Survey report on training courses on malaria and other vector-borne diseases and planning their control
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Roll Back Malaria Department
Operations Support and Capacity Development (MCO)
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SUMMARY

Since 1982, the World Health Organization (WHO) has sponsored 72 international training courses on malaria and other vector-borne diseases for endemic countries. By 2002, a total of 1017 health workers were trained in 24 venues in 18 countries. The training courses aimed at strengthening the capacity of national health services for malaria control. The duration of the courses varied from 2 to 3 months.

A survey was carried out in 2002 to assess the capacity of past participants, the significance of the training courses in tackling capacity needs at country level, the relevance of the training activities to other disease control programmes, and the use of Internet access for capacity building.

An automatic mailing list was generated from the training database, and a questionnaire was sent by post and/or e-mail to 712 past participants for whom there were complete addresses. A total of 240 individuals responded (34% response rate).

Of the 240 respondents, 196 (82%) were working in malaria control activities at the time the survey was conducted. Their level of involvement at national, regional/provincial and district levels was 43%, 23% and 25%, respectively. Those involved at national and regional/provincial levels spent more time on malaria control as compared with those at the district level \((P < 0.05)\). Relevance of the training courses to field situations and in addressing priorities of malaria control was rated at 84%, 14% and 2% for high, moderate and low, respectively. The training courses appear to have enabled (203) 87% of the respondents \((n = 233)\) to apply their skills outside malaria.

A substantial number (46%) were teaching in agency-sponsored courses and a quarter (25%) were recruited as consultants by international agencies and local institutions. Nearly 33% (60 of 180) of respondents felt that the training courses did not address their post-training needs for continued professional development and application of their acquired skills.

Internet access among the respondents was 65%, with an average of 3.8 hours per day at an average cost of US$ 2.14 per hour (range US$ 0.02–18.00). Most respondents with Internet access (66%) had to pay fees and there was a significant regional variation in terms of connectivity and costs. In the WHO African Region, slow connectivity was strongly associated with the high Internet fees \((P < 0.001)\).

The number of participants involved in malaria control was unexpectedly high. Of the 238 respondents, the involvement in malaria control by those who were trained before and after 1996 was 72% and 89% respectively \((P < 0.05)\). The level of involvement was higher at national and regional/provincial levels, which justifies further investment in district-level health workers. These international training courses, though useful for providing high-quality training by experienced international tutors and introducing new tools, are expensive (on average, US$ 5000–6000 per participant) and the number of people trained does not meet the huge country demands. The skills acquired in malaria control are highly relevant to other disease control programmes.
Future WHO-sponsored training activities should have post-training initiatives to ensure continued professional development, support and motivation of staff. The Internet access of African health workers, particularly at district level, is still low, slow and expensive. It can, however, serve as a supplemental medium for information dissemination and capacity strengthening in areas where it is readily available.
1. INTRODUCTION

Many developing countries remain endemic to many of the infectious diseases that are a major cause of suffering, disability and death.\(^1\) Malaria alone causes at least 300 million cases of acute illnesses each year, resulting in over 3000 deaths per day, mostly among young children. The disease exerts its heaviest toll in Africa and is the leading cause of mortality in children aged under five years, accounting for about 20% of all-cause mortality in this age group. In endemic countries, malaria accounts for 20–50% of hospital admissions, up to 30% of outpatient visits and consumes 40% of public health expenditure.\(^2\) Hence, malaria remains a major public health challenge, eroding development in the poorest countries and costs Africa more than US$ 12 billion annually, leading to a slow down in economic growth by 1.3% per year.\(^3\)

The Roll Back Malaria (RBM) initiative, launched in 1998, aims to halve the malaria burden by 2010 through scaling up of proven intervention strategies.

The pressing issues facing malaria control programmes stem from inadequacies in the broader health system. The health services in malaria-endemic countries have malfunctioned because of major constraints such as increasing resistance of the parasite to the less-expensive and widely used drugs and resistance of mosquito vectors to insecticides; lack of resources and infrastructure, shortage of skilled health workers and inadequate health education; low coverage and access to health care; and inadequate planning and management practices.

