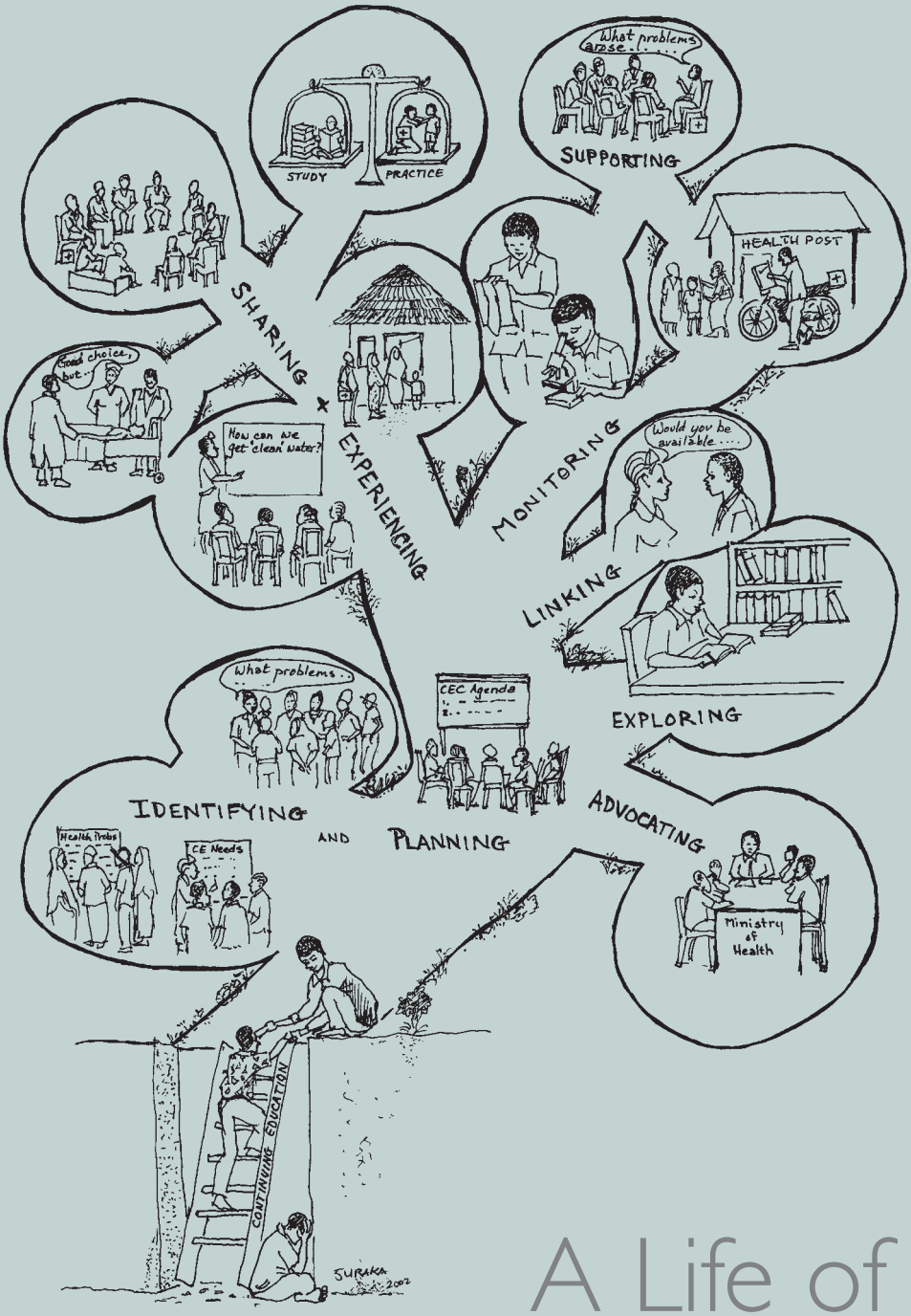


ILLUSTRATION OF THE PATHWAYS OF CONTINUING EDUCATION BY SALIM JUMA SURAKA

A Life of Learning

A participatory approach to continuing education

BEAT POVERTY BEAT POVERTY BEAT POVERTY BEAT POVERTY BEAT POVERTY BEAT POVERTY BEAT POVERTY

Save the Children

A Life of Learning

A participatory approach to continuing education

Faye Richardson

Save the Children

A Life of Learning

Participation in continuing education

Faye Richardson

Save the Children

Save the Children UK is a member of the International Save the Children Alliance, the world's leading independent children's rights organisation, with members in 29 countries and organisational programmes in more than 100 countries.

Save the Children UK works through a rights based framework with children, communities, NGOs, government ministries, UN agencies and G8 members to provide practical assistance while influencing public opinion, policy and practice, to bring about positive change for all children.

In Tanzania, Save the Children UK works to improve the delivery of basic health and education services to children: food security, social protection and HIV prevention. We are also monitoring the national poverty reduction strategy and are engaged in the formal reviews of the health and education service delivery sectors.

Published by
Save the Children
17 Grove Lane
London SE5 8RD
UK

Tel: +44 (0)20 7703 5400
Fax: +44 (0)20 7708 2508

Registered Charity No. 213890

Designed and typeset by Neil Adams, Grasshopper Design Company

Contents

Acknowledgements

To give credit to everyone who contributed in the making of this booklet would include listing everyone who's ever been in contact with the ***Continuing Education Programme*** in Zanzibar since 1991! Each person has made an impression. However, those who have made considerable contributions need to be recognised. This booklet could not have happened without their guidance, support and commitment. Special thanks go to:

