilitators have hands on experience and are also at the policy making level and are therefore credible than if we were using facilitators from other sectors which may not be conversant with policy issues. Working with the MOHCW personnel will also ensure sustainability since they are training their own personnel.

The parameters set out for coverage indicators of performance in response to the initial proposal in response to the RAF proved not to be realistic e.g. “supporting 124 DHT meetings per year” with the current budget. There is need to redefine some of the targets toward a more realistic goal.