1.1 Capacity development efforts

In recognition of these problems, the World Health Organization (WHO) has for many years provided technical guidance and support to malaria-endemic countries, in organizing and implementing programmes aimed at capacity strengthening. These involve:

- creating an enabling environment through strong political commitment, human resource policies, provision of resources and strengthening training institutions;
- supporting training and retraining of personnel;
- providing technical support and networking, e.g. information, communication and supply systems to support trained personnel, supervision, and monitoring and evaluation.\(^4\)

WHO, in collaboration with partners, has conducted several international training courses over a period of 20 years, using malaria as an entry point to tackle other vector-borne/tropical diseases. These training courses – with varying scope, objectives and audiences –

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have been organized mostly in malaria-endemic countries and over 1000 people have been trained. Most courses have focused on planning and programme management capacities, with the ability to transfer skills to other health workers, and have been targeted at either programme managers, or national, regional/provincial and district-level health officers. Well-designed training programmes mainly on malaria and other major tropical diseases have been the focus of such capacity-building exercises.

With the advent of the RBM initiative, the need for more skilled personnel became more apparent, and as a result, on-the-job training activities have been intensified over the last four years, targeting endemic countries in Africa. Similar international courses have also been conducted in the Middle East and Asia. All these different training programmes were aimed at changing the working behaviour of health workers to bring about targeted, improved and efficient services in the health system.

These training activities were conducted through problem-based learning processes and were targeted at building certain competencies (including new tools and strategies for different epidemiological settings) required to perform the services expected. The courses were also designed in such a way that acquired skills and approaches would be applicable to other tropical diseases of public health concern.

While the training of health workers is important, assessing the outcome of the training exercises is equally essential, to document the lessons learnt and improve future human resource development activities at regional and country levels.

Thus, this report describes the results of a questionnaire survey of past participants of the training courses on malaria and other vector-borne diseases and planning their control, conducted from 1982 to 2002. Comprehensive evaluation of the courses is impossible as no baseline data were collected before the courses began. A questionnaire survey cannot exhaustively assess all field conditions as the sources of bias are enormous. Therefore, careful interpretation of the results and conclusions of this survey is warranted.

1.2 Objectives

The objectives of the survey were to assess the:

- capacity and level of involvement of past participants in malaria control post training;
- significance of the courses in tackling the gaps in competency and in addressing the human-resource needs;
- relevance of the training activities in malaria to similar disease control programmes;
- past participants’ perception of the courses, so that future improvements can be made and cost-effective capacity building approaches can be developed, focused on the current needs of the RBM initiative;
- extent of Internet access and use by past participants to obtain information, for communication and for continued professional development.
2. SURVEY METHODS

2.1 Training database and questionnaire

Since 1982, WHO has organized 75 training courses in 24 different venues in 18 countries, in which a total of 1017 people were trained. Most of the courses were held in the WHO African Region. Details of the participants were entered into a training database, which has been regularly updated and utilized for other human resources planning and interventions.

A written questionnaire was developed, in English (Annex 1) and French (Annex 2), which was field-tested. The questionnaire consisted of a variety of questions on personal data, post-training status, perceived improvement of capacities, access to information and opinions on future approaches. Questions were either closed with limited options or open.

An automatic mailing list was generated from the database and the questionnaire, along with a letter explaining the purpose of the survey, was sent by post to the participants whose addresses were complete (n = 712). Where possible, the questionnaire and letter were also sent by e-mail.

2.1.1 Response

Responses from past participants to the first request were slow. A reminder sent to 551 participants boosted the responses. A total of 240 responses (either by post or e-mail) were received, making the total response rate reach 34%. The majority of the respondents were from the WHO African Region (n = 164; 68%). Table 1 shows the response rate within each WHO region and overall.