- the Continuing Education Unit, Continuing Education Committees, health workers and Ministry of Health programmes and officials (past and present) for their tireless efforts and dedication in keeping ***continuing education*** and participatory activities alive through the best of times and the worst of times.
- the many donors and supporters of the ***CEP***. Special mention goes to DANIDA (who got us started on the approach), the Aga Khan Foundation, GTZ, WHO and UNICEF, all of which have contributed to the programme and its development.
- the pioneers of participation who provided initial and continuous inspiration to keep trying new ways and approaches for the ***CEP*** to help health workers learn and take charge of their learning. In particular, David Werner's and Robert Chambers' works are referred to throughout this booklet—their practical, no-nonsense approach provides a lot of food for thought and examples for taking action.
- Save the Children UK, which supported the ***CEP*** from its inception, through its birth, toddler years and now, adolescence. Those who need to be remembered for their contributions during the initial growth of the programme include Chris Thornton, Dr Charles Douglas and Marion Molteno. Those in the SC UK Tanzania and regional offices have all helped keep the programme going, especially Dr Harry Jeene. He pursued the production of this booklet with support from the London Development Dialogue Team (Nick Tancock and Cathy Williams).
- the very talented artist, Suraka (Salim Juma Suraka), who created and adapted ideas into the drawings contained within. Many of the drawings were adapted from David Werner and Bill Bowers' *Helping Health Workers Learn* – our ideas are better illustrated in their drawings than in words.
- the reviewers who took the time out of their very busy schedules to provide valuable comments and recommendations to produce what follows.
  – Sharifa Awadh Salmin, continuing education officer – Unguja
  – Said Moh'd Ali, continuing education officer – Pemba
  – Dr Omar Shauri Makame, principal secretary, Ministry of Health and Social Welfare – Zanzibar

– Dr Hamed Hikmany, chair, Zanzibar Education Council and deputy chair, Tanzania Examination Council
– Khamis Salim Khamis, senior archivist, Zanzibar National Archives
– Amour Kassim Amour, librarian and CEC secretary – Mnazi Mmoja Hospital – Zanzibar
– Chris Thornton, past country director, SC UK – Tanzania
– Marie McGuire, who spent her Zanzibar holiday editing
– Megan Caine and Derrall Rikli, freelance copy editors

- my family and friends in the US, UK, Denmark and Africa (you know who you are) who have guided and supported my efforts, desires and hopes in changing the world into a better place by starting 'in your own backyard'. Knowing you all has made a difference.
- the people reading this. You are motivated to learn more about continuing education and improving your capabilities. I hope this booklet will bring new ideas, experiences, relationships and enjoyment into your life.

Zanzibar, December 2002

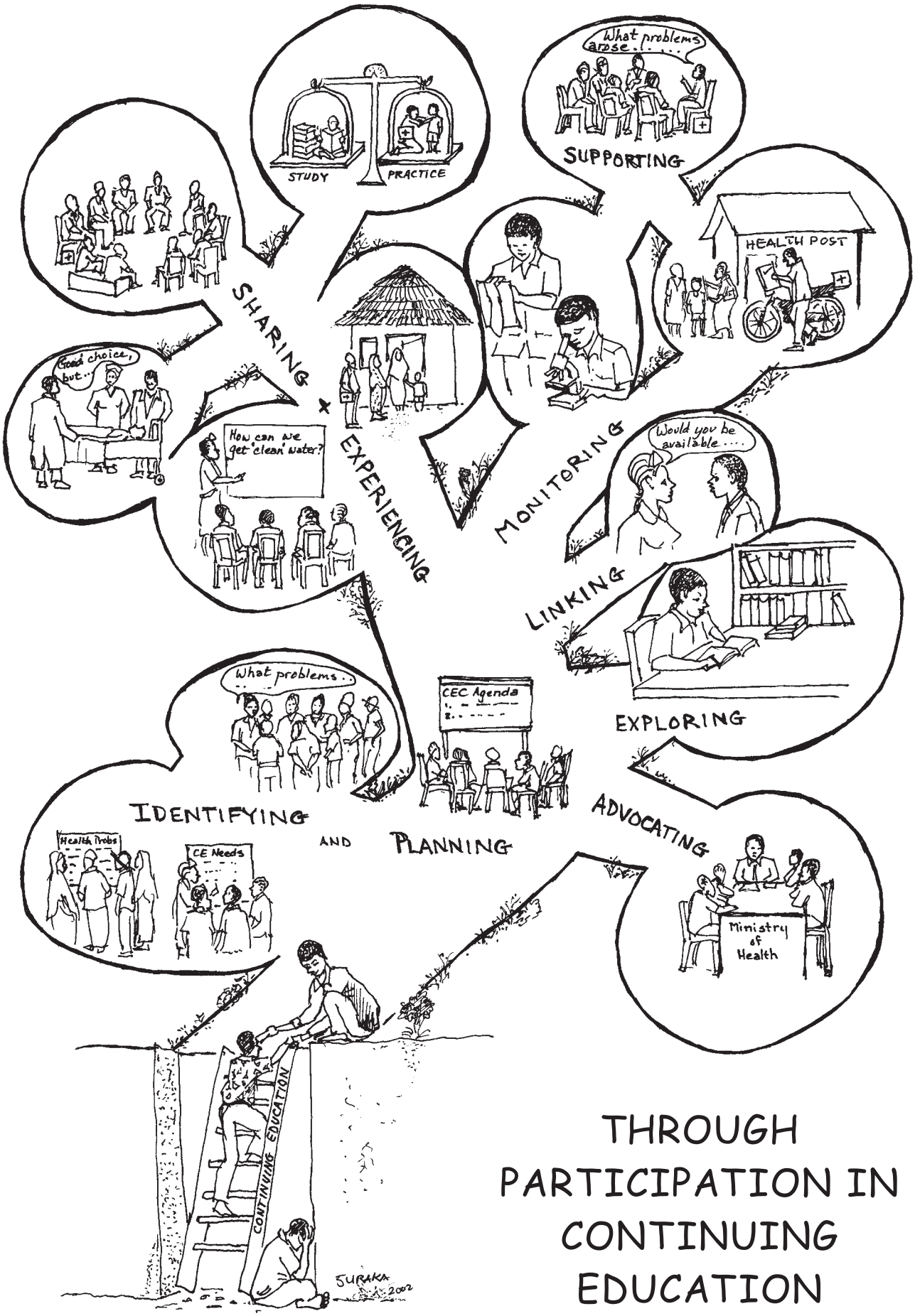
Faye Richardson, author
P. O. Box 1421
Zanzibar, Tanzania
Email: phaseout@cats-net.com
Tel: (255) 2422 31327

