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MODULE 1

Training in the Context of Personnel Management and Development

221.606 - Training Methods and Continuing Education for Health Workers

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1.1 Definitions of Personnel Development

Personnel Development consists of those management activities within an organization that are geared to recruiting and maintaining high quality human resources in the organization. These can be grouped broadly in to two categories, conditions of service and job performance.

| Conditions of Service | Job Performance |
|---|---|
| salary and remuneration location and time of work discipline benefits and allowances | job descriptions and responsibilities job qualifications working relationships supervision and reporting relationships continuing education |

Definitions of Personnel and Management

Folayan Ojo (1998) Personnel Management: theories and issues
 Panaf Publishing, Inc. pp 2-7.

The Meaning of Personnel

Manpower and human resources are generally used interchangeably even though, in a sense the latter seems to be a more modern concept and it is used more (than manpower) particularly in the U.S. "Personnel" is also commonly used along with manpower or human resources except that personnel is more commonly associated with the micro or organizational level as against the macro or national level. The terms "labor force", or "labor", is sometimes applied to denote manpower, human resources or personnel.

The definition of human resources or manpower has been discussed comprehensively elsewhere (Ojo, 1997c, chapter1). In brief, human resources refer to the energies, skills, and the knowledge of people which are, or which potentially can or should be applied to the production of goods and services (Harbison, 1973, pg3). In this book, the term "personnel" is applied almost exclusively to a "work organization" as against a country (or a region or state within a country). French (1987, pg33) has detailed out the origin of the term "personnel". It began to appear in its modern connotation around 1909 in the U.S. It appeared as a major item in the index of the Civil Service Commission of that year while in 1910 the American Secretary of Commerce and Labor used it in his annual report. In 1920, the first comprehensive text on the subject, *Personnel Administration*, by Teed and Metcalf was published.

The term "personnel" is used to cover all the persons collectively employed in a work organization. The organization may be a commercial, industrial or financial company (e.g, Lever Brothers, or First Bank), a factory, an educational institution (e.g, University of Ibadan), a military force (e.g, the Nigerian Navy), government agency (ministry or parastatal), a hospital, a local government or a religious body. Hence, we can refer to UACN personnel, NITEL personnel, University of Jos personnel, Nigerian Army personnel, etc.

Beach (1980, p. 5) excluded religious bodies from the concept of organizations. Today, at least in the Nigerian context, it is more realistic and more meaningful to include religious bodies, some of which have become big business. They perform many of the basic functions of a work organization. In essence, the issues, problems and principles involved in the

management of people at work are applicable to all types of organizations. As listed above, such organizations could be private business enterprises, government institutions or non-profit private organizations. Throughout this text, the terms organization, enterprise, firm, company, establishment and institution will be used interchangeably.

The Meaning of Management

Management is a very heterogenous concept which has been defined differently and assigned different functions by various scholars and authors. Beach (1980, p. 5) defined management as “the process of utilizing material and human resources to accomplish designated objectives. It involves the organization, direction, coordination and evaluation of people to achieve this goals”. Harbison and Myers (1959, p. 8) viewed management in broad terms by listing its functions as (1) the undertaking of risk and the handling of uncertainty; (2) planning and innovation; (3) coordination, administration and control; and (4) routine supervision.

It is only in a very small enterprise that these functions can be performed by the owner. The more general trend in modern medium and large companies is that these are performed by various persons who constitute the management team. The management team in an organization, comprises all levels of people who supervise the activities of others to achieve organizational goals. It is perceived as the hierarchy of individuals in any organization who play direct role in the performance of basic universal management functions in the private enterprise, voluntary and public sector organizations (Udo Udo Aka, 1985). In atypical manufacturing enterprise, for example, specialization in various management areas may cover production, marketing, finance, operations, and personnel.

Personnel Management Defined

“Personnel management”, “personnel Administration”, “manpower management” or “human resource management” are terms used interchangeably to refer to the management of people at work in an organization. Personnel management as a specialized area of management is concerned with development and effective utilization of human resources so as to achieve organizational objectives.

The Institute of Personnel Management of London (1963) defined personnel management as “a responsibility of those who manage people as well as being a description of work of those who are employed as specialists. It is part of management, which is concerned with people at work and with their relationships within an enterprise. It applies not only to industry and commerce but to all fields of employment”.

According to Armstrong (1980), personnel management can be viewed as:

Obtaining, organizing and motivating the human resources required by the enterprise; developing an organization climate and management style which will promote effective effort and cooperation and trust between all the people working in it; and helping the enterprise to meet its legal obligations and its social responsibilities towards its employees with regard to the conditions of work and quality of life provided for them.

Personnel management therefore consists of the designing and implementation of policies and all the practices that can assist in promoting efficient utilization of human resources.

The Scope of Personnel Management

Ubeku (1975, p. 10) examined personnel management from two angles:

1. As a function or responsibility of a manager or supervisor who has people under him all working towards the achievement of corporate goals;
2. As a function in an organization which is performed by a particular department, the personnel department. He then defined a manager as a “person who through guidance, leadership, encouragement and motivation makes men who form his team get the desired results”.

To continue with this line of reasoning, Flippo (1976, pg 6-7) distinguished between *line* and *staff* functions in organizations. A *line function* is any function that is vital and contributes directly toward the accomplishment of the major organizational objective. *Staff functions* are those that do not contribute directly toward the basic objectives, but rather do so indirectly by facilitating and assisting in the performance of line work. Such staff may be regarded as “auxiliary”, “service” or “supportive”. Personnel, accounting or finance are examples of staff departments.

Having dealt with the foregoing definitional issues, it should be noted that the general management of people at work is not done by the personnel department alone but predominantly by individual managers under whom the employees work. Furthermore, any manager who depends on productive efforts of other people has a personnel responsibility which should not be delegated to other department (Ubeku, 1975, pg11). In the same vein, Flippo, (1976, pg 6-7) observed that all the responsibility for personnel work cannot and should not be centered in a personnel department. By and large, a service or supportive unit can only assist the operating manager rather than completely relieve him of personnel responsibility. The personnel function must thus be done jointly by all managers in an organization.

By and large, there seems to be a convergence of opinion on the scope of personnel management, that is, the various activities covered by it. The major activities, which are also regarded as the functions of the personnel management, are human resource planning, recruitment and selection, employee training and management development, wages and salaries administration, labor-management relations, employee appraisal, employee welfare, motivation, organizational development and human resources accounting. Most of these activities will be discussed further in this chapter while many of them will form the contents of the subsequent chapters in this book

Organizational Objectives

The prime objective of an organization will be to create or produce and distribute a product or service. In pursuit of this corporate objective, other objectives will emerge so as to cater for the interest of the main parties connected with the organization. Also, depending on certain factors such as location, size, “financial power” and type of product or service, the community or society expects certain obligations from the organization. This is social responsibility which has become a popular and very important business objective.