<table>
<thead>
<tr>
<th>WHO region</th>
<th>No. of participants contacted</th>
<th>No. of respondents</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>393</td>
<td>164</td>
<td>42</td>
</tr>
<tr>
<td>Americas</td>
<td>8</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>128</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>European</td>
<td>29</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>117</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>37</td>
<td>20</td>
<td>54</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>712</strong></td>
<td><strong>240</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

2.1.2 Data management and analysis

Data entry using Access included coding and categorization to ease analysis. A descriptive data analysis was mostly used for frequencies of observations and where applicable, cross tabulation and bivariate analysis of factors to assess associations were applied. Unless stated, missing values have been omitted from the analysis.
3. RESULTS

3.1 Description of respondents

Of the 240 respondents, 42 (18%) were female and 198 (83%) male. The average age during attendance at the training courses was 38 years. Most respondents were qualified: 72% had at least a Bachelor of Science degree, 21% had diplomas in health, 8% were technical assistants, as shown in Table 2.

Table 2. Qualifications of respondents (n = 239)

<table>
<thead>
<tr>
<th>Position held</th>
<th>Examples of qualifications held</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher professional</td>
<td>Bachelor of Science, Doctor of Medicine, Master of Science, Doctor of Philosophy</td>
<td>171</td>
<td>72</td>
</tr>
<tr>
<td>Medium professional (e.g. medical officer, nurse)</td>
<td>Diplomas</td>
<td>50</td>
<td>21</td>
</tr>
<tr>
<td>Technical assistant (e.g. midwife, physician’s assistant)</td>
<td>Certificates</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

3.2 Post-training working status

In 2002, at the time of the survey, 196 (82%) respondents were still involved in malaria control activities (Fig. 1). The retention rate was highest for those trained after 1995 (Table 3). Of the 238 respondents, 72% of who were trained before 1996 were still working in malaria control. In contrast, the involvement of those who were trained from 1996 to 2001 was 89%. These differences in attrition rates are statistically significant (P < 0.05).

Table 3. Year of training and involvement in malaria control (n = 238)

<table>
<thead>
<tr>
<th>Year of training</th>
<th>Involvement in malaria control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1982–1995</td>
<td>25</td>
<td>64</td>
</tr>
<tr>
<td>1996–2001</td>
<td>17</td>
<td>132</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>196</strong></td>
</tr>
</tbody>
</table>

5 Totals are >100% because of rounding.
More than half the respondents spent more than 50% of their working time on malaria control; only 8% spent less than 20% of their time on malaria control (Fig. 2).

From figure 3 it can be seen that those at national and regional/provincial levels were more involved and spent more time on malaria control compared with those at the district level ($P < 0.05$).
3.3 Importance of the training courses

3.3.1 Improved capacities as a result of the courses

Past participants were asked to identify at least three improved capacities in their malaria control activities which could be attributed to the courses. The major improvements were in planning and programme management (40%), case management (19%) and vector control (16%), as presented in figure 4.

3.3.2 Relevance of the courses to field situations

The relevance of the training courses to field working conditions and in addressing the priorities of malaria control was rated as high by 84% of respondents. The relevance was considered moderate by 14% and 2% rated it low.
3.3.3 Change in the nature of work attributed to the courses

More than 30% of respondents, particularly those who were trained from 1999 to 2001, felt that the courses had changed the nature of their work to operate malaria control within the context of the RBM initiative. The nature of planning and programme management and overall efficiency had significantly changed (Fig. 5).

Figure 5. Post-training change in nature of work in the field (n = 162)
3.3.4 Usefulness of the courses outside malaria control

The training courses appeared to have enabled 203 (87%) of 233 respondents to apply their skills in health programmes other than malaria, and only 13% found the courses not useful outside malaria control.

Of the 44 respondents who had left malaria control, 22 (50%) were working in other health programmes and 12 (27%) in management-related jobs (Fig. 6).

Most respondents considered that the acquired knowledge was applicable outside malaria control. As described in figure 7, 36% had applied their skills to other disease control programmes and 33% to planning and programme management.