Harry Jeene, series editor

Abbreviations and Acronyms

AMREF	African Medical and Research Foundation
CARE	international NGO
CBHC	community-based healthcare
CE	continuing education
CE	continuing education as practised in Zanzibar
CEC	continuing education committee
CEO	continuing education officer
CEP	continuing education programme as practised in Zanzibar
CEU	continuing education unit
CHN	community health nurse
CPR	cardiopulmonary resuscitation
DANIDA	Danish government aid agency
DHMT	district health management team
DHO	district health officer
DMO	district medical officer
ELBS	English Language Book Society
GTZ	German government aid agency
HIV/AIDS	human immunodeficiency virus and autoimmune deficiency syndrome
HMTs	health management teams
MCH	maternal and child heath
MCHA	maternal child health aide
MoH	Ministry of Health
NGOs	non-governmental organisations
OXFAM	international NGO
PHCSP	Primary Health Care Support Programme
PS	Principal Secretary
PWP	people with power
PWOP	people without power
SC UK	Save the Children UK
STD	sexually transmitted disease
TALC	Teaching Aids at Low Cost
TBAs	traditional birth attendants
ToF	training of facilitators
TSH	Tanzanian shilling (950 TSH:US$ – May '02)
UNICEF	United Nations Children's Fund
VSO	Voluntary Service Overseas
WHO	World Health Organisation
ZANA	Zanzibar Nurses Association
ZHMT	zonal health management team
ZMO	zonal medical officer

BUILDING A LIFE OF LEARNING:

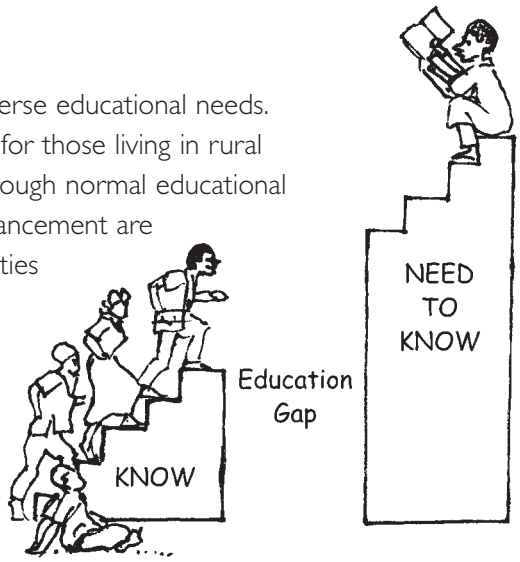


THROUGH PARTICIPATION IN CONTINUING EDUCATION

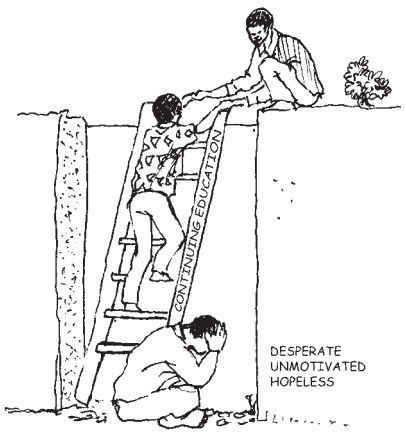
Introducing A Life of Learning

What is this booklet about?

Health workers in poor countries have diverse educational needs. Meeting these needs is not easy, especially for those living in rural areas. The possibilities for advancement through normal educational channels are few; yet the demands for advancement are increasing. Unless other learning opportunities become available, the gap between what workers 'know' and what they 'need to know' to do their jobs properly will grow wider. This is why we, in the Zanzibar Ministry of Health and Save the Children UK (SC UK), became involved in ***continuing education*** (***CE***).[1]



In Zanzibar, we face problems that are common to many countries, such as poor working conditions, low salaries and workers doing jobs for which they've not been trained. All this leads to low morale, dissatisfaction and little interest in work. ***Continuing education*** has reduced the effects of these problems by enabling health workers to take charge of their own learning and work situations. ***CE*** has made a difference.



When the ***Continuing Education Programme*** (***CEP***) began in 1991, it took participatory principles as its foundation. These principles have allowed ***CE*** to develop into a unique and "real example of what participation can do when its principles are put into practice".[2] Health workers have since volunteered their time to work on committees that organise learning activities for fellow workers. These Continuing Education Committees (CECs) have set up resource centres, in-service training, professional meetings and community education and health projects. They have done all this as well as their full-time duties in the Ministry of Health!

1 From this point, whenever the participatory approach to ***continuing education*** is being mentioned, it will be ***italicised and in bold***.

2 Quoted from Dr Peter Petit, evaluator of the ***CEP*** 1996–2001, at the National Continuing Education Meeting (9 March 2002), Zanzibar, Tanzania.

The ***Continuing Education Programme*** is a success because:

- it has made positive changes to the existing health services
- it's practical, appropriate and costs relatively little
- it provides up-to-date information and encourages innovation
- it's popular with workers
- it boosts workers' spirits and confidence.

Continuing education has provided the tools for individuals to share experiences and build new relationships. It has explored new ways of working and learning and has helped resolve problems at work and in communities. It can be adapted to any organisation or government service and will have similar kinds of success.

The author of this booklet was the continuing education adviser who helped set up the ***CEP***. With my Zanzibari colleagues, we hope to provide ideas, options, insights and suggestions that can help you develop a successful ***continuing education*** programme. In sharing this experience, we wish to provide "a small source of light in the darkness; a hope and inspiration"[3] for others to try ***Continuing Education: Zanzibar-style***.

Who is this booklet for?

- **Health workers** generally. In particular, those who:
  - need up-to-date practice information
  - have limited access to training or to learning materials
  - have sporadic communications (phone, media, post)
  - receive irregular supervision
  - have little contact with other health workers or colleagues.

  Continuing education addresses all of these issues.

- **Workers from any sector** (teaching, agriculture, water, community development) who need ***continuing education*** and work under similar conditions to health workers.