Consequently, an enterprise be it private or public has a number of objectives which are aimed at serving the interest and needs of its various interest groups-the stakeholders. For

example the Nigerian Bottling Company PLC, in its 1995 *Annual Report*, had this to say “The success of any endeavor hinges on its relationship with its different constituents in society”. It then listed its stakeholders who benefit in one way or another from its success and well being. The stakeholders are shareholders, employees, consumers, dealers (distributors), suppliers (raw materials and inputs) and the federal government (which received as much as over ₦1.2 billion in taxes from the company during the latter’s 1994/95 financial year).

A typical business enterprise therefore has multiple objectives and multiple interest groups who have legitimate rights and interests. The shareholders want good returns on their investment, the employees want fair competitive wages and job security, the customers want high quality products at reasonable price, suppliers want fair treatment and good price for what they supply, the community expects good corporate citizenship from the company while government will build its expectation on reasonable profit so as to maximize the return from company tax. Noting the expectations of these various interest groups, Wells and Walton have expressed the objectives of business enterprises as (1) profit making; (2) service; (3) social responsibility; and (4) survival (Beach, 1980, pg 31). Thus, Lever Brothers of Nigeria PLC, in its 1997 Annual Report, *inter alia*, stated its corporate purpose as follows:

“Our long term success required a total commitment to exceptional standards of performance and productivity, to working together effectively and to a willingness to embrace new ideas and learn continuously. We believe that to succeed requires the highest standard of corporate behaviour towards our employees, customers, and the society in which we live. This is Lever Brothers’ road to sustainable, profitable growth for our business and long term value creation for our shareholders and employees”

In sum, the basic goal of personnel management is derived from the objectives of the entire organization. This is due to the fact that the demand for labor is a derived-demand, derived from the demand for goods and services produced / provided by an organization. Therefore, the cardinal function of personnel management is to create a workforce which has the ability and motivation to accomplish the basic corporate goals. Next we will discuss the factors that enhanced the development of personnel practices in the advanced countries, as typified by the US, and in Nigeria.

1.1.1 Herzberg’s Two-Factor Theory

as summarized by Harold Rush in *The Behavioral Sciences and Training, Training and Development Handbook*, R.L. Craig, (ed.) McGraw-Hill Book Company

Herzberg’s research focused on factors in the job that lead to satisfaction or to dissatisfaction. These factors include the full scope of personnel management. The factors that employees listed as causing them satisfaction on the job were distinctly different in nature than those that cause dissatisfaction as seen below.

| Satisfiers | Dissatisfiers |
|--|---|
| <ul style="list-style-type: none"> • achievement • recognition • responsibility • work itself • growth • advancement | <ul style="list-style-type: none"> • working conditions • policies & administrative practices • supervision • interpersonal relations • salary & financial compensation • status • job security • personal life |

Further analysis suggested that the satisfiers are all integral to the performance of the job, and are therefore referred to as job-content factors, while the dissatisfiers have to do with the environment surrounding the job itself, and thus are referred to as job-context factors. Herzberg called the former *motivators* and the latter *hygiene factors*. He considered the hygiene factors as *replenishment needs* - factors that always go back to zero, and must therefore, always be replaced - e.g. salary - or repeated - e.g. supervision. Motivators are considered to be *growth needs* - they build on each other and increase the capacity and satisfaction of the employee. It would appear that satisfiers are most appropriately enhanced through training interventions.

1.1.2 The Role of Training in an Organization

from “Organization and Management of Training”
by Richard B. Johnson, in Training and Development Handbook, R.L. Craig (ed.)
McGraw-Hill Book Company, 1976

An organization, whether public or private, exists and grows because it provides the community with goods or services the community sees as worthwhile. To do this efficiently, the organization must function at an optimum level of productivity. This level is a direct result of the collective effort of all employees. Yet not every employee works at the level established by the standard of performance for the job he or she holds. Similarly, groups of employees may or may not consistently produce up to standards.

When there is a difference or gap between actual performance and what is needed (the standard), productivity suffers. Training can reduce, if not eliminate this gap. It does so by changing the behavior of individuals - by giving them whatever additional specific items of knowledge, skill or attitude they need to perform up to that standard.

Changing behavior, then is the function of training. The terminal objective is to help achieve the goals of the organization through optimum use of manpower.

Training can solve a variety of manpower problems which militate against optimum productivity. Included are all organizational operations that have a manpower component. These problems can emerge within any individual or group of employees including volunteers. These problems include the following needs:

- increase productivity
- improve the quality of work and raise morale
- develop new skills, knowledge, understanding and attitudes

- use correctly new tools, machines, processes, methods, or modifications thereof
 - reduce waste, accidents, turnover, lateness, absenteeism, and other overhead costs
 - implement new or changed policies or regulations
 - fight obsolescence in skills, technologies, methods, products, markets, capital management, etc.
 - bring incumbents to that level of performance which meets (100% of the time) the standard of performance for the job
 - develop replacements, prepare people for advancement, improve manpower development, and ensure continuity of leadership
 - ensure survival and growth of the enterprise
- Training can become a functional part of the organization anywhere. Some examples of ongoing training functions needed within organizations include -

- 1) orienting new employees to the goals, policies, structure, products or services of the organization
- 2) acquainting employees with a new organizational policy and how it is to be implemented
- 3) a new procedure, new record form, a new machine or a modification of existing forms, machines, etc., are introduced
- 4) improving the quality of report writing throughout the organization

These activities should be part of a training department/unit within an organization. This makes it possible for training to become a planned component of overall organizational management as opposed to an ad hoc arrangement. In order for the training function to be thus institutionalized, the position of training manager and the establishment of a training department must be legitimized in the form of an organizational policy.

1.1.3 Seeking the Right Solution to Organizational Problems

from Closing the Performance Gap, by Peter Petit
Health Action, March-May, 1994, page 4

A performance gap by employees does not necessarily or directly translate into a need for continuing education or training. Before deciding to put more resources into continuing education, we should look at the underlying causes of the problem. The lack of appropriate knowledge and skills is one case where continuing education may be the answer, but other reasons are related to lack of resources, poor motivation and poor work organization. These problems require different solutions. Some of these are listed in the table below

Obviously, many of these possible solutions are not easy. In developing countries there are few financial resources to buy equipment or to raise salaries for health workers. To change selection procedures or to re-organize work means changes at the policy level, not just announcing the changes but in following them through and making sure that they are implemented effectively.