Figure 6. Involvement of past participants outside malaria control \((n = 44)\)

![Figure 6: Involvement of past participants outside malaria control](image)

Figure 7. Application of skills of past participants to other fields \((n = 233)\)

![Figure 7: Application of skills of past participants to other fields](image)
3.4 Post-training professional activities

The majority of the respondents (98%) were involved in training others. A substantial number (46%) were teaching in agency-sponsored courses and over a quarter (29%) were recruited as consultants (Table 4). In the WHO African Region alone, 42 respondents had been involved in consultancy activities. Nearly 50% (117/236) of the respondents participated in other workshops or further post-training studies.

Table 4. Post-training involvement in training or consultancy

<table>
<thead>
<tr>
<th>Post-training activities</th>
<th>Details</th>
<th>No. of respondents involved</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training other health workers</td>
<td>Training other health workers, sometimes or often (n = 239)</td>
<td>234</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>As a trainer in agency-sponsored courses (n = 229)</td>
<td>102</td>
<td>46</td>
</tr>
<tr>
<td>Consultancy</td>
<td>As a consultant at least once (n = 240)</td>
<td>70</td>
<td>29</td>
</tr>
<tr>
<td>As a trainee at least once</td>
<td>Further study in malaria (n = 240)</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Participation in malaria workshops (n = 240)</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Further study on other health problems (n = 240)</td>
<td>47</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Other health-related workshops (n = 236)</td>
<td>23</td>
<td>12</td>
</tr>
</tbody>
</table>

Figure 8. Post-training involvement in consultancy (n = 70)

Of the 70 respondents who worked as consultants, most were hired by WHO (43%), the rest by other international organizations (30%) and local institutions (27%), as shown in figure 8. The involvement of past participants in training others was clear: 88% of respondents were involved in training health workers, 50% trained community workers and 8% school teachers and students, as shown in Table 5.
Table 5. Post-training involvement in training other health- and non-health-related personnel

<table>
<thead>
<tr>
<th>People trained</th>
<th>No. of respondents involved</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers</td>
<td>211</td>
<td>88</td>
</tr>
<tr>
<td>Community workers</td>
<td>119</td>
<td>50</td>
</tr>
<tr>
<td>School teachers and students</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Personnel in nongovernmental organizations</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Personnel in local authorities</td>
<td>9</td>
<td>4</td>
</tr>
</tbody>
</table>

Of the 175 respondents who rated the level of their confidence in training others (on a scale from 1 (low) to 5 (high)), most believed they had the confidence to train others: 39% chose level 5, 48% level 4 and 13% level 3.

3.5 Weaknesses of the training courses

While recognizing the good qualities of the training activities, 60 of 180 (33%) respondents felt that the training initiatives were often not comprehensive enough in addressing the post-training needs for continued professional development or for application of acquired skills.

Some 13% of respondents also felt that there was insufficient time allocated during the courses, considering what was scheduled to be covered.

3.6 Use of the Internet for information and communication

WHO has promoted the use of the Internet to disseminate health information and update the knowledge and skills of health workers in developing countries. With the increasing expansion of telecommunications and steadily decreasing fees in sub-Saharan Africa, Internet access could, in the near future, trickle down to the district and lower levels so that the health services at these levels could also benefit by strengthening the capacity of health workers through training, and providing and updating information.

Past participants were asked about their access to the Internet, and the degree of use for accessing malaria and related subjects was taken as an example.

3.6.1 Internet use

ACCESS – Some 65% (156 of 240) had Internet access for an average of 3.8 hours per day. Some 37% had access for more than 4 hours a day, but for 33%, their access was less
than 1 hour only per day. Internet connectivity was classed as very good for only 19% of the respondents (Fig. 9). Nearly 64% of the respondents from all regions needed less than 10 minutes to download the RBM web site\(^6\) (Fig. 10).

**Figure 9.** Internet connectivity of past participants (n = 149)

![Internet connectivity](image)

**Figure 10.** Average time required to download http://www.rbm.who.int (n = 156, all WHO regions)

![Average time required](image)

In the WHO African Region, almost 58% (95 of the 164 respondents) had Internet access and almost 78% of those with access had good connectivity, but 67 (71%) needed 5 minutes or longer to download the RBM web site.