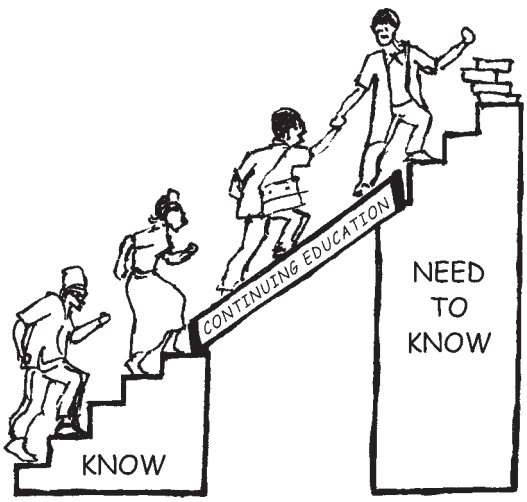
3 'Review of ***Continuing Education Programme*** 1997–2002', Dr P Petit, MoH, Zanzibar, April 2002, p. 13.

- **Others interested in *continuing education***, for example:
  - **Special or professional groups** – people who do the same kind of work and need current information in specific areas of practice (ie doctors, radiographers, traditional birth attendants)
  - **Trainers, educators, managers and supervisors** – who can use ***CE*** to develop workers' problem-solving skills, their initiative and their ability to take charge
  - **Decision-makers** – who develop policies and finance human resource development and training programmes
  - **Organisations** – that are involved in capacity-building of health workers (or others from rural areas) and their own staff.

What can *continuing education* achieve?

Continuing education is a tool for stimulating workers to keep learning while working, by receiving education throughout their working life. Improving workers' capacity through on-the-job or in-service training is a challenge faced by most organisations and government institutions. When budget and funding are scarce, training is often seen as a luxury. As a result, training is removed from the budget and receives no funds. ***Continuing education*** is an investment in people's development that costs little and gives big returns, for example:

- **Bridging the gap** between what workers 'know and do' and 'what they need to be able to do'. If health services are to improve, being up-to-date on practices and information is not enough. Knowledge alone doesn't change the way people do



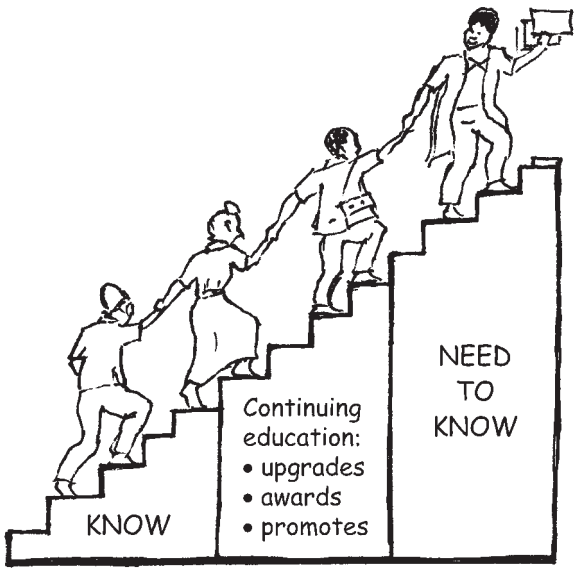
things. To change the way people work, reasons for low morale, frustration and hopelessness also need to be addressed.

Continuing education *is all about change. It provides opportunities for workers to work together to control what they learn and how they learn it. Confidence and self-esteem grow as abilities in planning, decision-making and problem-solving develop. They grow even more as new challenges are resolved successfully. Even though a lot of work is involved, sharing knowledge, experiences and friendship through* ***CE*** *is enjoyable, rewarding and fun!*

- **Better, more sensible and more practical use of scarce training resources**. Currently, millions of dollars are spent on workshops, seminars and training courses. Yet this has resulted in little improvement in the quality of health services provided by health workers.

  CE *is responsive and appropriate to the work and to workers' needs. Learning experiences are conducted that are practical and suitable for the particular situation. By conducting* ***CE*** *in the workplace, real problems can be discussed, acted on and followed up; and it costs less.* ***CE*** *can co-ordinate learning activities to identify proper target groups, avoid duplication and make clear how training and follow-up tasks will be shared out.*

- **Better opportunities for career advancement and upgrading**. Most personnel (human resource) policies reward long-time workers with salary increases and



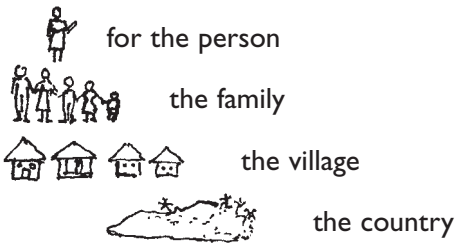
promotions regardless of how well they perform their jobs. Few health workers have the money or basic education required to enrol in formal educational courses to advance their careers. Prospects for advancement seem hopeless and there's little incentive for trying to work better.

Continuing education *can lead to recognition and to a qualification or an award that motivates workers to continue learning and performing better.* ***CE*** *can establish clear human resource development policies which say plainly what workers need to do to get to promotions, salary increases and career advances.*

- **Enabling and empowering of health workers to take charge and solve problems that affect their learning and working and the health of their communities**. Most governments and development organisations stress people's participation as the way forward, but the way it's practised may actually hinder people's progress. Participation can empower people to take charge and have control over their lives or it can be used to control and manipulate.

  Continuing education *can put principles and values of true participation into practice. Workers can learn participatory methods, approaches and attitudes. They can then apply these in different situations to help others gain control and become self-reliant in solving their own problems.*

HEALTH means SELF-RELIANCE

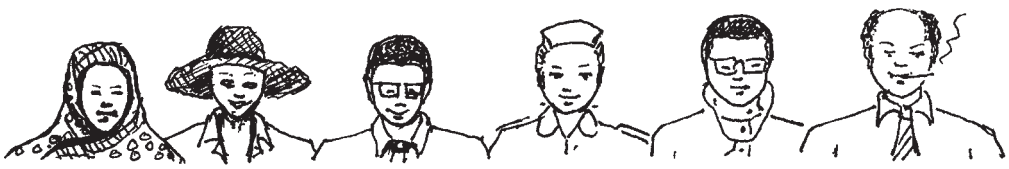


The healthy person, family, community or nation is one that can act for themselves – and can relate to others in a helpful, friendly way as an **EQUAL**.

Health workers' main job is to help people gain control over their health and lives – but they can only do that when they can do it for themselves first.