Continuing education and training is mainly a solution to problems created by the performance gap at the level of knowledge and skills of the individual worker. Nevertheless it is

still a very important factor. It will have the greatest impact when there is a degree of stability within the health system and when health workers remain in the same posts for some time.

| General Problem: Tuberculosis Patient Case Detection, Treatment and Holding is below national standards | | |
|---|---|--|
| <i>Specific Problem</i> | <i>Underlying Reasons</i> | <i>Possible Solution</i> |
| Sputum diagnosis is inaccurate or delayed | reagents and equipment are lacking | reallocation of resources to purchase needed supplies |
| Staff do not respond well to patients, patients' family members or to supervisors | staff are recruited on basis of ethnicity, religion or personal contacts and do not feel accountable | use of objective recruitment criteria |
| Staff report late for work or miss several days a week | Salary is inadequate so staff set up their own businesses or undertake private practice | advocate for increased salaries and other benefits |
| Patients wait for hours to receive attention even though the full compliment of staff are present in the clinic | organization and division of work is poor - too many assume supervisory role and leave clinic work to a few, less qualified workers | change in work structure |
| Staff do not understand current treatment protocols | Directly Observed Treatment (DOTS) was recently introduced without informing staff | continuing education to provide knowledge and skills on DOTS |
| Staff observed to call in sick on TB clinic day or yell at patients. | Social stigma/fear of TB patients | continuing education to address work attitudes |

1.1.4 Locating the Performance Problem

From: Learning for Health, 1992, Issue 1, page 15-16

Only 15% of performance problems are due to training. The other 85% are due to problems in the system - facilities, equipment, supplies, management procedures and so on.

The question is often asked - can in-service training of clinic staff be an effective way of changing clinical practice? Your first step should be to locate as accurately as possible the origins of your particular performance problems. They may have little to do with training, and more to do with the following:

- clinic timetables may be too rigid
- staff may be unwilling to change for various reasons
- clinic staff may feel isolated and unmotivated. They may also have poor accommodation and few incentives or opportunities for professional advancement
- staff may lack basic equipment, or it may be out of order
- perhaps there is a heavy case-load and not enough staff
- the referral system may be inadequate
- supplies may be irregular or inadequate
- there may be few visual aids for health education

The problems may not be the same in all clinics, but it is likely that there are some common ones. How could you go about finding them, if you do not have the time for a formal evaluation? No doubt, you have discussed the problem at management level - but have you done it thoroughly at the clinics themselves?

Critical Incident Analysis

One useful technique is critical incident analysis. A familiar example is the use of this technique is the prenatal mortality meeting (a type of ward round) where staff in a maternity unit regularly examine the perinatal deaths in their unit. The reason for the meeting is not to apportion blame, but to find ways of improving the unit's performance.

Critical incident analysis follows the pattern of a group discussion. The incident is the trigger or starter. Following a description of the incident, you go into more detail.

- What exactly happened?
- Who was involved?
- Why did it happen?
- When and under what circumstances did it happen?
- Has it happened before?
- Does it happen in other clinics as well?

When everybody understands the problem better you start planning solutions.

- What resources do we have and how can we best use them? (Resources include humans, equipment and supplies)
- What limitations are there which prevent us from making the best uses of these resources?
- How can we overcome these limitations?

It is important to bear in mind that both you and the clinic staff will have critical incidents in mind, each from your own perspective. Clinic staff will remember times when they ran out of important supplies or when they could not get transport to refer a critically ill patient. You have heard about, or seen medical disasters that happened in clinics, or you have received complaints from the community. It would be good to start with incidents raised by the clinic staff. The discussions coming out of them will probably deal with all the points you wanted to raise.

You may wish to use another method for discussion with clinic staff. However you go about it, the following concerns are important:

- Make sure there is enough time for the meeting
- All should know that the purpose of the meeting is not to find someone to blame,

- but to solve a problem together
- Clinic staff members must be free to speak out. Members of your management team must understand that it will not be productive if they act in an authoritarian way.
- The whole clinic staff team should attend
- There should be an opportunity for the clinic staff to put forward their own solutions to the problems.

You may also wish to use this technique once or twice when discussing the problems with your management team. In any event, a series of such discussions with clinic and management teams should help you to draw up a sensible, practical plan of action. Once you have started this and have some idea of its success, you may decide to repeat the exercise periodically. Among the 15% of the problems related to training, the following two are important to note:

Sharing from training - Often clinics send only one or two staff for a workshop with the expectation that on return these staff will become agents for change by sharing what they learned with their colleagues. Unfortunately, evidence suggests that this rarely works. Of course it is not possible to send all staff to a workshop, therefore specific arrangements need to be made to ensure that new knowledge is shared. One way it to hold a staff meeting where the recently returned trainee can share what she learned and from there arrange more formal tutoring. Also, visiting supervisors can be called in from the district team who will organize short training sessions on site for all staff at the same time.

Training and performance manuals - During training, staff often take copious notes, but these are seldom in a good form for reference some months or years later. Clinics need a set of good manuals on common clinical procedures that can be kept in a resource centre or library in the clinic.

1.1.5 Principles of Learning

excerpted from an article by Gerald J. Pine and Peter J. Horn
Adult Leadership, October, 1969, pp. 108-110

Principle 1

Learning is an experience which occurs inside the learner and is activated by the learner.:

The process of learning is primarily controlled by the learner and by the teacher (group leader). Changes in perception and behaviour are more products of human meaning and perceiving rather than any forces exerted upon the individual. Learning is not only a function of what a teacher does to or says to or provides for a learner. More significantly, learner has to do with something which happens in the unique world of the learner. It flourishes in a situation in which teaching is seen as a facilitating

process that assist people to explore and discover the personal meaning of events for them.

No one directly teaches anyone anything of significance. If teaching is defined as a process of directly communicating an experience or a fragment of knowledge, then it is clear that little learning occurs as a result of this process and the learning that does take place is usually inconsequential. People learn what they want to learn, they see what they want to see, and hear what they want to hear. Learning cannot be imposed. When we create an atmosphere in which people are free to explore ideas in

dialogue and through interaction with other people, we educate them. Very little learning takes place without personal involvement and meaning on the part of the learner. Unless what is being taught has personal meaning for the individual he will shut it out from his field of perception. People forget most of the content “taught” to them and retain only the content which they use in their work or content which is relevant to them personally.

Principle 2

Learning is the discovery of the personal meaning and relevance of ideas. People more readily internalize and implement concepts and ideas which are relevant to their needs and problems. Learning is a process which requires the exploration of ideas in relation to self and community so that people can determine what their needs are, what goals they would like to formulate, what issues they would like to discuss, and what content they would like to learn. Within broad programmatic boundaries what is relevant and meaningful is decided by the learner(s), and must be discovered by the learner.