European Region had the greatest access. The South-East Asia Region had greater access than the Western Pacific Region (Fig. 11).

\(^6\)http://www.rbm.who.int
The proportion of Internet time used as a resource for malaria and related subjects is indicated in figure 12. Of the 150 respondents, 63% used less than 30% of their Internet time for searching for information on malaria and related subjects.

**COST** – Most respondents with Internet access (66%) paid an average cost of US$ 2.14 per hour (range US$ 0.02–18.00). The costs for Internet access were highest in the WHO African Region. There was a strong association between download time and payment for Internet access.
use, showing that people who had very slow access did not have free access \((P < 0.001)\) (Fig. 13).

**Figure 13.** Download time versus free Internet access \((n = 140)\)

![Graph showing download time versus free Internet access](image)

**LEVEL OF INVOLVEMENT IN MALARIA CONTROL AND INTERNET ACCESS** – There was a strong association between level of involvement in malaria control and Internet access \((P < 0.001)\): 84%, 53% and 41% of respondents at national, regional/provincial and district levels, respectively, had Internet access (Fig. 14).

**Figure 14.** Level of involvement versus Internet access \((n = 183)\)

![Graph showing level of involvement versus Internet access](image)
4. DISCUSSION

In spite of the difficulties in locating trained participants because of change of address and generally high attrition rate of health workers in general, the response rate to the questionnaire of 34% was encouraging. The questionnaire using post and e-mail was a cost-effective survey method.

The findings of the survey provide an understanding of the respondents post-training situations, offering some evidence on which to base future planning for the training of health workers in resource-limited settings. They also give insight into the in-service training approaches and the possible outcomes of training.

The high retention rate of trained health workers in malaria control activities is very rewarding, considering the high attrition rate of health workers in the overall health sector. This high retention rate is partly attributable to the non-exportable nature of the training outside the countries and non-accreditation of the international courses. Those at the national level have relatively stayed for longer period in malaria control as compared with those in districts, highlighting the need for future investment to focus on district health workers. National and regional/provincial level health workers tend to spend more time on malaria control as compared with those at the district level. This could be partly due to the fact that health systems in most countries are more integrated at the district level and hence there is less time for malaria-control activities. The trainees at national and regional/provincial levels assumed a relatively higher leadership role.

The training courses have been useful in upgrading the technical and programme-management competencies of health workers, mainly at national and regional/provincial levels. The skills acquired in malaria control are useful to other disease control programmes.

Most respondents were satisfied with the relevance of the course to their specific work and hence in answering their country’s needs for health staff with improved skills for a particular programme. However, these international courses produce only a small number of trainees per country and do not meet the training needs of the malaria-endemic countries.

The survey showed that almost all the WHO-sponsored training activities on malaria had few follow-up activities after training to ensure continued professional development, support and motivation of staff.

At the time of the survey, Internet access was still beyond the reach of over 40% of health workers in the WHO African Region, particularly at district level. The Internet can, however, serve as a supplementary medium for information dissemination and capacity strengthening.
5. CONCLUSION

The survey indicated that the retention rate of health workers trained in short malaria-related courses was fairly high. Other health programmes significantly benefited from the skills and knowledge acquired in malaria-related training. Training in certain non-exportable skills could contribute to the alleviation of the acute shortage of trained health workers encountered in many of the poor malaria-endemic countries.

Although international courses are important venues at which new intervention tools and strategies can be communicated to planners and implementers at regional and national levels, they are often highly expensive and hence it is difficult to reach the district-level workforce. Therefore, future capacity-building directions for malaria control in poor endemic countries should focus on local institutional capacity building, to reach district and peripheral health workers.

Training on malaria control should be integrated with control activities for other diseases, particularly those related to cross-cutting issues such as planning and programme management. For in-service training initiatives to be cost effective, there needs to be a post-training component that ensures the applicability of acquired skills and continued professional development. Plans for future training should also include mechanisms to enable trained personnel to network with resource institutions and individuals.