Continuing education **is a way for them to learn how...**

This booklet (along with the video called '*Continuing Education: The essence of participation*'[4]) shows what people can achieve when they are given an opportunity to take charge and to control learning and problems in the workplace. In Zanzibar, the impact of both ***continuing education*** and participation on health workers and on their work has been unique and successful. We hope our experience will convince you to try ***continuing education*** – that will ensure "A Life of Learning" that's interesting, challenging, rewarding and fun!

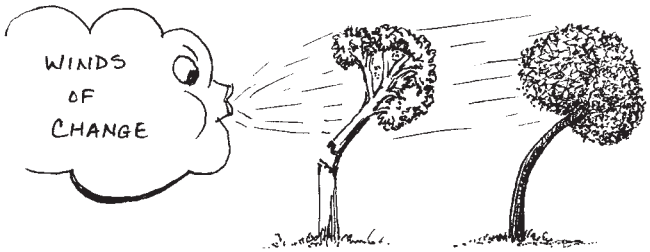


Continuing education enables us to control the way we learn and work.

4 To obtain a copy of the 20-minute video, submit requests to Save the Children UK at health@scuk.or.ke

Part 1
Continuing Education: Zanzibar-style

The world today is fast-changing, uncertain and unstable; and emergencies, politics, natural disasters and diseases can create chaos overnight. Those living and working in East and Central Africa experience these conditions almost daily and must constantly adapt to new situations. To adapt successfully, we must be able to change and make changes. Whether working in refugee camps, conflict zones, health facilities or government offices, workers need to be flexible and responsive in meeting life's unpredictable challenges.



Our knowledge is essential in meeting these challenges, but it is not enough. We also need strong people skills[5] that enable us to work with others in resolving challenges together. These abilities (technical and personal) aren't learned in classrooms, but in real[6] settings where workers have a chance to observe, share ideas, practise, experience and discover what works in their setting. In Zanzibar, we refer to this approach to learning as ***continuing education (CE)***.[7]

The ***continuing education*** used in Zanzibar is different from what people normally expect. Usually, they picture workshops and seminars that give information… and money. These are usually planned and organised by bosses[8] who have decided what workers need to know. But in Zanzibar, health workers (not bosses) decide what they need to learn and they organise activities themselves. Both approaches help workers develop, but only one develops *and* empowers workers. Enabling workers to control their own learning has had widespread effects that have made a positive difference in Zanzibar.

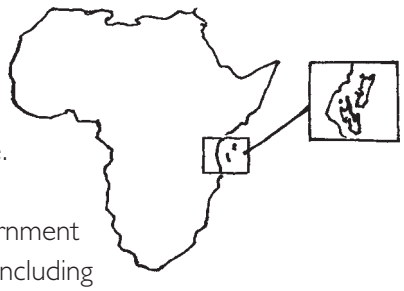
5 Skills such as being flexible, innovative, trustful, wise, confident and truthful.

6 'Real' refers to actual and real-life experience where workers live and work.

7 Remember, ***continuing education*** that is ***italicised in bold*** refers to the kind practised in Zanzibar.

8 'Bosses' refers to supervisors, managers and officials who make decisions for others.

About Zanzibar



Two small islands off the coast of Tanzania make up Zanzibar. The two islands are about the size of Swaziland and together have about 1,000,000 people. Tanganyika and Zanzibar joined in 1964 to form the United Republic of Tanzania. Many of Zanzibar's government structures are separate from those on the mainland including its own President, House of Representatives and Ministries (Health and Social Welfare, Education, Sports and Culture, Women, Children and Labour, Finance and Planning, Trade and Tourism, etc).

Until the mid-1990s, Zanzibar's development was similar to that of mainland Tanzania. However, in 1995 donor support was withdrawn from Zanzibar, and the provision of social services suffered greatly. The Ministry of Health, which relied heavily on donors, experienced serious constraints in providing adequate healthcare. The state of buildings and equipment declined, medical supplies became scarce, salaries stayed low and opportunities for training did not improve. As conditions worsened, so did the morale of health workers.

But things seem to be changing. With political differences mending and renewed interest by donors to revive Zanzibar's development and reform processes, the time of isolation and conflict seems to be over and healing can begin.

Since 1991,[9] the Zanzibar Ministry of Health has been developing a unique ***continuing education programme*** that is popular, successful and low cost. The basis for the ***CEP*** is **participation** – in both its learning methods and its management approaches. In ***CE***, health workers have regular opportunities to come together to take charge of and solve the problems they have concerning learning and working. Support of this unusual ***CE*** approach has brought many changes and unexpected positive effects. Over the past decade, the ***CEP*** has continued to respond, adapt and expand despite serious limitations and obstacles.

9 Before 1991 the continuing education programme was connected to the College of Health Sciences that conducted in-service workshops designed mainly for nurses.

Why a need for *continuing education*?

In 1991, the Ministry of Health (MoH) asked Save the Children UK (SC UK) to help revive the programme of continuing education for health workers. It would aim to:

- **improve the quality of work performance, health services and health workers' attitudes**
  CE would provide information updates and create opportunities for workers to upgrade their positions, especially workers without previous training. With ***CE*** options to learn and to advance at work, staff would not feel so desperate or hopeless, and as interest in work improved, so would morale and the health services provided.

- **improve and co-ordinate in-service training opportunities**
  In 1991 there were 12 MoH programmes each conducting their own workshops without any co-ordination among them. Back then, the same supervisors and managers were usually invited to the workshops with the assumption that information would somehow be passed down to workers. In reality, the supervisors and managers were constantly in workshops and workers hardly ever saw them. They rarely shared information. People were happy to attend workshops because the allowances were almost equal to a month's salary! Workshops for other workers were few and very expensive. Workers in hospitals, who were the majority, were rarely included in training sessions because the interest was in preventive healthcare. Non-professional workers (orderlies, drivers, office support, cleaners, laundry workers, cooks, etc) were never considered.

- **improve learning methods and materials**
  Workshops relied on lecturing and the curriculum was written and taught in English. All workers use Kiswahili on a daily basis and few are comfortable in English. It's no surprise that lectures were rarely understood or put into practice! The two medical libraries contained many books, but most were old and too technical for the average health worker.

Save the Children responded by sending an adviser [me] to work with the newly appointed Continuing Education Officer (CEO) [a nurse midwife with no formal teaching background which turned out to be a blessing!] and £5,000 to start up the new ***Continuing Education Programme (CEP)***!