Principle 3

Learning (behavioral change) is a consequence of experience. People become responsible when they have really assumed responsibility, they become independent they have experienced independent behaviour, they become able when they have experienced success, they begin to feel important when they are important to somebody, they feel liked when someone likes them. People do not change their behaviour merely because someone tells them to do so or tells them how to change. For effective learning giving information is not enough, e.g. people become responsible and independent not from having other people tell them that they should be responsible and independent but from having experienced authentic responsibility and independence.

Principle 4

Learning is a cooperative and collaborative process. Cooperation fosters learning “two heads are better than one”. People

enjoy functioning interdependently. The interactive process appears to “scratch and nick” people’s curiosity, potential and creativity. Cooperative approaches enabling. Through such approaches, people learn to define goals, to plan, to interact, and to try group arrangements in problem solving. Paradoxically, as people invest themselves in collaborative group approaches they develop a firmer sense of their own identification. They begin to realize that they count, that they have something to give and to learn. Problems which are identified and delineated through cooperative interaction appear to challenge and to stretch people to produce creative solutions and to become more creative individuals.

Principle 5

Learning is an evolutionary process. Behavioral change requires time and patience. Learning is not a revolutionary process. When quick changes in behaviour are demanded we often resort to highly structured procedure through which we attempt to impose learning. Whether such learning is lasting and meaningful to the learner is doubtful. Implicit in all the principles and conditions for learning is an evolutionary model of learning. Learning situations characterized by free and open communication, confrontation, acceptance, respect, the right to make mistakes, self-revelation, cooperation and collaboration, ambiguity, shared evaluation, active and personal involvement, freedom from threat, and trust in the self are evolutionary in nature.

Principle 6

Learning is sometimes a painful process. Behavioral change often calls for giving up the old and comfortable ways of believing, thinking and valuing. It is not easy to discard familiar ways of doing things and incorporate new behaviour. It is often “downright” uncomfortable to share one’s self openly, to put one’s ideas under the microscope of a group, and to genuinely confront other people. If growth is to occur, pain is often necessary. However the pain of breaking away from the old and the comfortable is usually followed by appreciation and pleasure in the discovery of an

evolving idea or a changing self.

Principle 7

One of the richest resources for learning is the learner himself. In a day and age when so much emphasis is being placed upon instructional media, books and speakers as resources for learning we tend to overlook perhaps the richest resource of all—the learner himself. Each individual has an accumulation of experiences, ideas, feelings, and attitudes which comprise a rich vein of material for problem-solving and learning. All too often this vein is barely tapped. Situations which enable people to become open to themselves, to draw upon their personal collection of data, and to share their data in cooperative interaction with others maximize learning.

Principle 8

The process of learning is emotional as well as intellectual. Learning is affected by the total state of the individual. People are feeling beings as well as thinking beings and when their feelings and thoughts are in harmony learning is maximized. To create the optimal conditions in a group for learning to occur, people must come before purpose. Regardless of the purpose of a group it cannot be effectively accomplished when other things get in the way. If the purpose of the group is to design and carry out some tasks, it will not be optimally achieved if people in the group are fighting and working against each other. If the purpose of the group is to discuss current issues and problems in a given field with reason and honesty then it will not be achieved if people are afraid to communicate openly. Barriers to communication exist in people and before we can conduct “official business” we need to work with the people problems that may exist in a group. It might be said that in any group, regardless of the people problems which exist, enough group intellectual capacity remains intact for members of the group to acquire information and skills. However, to maximize the acquisition and internalization of ideas it seems reasonable that the people problems would have to be dealt with first.

Principle 9

The processes of problem solving learning are highly unique and individual. Each person has his own unique styles of learning and problem solving. Some personal styles of learning and problem-solving are highly effective, other styles are not as effective, and still others may be ineffective. We need to assist people to define and to make explicit to themselves the approaches they ordinarily use so that they can become more effective in problem-solving and learning. As people become aware of how they learn and solve problems and become exposed to alternative models used by other people they define and modify their personal styles so that these can be employed more effectively.

1.2 Training in the Context of Continuing Education

1.2.1 The Problem of Continuing Ignorance

from: Continuing Education for Health Workers
African Medical and Research Foundation (AMREF), Nairobi, 1983

To do any job requires a mixture of knowledge, skills and attitude. In theory health workers acquire all the knowledge, skills and attitudes they will need during basic training. They then 'qualify and expected to remember everything they learned in basic training for the whole of their professional lives.

In practice, things are a little different. To begin with, some of the things we learned in our basic training were irrelevant; they do not help us to do our jobs. On the other hand, there are things that we **do** need to know but were never taught. Often these are procedures or solutions to practical problems that we face in our day to day work. At the same⁴ time we have forgotten some of the useful and relevant information that we did acquired during basic training, especially if there has been no opportunity to review that information or discuss it with others. Meanwhile the job for which we were trained has changed because circumstances have changed and new drugs and medical techniques have been developed.

For all these reasons, it is clear that basic training by itself is not enough. If the health worker is to do his job effectively, the learning process must be lifelong; it should not stop at the time of qualification. This is what we mean by 'continuing education'-the part of a person's education that begins where basic training ends.

Nowadays continuing education has become a popular catch phrase- like 'primary health care'. Many pay lip service to the phrase but then don't really do any thing about it. Therefore I would like you to consider the problem that the continuing education is designed to prevent, which I shall call 'continuing ignorance'. I would like you to think of the epidemiology of the of this problem we are trying to prevent and to look at the question that an epidemiologist would ask about it:

- **who** is the population at risk? who actually has the disease?
- **where** are the affected individuals?
- **when** does the disease occur?

We should not stop there, however. For in order to assess the importance of the problem, we must also ask the applied epidemiologist's question:

- **so what?**

Epidemiologic Aspect of Continuing Ignorance

WHO?

Our first question as epidemiologist is: who is the population at risk? clearly all health workers, from the driver at the health center to the professor of medicine or senior health ministry official may suffer from continuing ignorance. There is no natural immunity.

It is important to assess the size of the population at risk and realize how many people are involved. You can estimate the size of the population at risk in your own province or district simply by looking at the staff roster of the ministry of health, mission and private health

facilities, private practitioners and so forth.

To determine who among the at-risk population actually has the disease, we would need to do a survey and screen for continuing ignorance. In a later section of this manual we shall describe precisely how such a survey is done and how its results are used to design programmes for prevention and control of continuing ignorance.

WHERE?

Let us consider the distribution of the population at risk. To begin with, the people at risk are spread all over the district of the country. Some work in hospitals while others work by themselves in health centers and dispensaries in the community. The latter group- those who work by themselves-are at increased risk. They have fewer professional colleagues to talk to and are often visited only once a month or even only once in six months by supervisory staff. They have fewer things to read and very seldom have opportunities to attend meetings or visit a library. This kind of professional isolation is clearly a major risk factor for continuing ignorance, for the disease breeds in an isolated environment. And professional isolation increases with increasing distance from medical centers and hospitals.