Where the Internet is readily accessible, it can be used for optimal innovative and cost-effective learning initiatives, and for networking of health workers with resource institutions and individuals. This would enable knowledge and technical and operational support to be updated at regional, subregional and national levels.
ANNEX 1. QUESTIONNAIRE FOR PAST PARTICIPANTS
(circle the answer where appropriate)

PERSONAL AND PROFESSIONAL DATA

Family name: ___________________________ First/other names: ___________________________

Date of birth: ___/___/_______

Nationality: ___________________________ Gender: M F

Qualifications: ___________________________

Current title or position: ___________________________

Name of organization/institution: ___________________________

Mailing address: ___________________________

Province/State: ___________________________

Work phone: (___) (___) ________________ Fax: (___) (___) ________________

E-mail address: ___________________________

Do you have Internet access? YES NO

If yes for how many hours per day? ________________

Grade your connectivity: Poor Good Very good

How fast are you able to download, e.g. from RBM website (www.rbm.who.int)?

< 5 min 5–10 min 10–30 min ≥ 30 min

Do you have free Internet access? YES NO

If NO, what is the cost per hour (in US$)? ________________

What percentage of your Internet access time do you use for malaria and related subjects?

< 10% 10–30% 30–50% > 50%

STATUS POST-TRAINING

1. When and where was the training course you attended?

Place ___________________________ Year ___________________________

Funded by ___________________________

2. To what extent did the training objectives and course contents address priorities of malaria prevention and control? Poor Good Very good
3. Relevance of the course to your working situation?  
Low  Moderate  High

4. Give three main areas that the course you attended has improved your capacity on malaria control activities in your area.
   a) __________________________________________
   b) __________________________________________
   c) __________________________________________

5. Are you currently involved in malaria control?  YES  NO
   If YES, what percentage of your time?  < 20%  20–50%  50–80%  > 80%
   If YES, at what level are you involved?  National  Regional/provincial  District
   If YES, how has the nature of your work within malaria control changed?

6. Has the training enabled you to apply your skills outside malaria?  YES  NO
   If YES, in which field:

7. Have you participated in any other training sessions or pursued further study since your WHO training?  YES  NO
   If YES, name: the field studied/year/institution/sponsor:

8. How often are you involved in training others on malaria?

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>health workers</td>
<td>community workers</td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. In which of the following subject areas do you train others?

   - malaria diagnosis
   - entomology and vector control
   - case management
   - epidemiology
   - prevention and control of epidemics
   - planning/programme management
   - other (please specify)

10. On a scale from 1 (low) to 5 (high), how do you rate your own confidence in training others?
    1  2  3  4  5

11. Have you taught in any courses sponsored by WHO or other agencies?  YES  NO
    If YES, please specify time, agency, and type of course:
12. Have you ever been recruited as a consultant?  
   YES  NO  
   If yes, by which Institution/Organization:  

13. How do you rate your contacts with any of the individuals whom you met during our 
    training courses?  
   None    Poor    Good    Very good  

14. Which of the following mechanisms do you feel would best help to improve/maintain your 
    contact with us at WHO and with other past participants?  
   – mailed newsletters  
   – information sent by fax  
   – e-mail circulars  
   – WHO web site postings  

15. Do you have any comments or recommendations on how we might be able to improve 
    future training courses? (Please use an additional sheet if necessary)  

__________________________________________________________________________  

__________________________________________________________________________  

__________________________________________________________________________  

ANNEX 2. QUESTIONNAIRE POUR LES ANCIENS PARTICIPANTS (encerclez vos réponses lorsque nécessaire)

DONNÉES PERSONNELLES ET PROFESSIONNELLES

Nom de famille : ___________________________________________ Prénom/autre nom : ___________________________________________

Date de naissance : __/__/_________  JJ    MM     AA

Nationalité : ___________________________________________ Sexe : M    F

Qualifications: ___________________________________________

Titre ou position actuelle : ___________________________________________

Nom de l’organisation/institution : ___________________________________________

Adresse postale : ___________________________________________

Province/État : ___________________________________________

Téléphone professionnel : (____) (____) _______________ Fax : (____) (____) _______________

Mél: ___________________________________________

Avez-vous accès à Internet ? OUI NON

Si OUI, pendant combien d’heures par jour ? _______________

Votre connectivité est : Médiocre Bonne Excellente

Combien de temps vous faut-il pour charger, par ex. depuis le site RBM (www.rbm.who.int) ?