Where to start

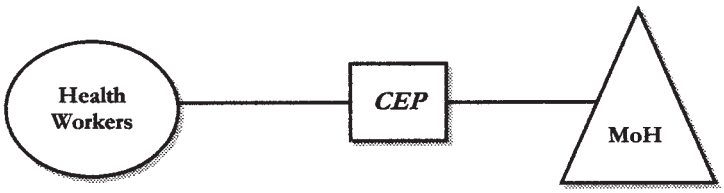
Getting started required finding out what MoH policies and human resource plans existed to guide the programme, but we soon realised that no policies, guidelines or data were available on health workers or training priorities. For the first few months, we actively looked for more information about the MoH, its organisation and its current training programmes. The CE Unit (CEO and adviser) interviewed every manager, supervisor and director to find out:

- the different kinds of health workers and their training backgrounds
- the relationships and lines of responsibility and authority in the ministry
- the views on how continuing education might work (with the present amount of funding).

Important findings that *CE* needed to address included:

- Over 3,000 staff were working in the MoH and more than 25 categories of professionals were identified!
- Most workers had low basic education qualifications that didn't meet entrance requirements for higher education institutions. Most were in careers that had no prospects.
- Most workers didn't know what the requirements of their job were. They were hired to do one thing, but ended up doing things beyond their experience or training. Also, a supervisor might give instructions to do something one way then another supervisor would tell them to do the same thing differently – whose orders should they follow?
- Professionals were trained in various foreign countries and had different ways of managing patients. Professional regulatory bodies that standardise training, qualifications and practices existed only in nursing.
- Most supervisors wanted to continue with workshops and seminars, but they wanted to include all professional workers, especially those in hospitals.

From the information collected, we identified key decision-makers, those involved with in-service training, and major issues for ***CE*** to address. Building the first MoH organogram (which all officials contributed to and agreed with) showed very clearly the lines of responsibility in the MoH and the Ministry's scope. We decided then that the ***CEP*** could also provide a link between health workers and Ministry decision-makers. But how could just two people do all these things?



How the approach to *continuing education* was adopted

As mentioned, the ***CEP*** consisted of the CE officer, an adviser, an office in the MoH (known as the Continuing Education Unit or CEU) and £5,000 to find ways to meet the educational needs of over 3,000 health workers [about $2.50 per person]! We knew the task was impossible if we followed the normal continuing education practices. We had to try something new.

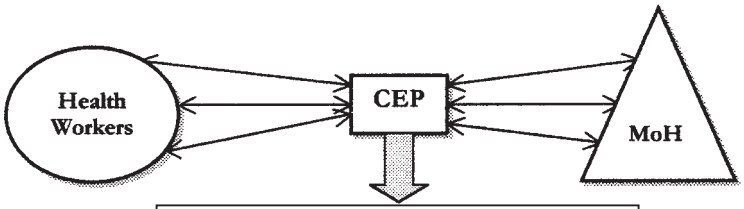
Luckily, at that time, the MoH was introducing health sector reform and community participation through community-based healthcare (CBHC). To work in a similar way to these initiatives, we decided early to use the principles of participation (see **Practical Pointer 2**) in our ***continuing education***. Since neither I nor the CE officer had ever been in a situation like this before, we decided to start by getting ideas from Ministry workers to see how we might set up the ***CEP***. We met first with MoH officials, and then with health workers to discuss their work problems and how ***CE*** might help them do their jobs better.

The biggest concern identified was workers' low morale, frustration and hopelessness. The next big concern was supervisors not recognising these problems and instead calling workers "lazy", "not smart enough" or "not caring enough" to do work properly. But workers' dissatisfaction was reasonable, for reasons such as:

- Few workers had chances for further education.
- Limited supplies and equipment in health facilities created difficulties in practising in the way workers had been taught.

- Workers did not know who made decisions about them (where, in what position and under what conditions they worked).
- Workers had little or no input into issues and decisions that affected where and how they worked.

From these discussions, we developed goals and objectives for the programme.

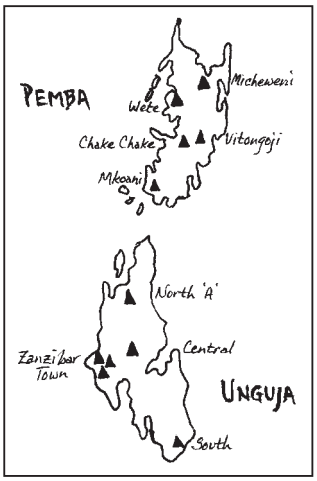


Goal

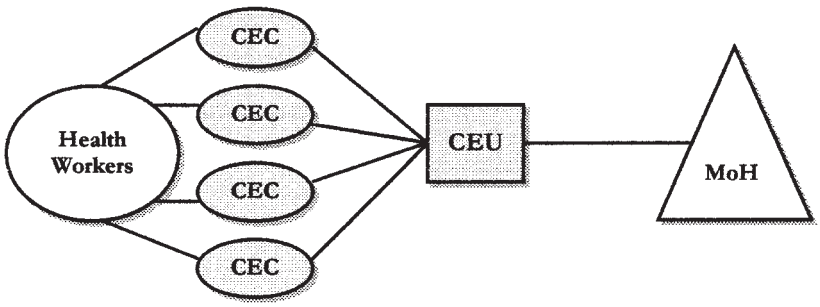
To provide educational opportunities to all health workers in order to improve their personal and professional growth that will in turn improve the services they provide to the Zanzibari people, especially women and children.

After gaining the Ministry's approval of the goal and the participatory approach, we returned to meet with health workers to discuss how best to begin. Initial discussions took place in all ten hospitals and health centres with department heads and supervisors. The discussions focused on:

- What is continuing education?
- In what ways can continuing education be provided?
- Who is continuing education for?
- Who's responsible for continuing education?
- What major problems do workers have in doing their work properly?
- Which of these problems can be solved through continuing education?
- What topics are workers interested in learning more about?



After several meetings discussing these questions, volunteers agreed to act as a link between health workers and the CEU in organising continuing education activities in the workplace. These volunteers became known as Continuing Education Committees (CECs) and were (and still are) based in health facilities throughout Zanzibar's two islands (see map). The ***Continuing Education Programme*** now consisted of the ***CEU*** and the ***CECs***.