WHEN?

If we want to determine when continuing ignorance begins to attack the health worker, we need to consider the natural history of medical know-how. Such know-how increases during the basic training. This is particularly true of the theoretical knowledge, which may reach its peak at the time of qualification. When health workers start work, they often begin to acquire additional practical skills at the same time as they start forgetting some of their theoretical knowledge. For a time, the acquisition of new skills may balance the forgetting of theory. This is the subclinical face of continuing ignorance. As time passes, however, and forgetting accelerates, signs and symptoms of deficient work performance begin to appear, and the syndrome of continuing ignorance becomes clinically apparent.

From our brief look at who, where, and when, we can thus identify two major **risk factors for the development of continuing ignorance:**

- Professional isolation
- Time since basic training

It remains to ask the last question: So what?

SO WHAT?

We have seen that a large number of staff are at risk of continuing ignorance ; we have seen that the condition may affect all, especially those working away from medical centers; and we have seen that the risk increases with time after qualification. What should we do?

We must, first of all, recognize that continuing ignorance is a preventable affliction. That being the case, it is useful to consider the application of primary, secondary, and tertiary preventive measures.

The Prevention of Continuing Ignorance

Primary prevention: Primary prevention means preventing people from getting the disease in the first place. During basic training the health worker receives a priming dose of knowledge. But like many other immunizations, the immunization against ignorance

requires periodic boosters. Most health workers will not be able to report back to learning centers for all the boosters they need, so they must be taught-during basic training-how to administer their own booster doses by acquiring a habit of self-learning that will remain with them through their professional lives. The health worker who has learned to study on his own will maintain active immunity against continuing ignorance for many years after qualification. And if a large enough proportion of health workers can be immunized in this way, herd immunity may confer some protection on the rest when colleagues meet to exchange ideas.

Secondary prevention: Secondary prevention is aimed at detecting people who have a disease as early as possible-preferably when the disease is still in subclinical stage-in order to cure it and prevent chronic illness and disability. The first step in secondary prevention, then, is detection; and in order to detect the insidious early signs of continuing ignorance, we need to survey the health workers in our district or province. How to do such a survey is described later in this manual.

Once having found those afflicted with the disease, secondary prevention aims for cure. So we need to look at what treatments are available for continuing ignorance:

- P We can improve informal learning opportunities, such as supervision and meetings, and increase their frequency .
- P We can increase the distribution of learning resources, such as manuals and journals.
- P We can improve and increase formal learning opportunities, such as refresher courses, and extension courses.
- P We can develop new methods of learning through tutorials, correspondence courses, radio programmes, and so forth.
- P We can apply rewards, such as salary increments and promotions, for those who do extra study.

The definitive treatment of continuing ignorance is not easy, and combination therapy, using several of the above methods, is more likely to be effective than anyone treatment given alone. There is also a danger in treatment prematurely. Once initiated, the treatment of continuing ignorance must be repeated periodically throughout the health worker's professional career-otherwise relapse is likely.

Tertiary prevention: Tertiary prevention refers to the prevention of further disability in a person who cannot be cured. When we encounter continuing ignorance in its late, chronic stages-usually in the health worker who qualified many years earlier and has worked since in isolated surroundings-radical cure may not be feasible, especially if attitude has deteriorated along with knowledge and skills. In such cases, we will not be able to restore the health worker to his previous state of robust knowledge, but we can at least aim to prevent further deterioration. The methods described above for secondary prevention have relevance in tertiary prevention as well, although in advanced cases these methods may have to be reinforced with incentives (e.g salary increases) and sometimes even sanctions (limiting the period of registration or restricting the promotion to those without continuing education, for instance). Tertiary prevention is likely to be

considerably more difficult than preventive measures applied at earlier stages, for by the time continuing ignorance has become chronic the health worker has developed longstanding habits of faulty practices that he believes have served him well. A great deal of patience, sympathy, and encouragement is required to motivate such health workers and to help them overcome the pain of unlearning old habits and acquiring new ones.

Control of Continuing Ignorance

The discovery of a serious disease in a community should prompt control measures by the responsible authorities. We have seen that continuing ignorance is serious disease, and probably an endemic one, among health workers. An effective control programme for continuing ignorance should therefore aim to reduce its incidence to the point that it is no longer a threat to public health. That is what this manual is all about: a strategy for the control of continuing ignorance. And like any other disease control programme, it must follow certain basic steps:

- There must be a **precontrol survey** so that the local frequency and distribution of the disease is known. This is essential for later evaluation, to see if the programme is effective in reducing the incidence of the disease.
- Certain **knowledge and skills** are needed by the medical staff for control methods.
- The **technical requirements** in money, staff, and supplies must be available.
- The **organization and a plan of action** must be worked out at the beginning.
- The **evaluation** needs to be carried out both during the programme and after it is finished. Only in this way can we know if the number of cases has reduced .

At the moment, more than half of the health budget of most countries goes on salaries. That is, more than half of the health budget is paying for a dwindling asset of know-how, and sometimes also morale. Viewed in this perspective, continuing education is a very small investment that could yield a very large return. An ounce of prevention is worth a pound of cure.

1.2.2 Defining Continuing Education

Not every district health team will have the resources to run a comprehensive continuing education programme. Some teams may wish to start on a small scale-such as running a few refresher courses only-and gradually build up a larger programme from there. In other areas, resources may permit only a single approach to continuing education, such as the use of supervisory visits to assess and correct the performance of health workers on the job. The appropriate chapters in this manual can also be used for planning individual components of a continuing education programme, such as running refresher courses.

It should be stressed that all health workers have a responsibility to pass on their knowledge and skills to people who have had less opportunity to learn. Continuing education is thus an integral part of the duties of all health workers, and continuing education means both upgrading one's own knowledge and skills and helping others to learn.

WHAT IS CONTINUING EDUCATION

The education of a health worker is a lifelong process. The part that takes place in the training school, before the health worker qualifies, is called basic training. The part that begins when basic training ends is continuing education. Both components of the health workers' education are essential. Good basic training lays the foundation for all further learning and provides the health worker with the fundamental knowledge he needs to start his job. Continuing education builds on that foundation to improve the health worker's competence and enable him to adapt to changing health needs in the community and changing practices in the health care. Thus basic training and continuing education are inseparable components of the same overall process, and plans for continuing education must be a part of every basic training programme.

The approach to learning

In basic training, learning is standardized; all students must acquire a predetermined, comprehensive body of knowledge and set of skills. Continuing education, on the other hand, helps workers learn to *apply* and *adapt* their training to the particular circumstances of their daily work. Acquisition of knowledge is no longer paramount; rather, problem-solving skills are stressed. Furthermore, participants in continuing education programmes are no longer treated solely as individual students but as members of working teams.