< 5 min 5–10 min 10–30 min ≥ 30 min

Avez-vous un accès Internet gratuit ? OUI NON

Si NON, quel est le coût d’accès par heure (en US$) ? _______________

Pourcentage de votre temps d’accès à Internet consacré au paludisme ou sujets connexes ?

< 10% 10–30% 30–50% > 50%

STATUT POST-FORMATION

1. Quand et quelle formation avez-vous suivie ?

Lieu ___________________________________________ Année ________________________________

Financement ___________________________________________

2. Dans quelle mesure les objectifs de formation et le contenu de l’enseignement ont-ils couvert les priorités de la prévention du paludisme et la lutte contre celui-ci ?

Médiocre Bonne Excellente
3. Pertinence de la formation pour votre situation de travail ?
   Faible  Modérée  Marquée

4. Citez trois domaines principaux où la formation que vous avez suivie a amélioré votre compétence en matière de lutte antipaludique dans votre zone :
   a) ___________________________________________
   b) ___________________________________________
   c) ___________________________________________

5. Etes-vous impliqué(e) dans des activités de lutte antipaludique actuellement ?
   OUI  NON
   Si OUI, temps passé (en %) ? < 20%  20–50%  50–80%  > 80%
   Si OUI, à quel niveau ? National  Regional/provincial  District
   Si OUI, comment la nature de votre travail a-t-elle changé au sein de la lutte ?

6. La formation vous a-t-elle permis d’appliquer vos compétences en dehors du paludisme ?
   OUI  NON
   Si OUI, dans quel domaine :

7. Avez-vous pris part à d’autres sessions de formation ou poursuivi d’autres études depuis votre formation OMS ?
   OUI  NON
   Si OUI, domaine étudié/année/institution de formation/source de financement :

8. Vous arrive-t-il de former d’autres personnes au paludisme ?
   Jamais  Parfois  Souvent
   Qui formez-vous : Agents de santé  Agents communautaires
   autres (précisez) :

9. Dans quel(s) domaine(s) assurez-vous la formation ?
   – diagnostic du paludisme
   – prise en charge des cas
   – prévention et lutte anti-épidémies
   – entomologie et lutte antivectorielle
   – épidémiologie
   – planification/gestion des programmes
   – autres (précisez) :

10. Sur une échelle de 1 à 5, évaluez votre confiance à former d’autres personnes?

11. Avez-vous assuré une formation dans d’autres cours sous l’égide de l’OMS ou d’autres agences ?
   OUI  NON
   Si OUI, indiquez l’époque, l’agence et le type de formation :
12. Avez-vous jamais été recruté(e) comme consultant(e) ?

OUI  NON

Si OUI, par quelle institution/organisation :

__________________________________________________________________________________________

13. Comment évalueriez-vous vos contacts avec les personnes rencontrées en formation ?

Aucun       Médiocres  Bons  Excellents

14. Parmi les mécanismes ci-dessous, lequel à votre avis serait le mieux à même d’améliorer/ conserver vos contacts avec nous à l’OMS et les autres participants ?

– bulletins d’information envoyés par courrier
– information envoyée par télécopie
– circulaires envoyées par courrier électronique
– affichage sur le site web de l’OMS

15. Autres commentaires ou recommandations sur ce que nous pourrions faire pour améliorer les formations à venir (utiliser une feuille supplémentaire si nécessaire)

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
Survey report on training courses on malaria and other vector-borne diseases and planning their control.