During this starting-up period, we saw many advantages for the MoH in developing the CECs. We saw the CECs as:

- a way to organise regular educational activities for all workers in health facilities. Activities would meet their needs and interests and also be appropriate to local conditions and the resources available
- a resource for educating and for providing supportive follow-up after learning activities
- a skilled force (10–20 people) in each district that could be activated to plan, educate and manage other MoH or district functions using participatory methods
- an example of MoH initiatives in action (health sector reforms and decentralisation; CBHC and participation)
- a tool for quick contact or communication between health workers and the MoH.

These ideas all looked good in theory, but how could we put them and the CECs into action?

Starting up *continuing education* committees (CECs)

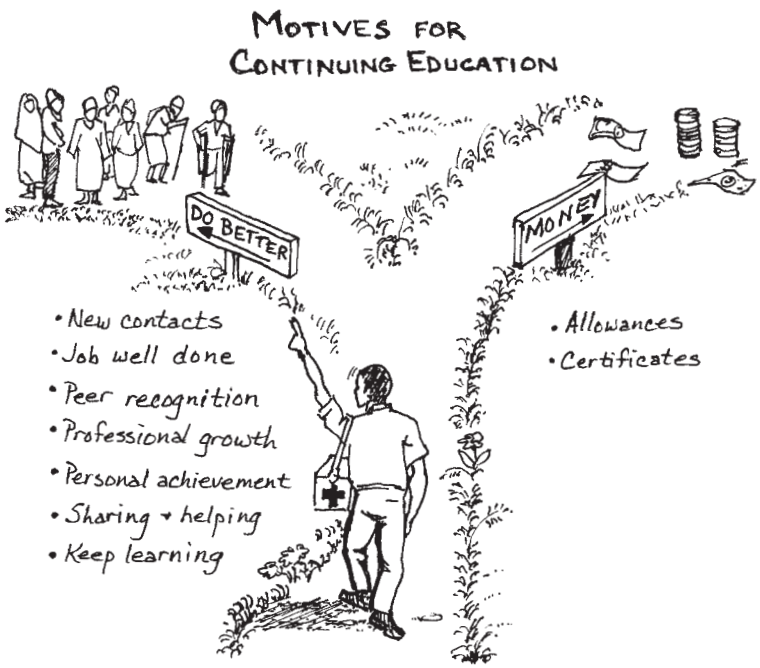
Once the CEC volunteers were identified, the CEU began working with them regularly in step-by-step processes. A summary of how the CECs began operating follows:

1. Deciding CEC membership and responsibilities

Each CEC agreed on its own criteria and rules for membership, how long officers would be in post and what their responsibilities would include. Each CEC has written its own charter and some have been revised after the CEC decided that changes were needed.

Some CECs have up to 20 members; others have between 5 and 10. Members are nurses, doctors, pharmacists, laboratory staff, health officers, orderlies, dentists, MCH aides, x-ray technicians, repairmen and other support staff. Anyone interested in ***continuing education*** *can participate.*

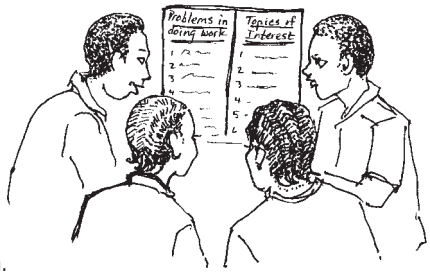
Initially, mainly supervisors and heads of departments were appointed to the committees. But as work and responsibilities increased, many CECs made membership and rule changes. Opportunists dropped out early and were replaced by others more interested and more committed to learning to help others learn.



"Start with a committee that is not too big or not too small. Members must have commitment. No limitations of numbers. Anyone who wants to be on the committee should be allowed to be. Members should not be appointed but chosen as representatives from each department or group."

Saidi, nurse and CEC member – Chake Chake

2. Determining workers' learning needs and interests



CEC members used different methods to find out what problems workers faced in doing their work properly and what they're interested in learning more about. Interviews, questionnaires and group discussions were used to collect information. CEC members close to certain groups of workers were responsible for collecting information from their co-workers.[10] Once the data were collected and analysed, the CEU helped prioritise general needs for the district and also needs of specific groups of workers. From these priorities, the CEC had to decide which ones would be addressed first.

"You can't start anything unless you have found out what the problems and their background are. To find ways of how to solve them and then ask the question 'can it be solved by training?' is a way to start…."

Salma, nurse and CEC member – South

"If you address the problems and the interests of a group, you will be more successful in your programme. If the participants don't feel it's a problem that concerns them or doesn't interest them, then you're wasting your time."

Juma, lab technician and CEC member – Mkoani

"We now know the roles and activities of different professions other than our own and can now relate to and appreciate their problems."

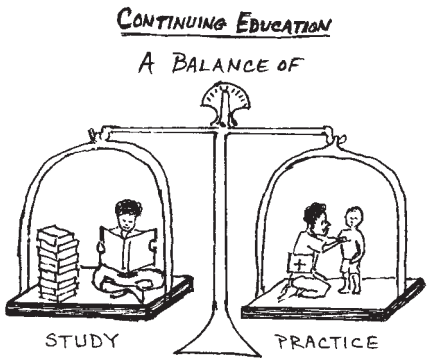
Saada, nurse and CEC member – Micheweni

Based on this assessment, the top priority for all CECs was English! Since it became the CECs' priority, the CEU's priority has become finding ways of teaching English in each area.

10 Some supervisors who were members of the CECs were given the task of collecting information from their workers (ie nurses and orderlies), which sometimes did not work well. When differences in education or hierarchy are too big, workers can be easily intimidated and responses can be manipulated.

3. Initial training and planning with the CECs

Most training consisted of on-the-job meetings with each CEC to plan step-by-step. We discussed and practised different learning approaches;[11] and we planned the first ***CE*** activities, which included preparing budgets. Development of the activities needed to broaden thinking and practice was emphasised. Activities were implemented and feedback was given. Then the planning process began again for the next activity on the priority list. When each CEC felt comfortable to plan on its own, the CEU slowly began removing itself from the planning process and became the 'learning adviser' who reviewed and approved ***CE*** plans.