The use of resources

In basic training, most of the educational resources come from outside the student and his experience—books, lectures, clinical demonstrations and the like. The student is a novice on entering a basic training programme; he has no backlog experience on which to draw, and so his teacher must furnish that experience for him.

In continuing education, by contrast, the most valuable resource is the health worker's own experience. A class of 20 health workers called for a refresher course usually represents between 100 and 300 years of working experience. If continuing education is going to be successful, it must try to use this experience and build on it. The teacher's role is no longer to furnish experience to novices; it is to focus and help interpret the experience of the veterans.

Content and emphasis

Continuing education for rural health workers, in contrast to basic education, is concerned less with knowledge and more with skills; less with theory and less with practice; less with medicine per se and more with the personal interaction of service and administration in rural communities; less with disease and more with health.

Continuing education is not, or should not be, a repetition of basic training. The focus of continuing education is on common field problems. The training methods must be anchored in practical experience. Where curriculum design in basic training is largely deductive—based on a predetermined catalogue of what a health worker should know—curriculum design for continuing education is inductive: it proceeds from an inventory of needs and deficiencies to a program designed to address those needs and deficiencies.

What is continuing education programme

A continuing education programme is just what the name implies: an integrated system for extending the education of the health worker beyond basic training, across his whole career. An effective continuing education programme usually includes the following features:

- < it should be **comprehensive** in its coverage of health personnel; that is, it should be available to all health workers at all levels.
- < it should be **based on a survey of needs**, so that it is relevant to the tasks that the health worker performs and the problems he faces in his daily work.
- < it should have planned **continuity** throughout the health worker's career. One or two unrelated refresher courses offered sporadically are not a continuing education programme.
- < it should be **co-ordinated** with the health care system as a whole to permit sharing of resources and to minimize overlap between the efforts of different agencies.
- < it should be regular part of the routine activities of the district health team.
- < it should include the consumers (the health workers) in the planning and evaluation phases. That is, the curriculum should take into account what the health workers themselves *want* to learn.

Occasional seminars and workshops run by people who are paid to do something else full time and supported only by outside agencies are not by themselves a continuing education programme. They are potential components of a programme, but-like pieces of a puzzle-they are incomplete until fitted together into an integrated whole.

Obstacles to continuing education and ways around them

He who knows not and knows not that he knows not is a fool; shun him.
 He who knows not and knows that he knows not is a child; teach him.
 He who knows and knows not that he knows is asleep; wake him.
 He who knows and knows that he knows is wise; learn from him. ---- *Chinese proverb.*

Continuing education is like public sanitation; everyone agrees it needs to be done, but not everyone is sure that they want to do it themselves. Merely establishing a continuing education programme will not by itself ensure that health workers will improve their level of or that they will even attend. Preparation for continuing education must take that into account.

Why should health workers view continuing education with less than complete enthusiasm? To begin with, many health workers are unaware of their need to learn. They may feel that they are doing a splendid job already and therefore wonder why they should have to waste time in a dreary programme that sounds suspiciously like the old days in the classroom.

Continuing education, in the second place, involves a degree of threat to the health worker's self esteem. The implied message in a continuing education programme is that the health worker is not as competent as he thought he was, that he needs to unlearn bad habit as well as learn new techniques for the first time. No one likes to feel incompetent.

In the third place, the health worker may see little reward to himself in taking time for continuing education. He may wonder what he has to gain by traveling many miles to a course and sitting in a classroom for a week when there are many other interests and responsibilities competing for his time. Thus he may view continuing education as yet another burden imposed on him by the authorities.

For all these reasons, health workers may not welcome the idea of continuing education, and the continuing education programme should provide a mechanism for explaining its purposes and motivating health workers to participate. Among the methods for doing so are the

following:

- < provide the health workers with self assessment exercises preferably in a form that they can do in private (e.g. Quizzes with answers supplied). This type of exercise may enable the health worker to come to his own realization of his strength and weaknesses.
- < involve the health workers in planning their own continuing education programme, to address their felt needs, so that they feel it is their programme and not something imposed on them by others.
- < avoid blaming the health workers for their own deficiencies. Make the learning environment as relaxed and unthreatening as possible.
- < make the courses interesting and relevant.
- < schedule time during working hours for continuing education. Do not make it something extra that imposes an additional demand on the health worker's time.
- < wherever possible, incorporate the continuing education programme into a career development structure. Continuing education may be, for example, a prerequisite for recertification, promotion, or salary increases.

In addition to potential problems in the learners, continuing education also face obstacles related to the teachers who will participate in those programmes. Many medical people who have the responsibility for teaching health workers are not themselves trained in teaching methods. They may not know how to design a course that is relevant or how to use classroom time in a manner that will encourage learning. Thus the health worker may find himself sitting through lectures that are simply a repetition of those he sat through during basic training, and he may well wonder why he bothered to come.

The planning phases of a continuing education programme must therefore include some consideration of teaching strategies, right from the outset. Planning should take into account the following:

- < Trainers for the continuing education programme should themselves undergo training before the programme is launched.
- < Courses should stress competence. They should be designed to solve specific problems identified by the health workers.
- < Learning methods should permit maximum participation by the learners.
- < The learners should be in the evaluation of the courses.

Finally, there are obstacles to continuing education imposed by the very situation that makes continuing education necessary. Many if not most of the potential learners work in isolated conditions, and it may be difficult and costly to bring them together for a course. Supervision of these health workers is often minimal, and supervisory staff may not be adequately trained for their supervisory duties. Such obstacles need to be identified in an early phase of planning, when doing a health services inventory, so that the planning team can adapt their programme to the specific constraints of their districts. In the initial planning stages, then, one has to look at the alternate strategies for continuing education and decide which will be most cost-effective and feasible.

The exercise of all these obstacles to continuing education should not discourage the district health team. Has shown that while such obstacles do exist, they are not difficult to overcome. Indeed, the obstacles have been more counterbalanced by the popularity of continuing education programmes once established. Refresher courses, for example, have been

received with enthusiasm by health workers who enjoy the chance to meet colleagues, share problems, and have a change of pace from their routine duties.

Methods of continuing education

A comprehensive programme of continuing education will employ a variety of methods. The method that we shall deal with most extensively in this manual is the refresher course. It should be stressed, however, that there are many other strategies for providing continuing education, such as:

- < Staff meetings within health facilities.
- < Meetings with professional colleagues (e.g. conferences, workshops, seminars)
- < On-site supervision and coaching.
- < Reviews of patient records, analysis of monthly reports, etc
- < Self-study, using books, journals, correspondence courses, or self assessment examinations.
- < Radio programmes and other mass media methods.
- < Exchange visits among health workers from different facilities.

The choice of strategies for continuing education will be dictated by many factors, including costs, manpower resources, distances and the nature of the problems that the programme is trying to solve. What is feasible in one district may not be feasible in another. When health workers are widely scattered in remote dispensaries, for example, supervisory visit to dispensaries by district health teams may be more cost-effective than trying to bring widely dispersed personnel together in one place for a course. Distance learning techniques may enable wider coverage on a limited budget, especially where transport is a major obstacle. Thus those planning continuing education programmes need to remain flexible in their approach and to consider alternative paths to the same goal.

1.2.3 A Philosophy of Training

from US Peace Corps
Programming and Training Systems Manual

- Training efforts must be collaborative between trainers and trainees
- Training activities must be integrated with each other to produce a logical flow so that each activity builds on the one preceding it
- Training is an ongoing effort that begins with placement and continues until the person leaves service
- Training components include both the technical - what tasks will be performed - as well as the managerial - how those tasks will be carried out within the organizational and local cultural environments
- Training must be competency-based, specifying specific knowledge, skills and attitudes that the trainee will acquire as a result of training
- Training efforts should be based on the principles of experiential, adult learning -

adults are valuable learning resources themselves.

1.2.4 Principles of Learning/Adult Education

by Malcolm Knowles, North Carolina State University, 1975

| Underlying Assumptions | Pedagogy Teacher-Directed Learning | Adult Education Self-Directed Learning |
|------------------------------|---------------------------------------|---|
| Concept of the learner | dependent personality | increasingly self-directed, self-actualizing |
| Role of learner's experience | to be built on rather than used | as a rich resource for learning and to be shared among learners |
| Readiness to learn | varies with levels of maturation | develops from life tasks and problems |
| Orientation to learning | subject-centered | task or problem centered |
| Motivation | external rewards and punishments | internal incentives and curiosity |

| Elements | Pedagogy Teacher-Directed Learning | Adult Education Self-Directed Learning |
|---------------------------|---|--|
| Climate | Formal, authority-oriented, competitive, judgmental | Informal, mutually respectful, consensual, collaborative, supportive |
| Planning | primarily by the teacher-trainer | by participative decision-making |
| Diagnosis of Needs | primarily by the teacher-trainer | by mutual assent |
| Setting Goals | primarily by the teacher-trainer | by mutual negotiation |
| Designing a learning plan | content units, course syllabus, logical sequence | learning projects, learning content sequenced in terms of readiness |
| Learning Activities | transmittal techniques, assigned readings | inquiry projects, independent study, experimental techniques |

| | | |
|------------|---------------------------------------|---|
| Elements | Pedagogy Teacher-Directed Learning | Adult Education Self-Directed Learning |
| Evaluation | primarily by the teacher-trainer | by mutual assessment of self-collected evidence |

1.2.5 Examples of Continuing Education Activities

from Closing the Performance Gap, by Peter Petit
Health Action, March-May, 1994, page 4

Continuing education is something that ordinary health workers can initiate and contribute to. The key is to create and maintain a ‘culture of self-improvement.’ Here are some of the ways health workers can initiate continuing education -

- Use your ward round or your supervisory visit as a way to teach other health workers.
- Organize informal clinic meetings on a monthly basis. Discuss how you do things now and how they can be improved.
- Maintain a notice board for new information
- Improve prescribing behaviour by providing an alphabetical; list of generic versus brand names of pharmaceutical drugs. Set standards and indicators for monitoring use.
- Set aside a reading room with a small library. Make sure that your library books, training materials and newsletters are not locked away, unknown and unused. Order free newsletters.
- See if some of your staff members can attend teacher training courses. Take advantage of their new skills.
- Make contacts with other educational institutions, such as institutes of adult education, correspondence courses and open universities.
- Invite staff from other agencies and organizations to talk about their activities.
- Organize a visit to a nearby agency that has started a new programme.

Who Gets Training Opportunities?

Continuing Education Experiences of District Level health Staff in Nigeria. By Onuoha PC and Brieger WR. *International Quarterly of Community Health Education* 1992-93; 13(4): 389-403.

Primary Health care implementation has stimulated the need and interest in developing continuing education programmes in Nigeria. A population study of 114 government (69%) and private (31%) health workers in the Ibarapa District of Oyo State documented their continuing education opportunities. Only 39% had attended an in-service training programme in the past five years. Fewer (32%) had received a supervisory visit within the previous month, and most of these visits contained little of educational relevance according to the respondents. Slightly over

half (54%) reported attending a staff meeting in the previous month, but 72% had attended one in the past six months. Like supervisory visits, these meetings were not primarily educational in nature. Only 58% engaged in self-study through reading in the past six months, but quality reading materials were scarce, forcing health workers to rely on old texts and popular health magazines. Local government health staff and workers with formal health training were more likely to have had an in-service training opportunity. Trained health workers and males were more likely to have engaged in self-study. New primary health care management structures have their potential in filling continuing education gaps and redressing the imbalance in continuing education opportunities in this and other rural districts throughout the country.

| Continuing Education Activity | Work Sector | | | | p value |
|-------------------------------|-------------|------------------|------------------|------------|----------|
| | Private | Local Government | State Government | University | |
| In-service Training | 11.1% | 45.8% | 26.7% | 50.0% | < 0.0008 |
| Supervision | 24.4% | 50.0% | 31.8% | 27.3% | < 0.03 |
| Staff Meeting | 60.0% | 60.1% | 34.5% | 59.8% | > 0.10 |
| Self-Study/ Reading | 62.0% | 58.0% | 58.0% | 50.0% | > 0.82 |
| NUMBER | 45 | 48 | 29 | 22 | |

1.2.6 Distance Education

by Senga Pemba and Sidney Ndeki
in Health Action, Issue 8, March-May 1994, p. 6-7

Distance learning involves participants studying away from an institution, generally through correspondence courses, rather than attending workshops and seminars. More often these days, distance education can be conducted via the internet if the trainee has access to a computer. The main reason for using distance learning is to establish an appropriate learning system for all types of health workers which is cheap, affordable and accessible. It is also an important strategy to sustain continuing education after donor support has ended for formal training workshops. In Tanzania, financial and technical support from the African Medical and Research Foundation (AMREF) enabled the continuing education programme to develop distance learning modules covering essential drugs, environmental sanitation and water, vector control, food quality control, and diarrhoeal diseases.

The Ministry of Health has also developed distance learning for rural medical officers, in collaboration with the Wellcome Tropical Institute (WTI). It began by training zonal trainers in basic education principles, organization and conduct of the course and the preparation of materials for self-directed learning. WTI prepared learning modules on obstructed labor, acute

respiratory infections and epidemiology.

In 1988/89 the Centre for Educational Development in Health, Arusha (CEDHA) conducted a pilot project in Northern zone using these modules. Each participant received direction from a distance by a tutor, who could refer them to subject specialists (expert tutors) if necessary. The study period began and ended with two days of workshop for briefing and debriefing, but otherwise participants stayed in their workplaces. At the end of the study, participants evaluated the standard and usefulness of the modules, which were then modified accordingly. The revised and extended modules are still in use for distance education in Tanzania.

Distance Education at the African Medical and Research Foundation

by Stephanie Nduba (ARHEC Graduate of 1977) and Joan Mutero
Distance Education in Health News, AMREF, 1990

The Training Department at AMREF pioneered the use of distance education for health workers in Africa. This method of teaching, though popular with many other professions, was unknown in the medical profession of this region.

The term distance education is used to cover various forms of study where the learner is not in direct physical contact with his teachers most of the time. In other words, through the use of modern technology, it is no longer necessary for us who wish to acquire new skills or knowledge to sit in front of a teacher. One can achieve the same objective through distance learning. Distance education includes:

- education through print, otherwise known as correspondence studies
- radio programmes
- audio cassette programmes
- television and video programmes
- internet based programmes for those who have computers

All these forms can be used to compliment each other. They can also be supplemented with face-to-face teaching. Of course, not all the forms we have mentioned can be used, especially in our developing countries. This is because the resources available in our environments may not be the same. For example, you may have access to a TV and a video while I may not.

AMREF's distance education uses print and radio. This is because surveys carried out prior to the beginning of the programme showed that every health worker had access to postal services as well as a radio.. AMREF is currently trying out the use of audio cassettes on a pilot basis and they may also be used in the future. Whatever form distance education takes, it allows people to study at their own pace and without having to leave their places of work or homes.

Correspondence Studies or the print medium, is the oldest of all distance education elements. For example, in 1840 by Sir Isaac Pitman began his famous secretarial training correspondence courses that are still popular. Today AMREF offers a variety of correspondence courses on -

- communicable disease
- child health
- community health
- family planning
- helping mothers breastfeed

- environmental health
- medicine
- mental health
- obstetrics and gynecology
- rural surgery

Each lesson consists of a study guide, an assignment and some handouts. The study guide is based on a lesson plan. The study guide contains questions that carefully structure the learning and encourage the learner to relate the content to his/her own experiences. When a lesson is completed and the learner is satisfied that the stated learning objectives have been met, he/she completes the assignment and posts it to AMREF for corrections, comments and suggestions. These are mailed back with the next assignment in the course.

All health workers are eligible, and may write to AMREF for application forms. These are sent along with a pre-test. At present, AMREF has donor financial support to provide these courses free to interested health workers.

1.2.7 Setting up a Resource Centre

Health Action, Issue 8, March-May 1994, p. 6

Resource centers are essential components of continuing education. They encourage students to explore problems and seek solutions themselves. They enable problem-based learning as the learner can go directly to the resource centre in his/her clinic or health agency to find the answer to a current and pressing service delivery problem. Resource centers are more than libraries in that they may contain videos, slides, photos, job aids, posters and other educational materials. A staff member must be put in charge of the centre to ensure that it is kept up-to-date and accessible to all staff. Here are some ways to make a resource centre accessible and relevant:

- T consider who your users are and what they want from you - then try to provide it
- T make yourself accessible. Keep resources where people can use them
- T organize material so it can be easily found and used
- T actively seek out resources - not just books and journals but information sources, videos, cassettes, lists of individuals and organizations
- T write for free health newsletters, magazines and journals
- T expose users to a range of learning approaches, not just a medical one
- T build links with other educational institutions
- T encourage your user in habits of self-directed learning

Setting up a Resource Centre

by Suzanne Pustukian, AHRTAG
in Contact, Number 134, December 1993

To ensure that a resource centre will be successful, it is vital that its purpose is clearly defined. As far as possible, it is useful to discuss the aims and objectives with all those are working in the organization, movement, community or group which has decided to set up a

resource centre. With their help, a strategy to develop a the resource centre should be planned. The planning should also involve as many as possible of people whose work will be affected by the resource centre.

To help to define why the resource centre is being set up, ask yourself the following questions.

What is the relationship of the resource centre to the organization, movement, community, or group as a whole?

Are there shared objectives and policies? If the resource centre is linked to an organization, are the managers supportive? If the resource centre is the inspiration of a movement or a group, will be a central part of its activities?

Who will be responsible for coordinating the work of the resource centre?

Will the organization or group employ someone motivated to run the centre, or will they expect the existing staff to do it as an “extra”. Who will be responsible for managing and supervising the resource centre staff? Who will make decisions such as which materials to buy and how money should be spent?

Who is the resource centre for, who is expected to use it?

Will it be opened to the public, or only to health workers or health educators? what is the literacy level of the users? The answers will influence the type of materials acquired. Bear in mind that those using the resource centre need training in how to make best use of the centre. It is helpful to put up posters inviting people to come to the resource centre. When preparing the posters, think carefully about who you are hoping to attract. Design the posters accordingly. Give clear information about the opening hours of the resource centre. If possible, form a committee of people who are interested in helping to run the resource centre. They can help with the selection of materials, and generally help to make the resource centre a success.

What role will the resource centre play?

A resource centre is **not** just a collection of books, with an administrator acting as the guardian. While a resource centre should collect, process and organize materials, its priority should be to seek ways to share what information is available. The resource centre worker may decide to launch a newsletter, run a workshop or hold an exhibition to encourage maximum use of the facilities.

PRACTICAL DETAILS

Design - The amount of space given to the resource centre will depend on what is required and what is available. Ideally, a resource centre will have a room to itself, but it can be just a few shelves of materials in the corner of a room. A good working environment makes a difference, somewhere bright and airy with natural light is best. There should be a place for the administrator to work, as well as work space for those using the resource centre. Think about which area could be used to hold a workshop. Do not cover all the walls with shelves, but have display space for posters or exhibitions or displays of materials from books.

Equipment - Much of the necessary equipment can be made locally, for example, shelving, tables, blackboards and pamphlet boxes. More expensive items, such as personal computers and photocopying may have to be imported. A photocopier is almost essential (preferably located outside the main room for noise and health reasons). An overhead projector, slide viewer and video recorder are all increasingly useful as teaching aids. These may already be available elsewhere within the organization.

Arranging Material - A basic principle is 'keep it simple.' Take into account who the user are and what their needs are likely to be. Start with broad main headings for the main subjects you cover, then break this down into subheadings. For example, a main heading like 'mother and child health' could be subdivided into 'breastfeeding,' 'growth monitoring,' 'immunization,' and so on.

Budget - Setting up and running costs vary with the kind of service on offer. Opening hours, what materials are stocked and staffing arrangements all affect the budget. Work out a budget in detail before starting. Do not forget hidden costs, such as carrying out a needs assessment survey.