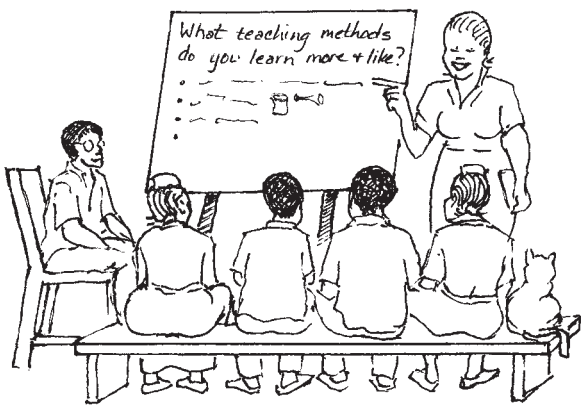


*"Participating in organising **CE** activities has widened the capability of CEC members in doing planning processes in their wards, departments and communities."*

Dr Mkoko, ZMO and past CEC member – South

4. Implementing *continuing education* activities and feedback

When the CECs conducted their first activity, times were arranged when the CEU and other CECs could attend and give feedback. This provided an opportunity to try new and unfamiliar methods (role-play, facilitating groups, problem-posing sessions, clinical rounds, on-site visits) in a trusting environment. If other people were conducting an activity, the CEC provided a guide to key issues to address with groups. After each activity, feedback was given that included ideas for improving future activities. As the CECs gained confidence in conducting activities, they increased plans to include



11 At this stage, *Helping Health Workers Learn* was a vital tool for all of us to learn better ways of educating others.

activities for a month… then a quarter (three months)… then a half year. Finally, they produced annual plans and budgets!

"When doing an activity, it's like a refresher course for the teacher and learner. The facilitator has to do research and learn more about the topic than the participants."

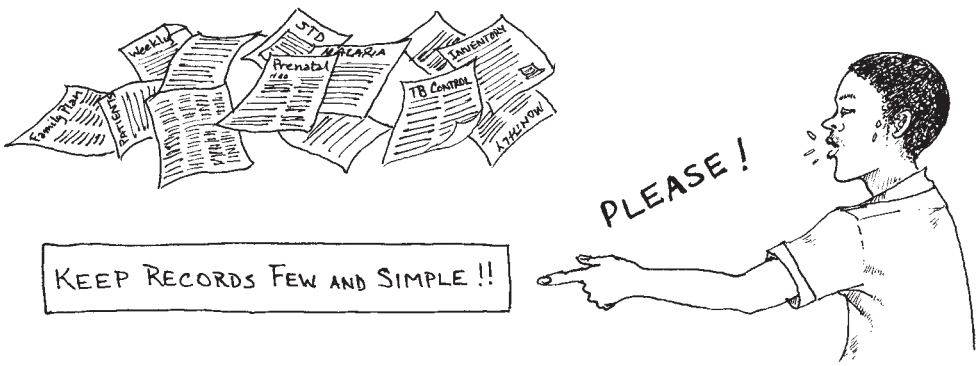
Suleiman, nurse and CEC member – Mental Hospital

*"**CE** makes all who participate feel important, not like some workshops that tell you to do this and this and this…"*

Fatma, MCH aide and CEC member – Vitongoji

5. Reporting and managing *CE* activities

While planning with the CECs, questions came up on record-keeping, acceptable costs and allowances and proper documentation. Guidelines were needed for using and managing ***CE*** funds and reporting ***CE*** activities. The CEU developed guidelines and formats for reporting that would satisfy both MoH and donor requirements yet not involve too much extra work by the CECs. These guidelines are still in operation and few changes have been needed over the years.



6. Funding the CECs

At first, it was easy to pay for expenses for approved plans from ***CEP*** funds because each activity's cost was between 10,000 and 15,000 Tanzanian Shillings (TSH) (about $15–$20). But as the CECs began planning activities on a monthly and then a quarterly basis, the $5,000 per year would quickly be spent. The CEU either had to find more funds or limit how much CECs could spend in a quarter. We ended up doing both. (More about this later.)

What the CECs have been able to do

As the CECs gained more confidence and competence, they looked beyond the health facility for improving ***continuing education***. Along with the regular clinical sessions with health workers, they began collaborating with others (MoH programmes, other CECs, health providers in the traditional and private sectors, other ministries, non-governmental organisations [NGOs] and community groups) in order to find better learning experiences and 'specialist' resources. Activities and linkages developed from these relationships, and ***continuing education*** now includes others who are working to improve people's health. Over the years, CECs have conducted various ***CE*** activities and joint initiatives (see box) for health workers to learn throughout the year.[12]

Conduct district activities

Every year the CECs develop a learning priority list based on supervisor reports, MoH initiatives and health workers' interests. From this list, various activities are planned to meet the needs of specific groups. To keep costs low, many activities are held during working hours. Most CECs have meetings at weekends or during the holidays so that they have enough time to cover topics and discussions. No interference with work responsibilities occurs.

Once the CECs were comfortable in facilitating ***CE*** activities, the task of following up learners was introduced. The CECs now co-ordinate with supervisors and health management teams (HMTs) to follow up and monitor workers after training.

Continuing education activities in districts

- On-the-job practice
- Clinical rounds
- Site visit
- Lecture and discussion
- Work exchange visit
- Visiting consultant on patient management
- Survey and research
- Resource centres
- Topic modules
- Group discussions
- Case studies
- Staff meetings
- Short courses
- Reviews
- Problem-solving
- New tasks or duties
- Building pit latrines
- Inspections (schools, cafés, wells, pharmacies)
- Income-generation
- Health education in communities
- Working with village health committees and other sectors on health problems

12 Remember that CEC members have full-time MoH responsibilities and that ***continuing education*** is done on a part-time, voluntary basis.

All ***CE*** activities are reported quarterly to the CEU (including plans, activity reports, monitored changes and funds used in each of these areas).

*"**CE** is able to identify problems and priorities better than others who are far away when they plan. It is very close to health workers and resources are available for appropriate learning activities for the appropriate health workers – the parent knows more about the situation in the house than the neighbour living far away."*

Issa, nurse and CEC member – Mkoani

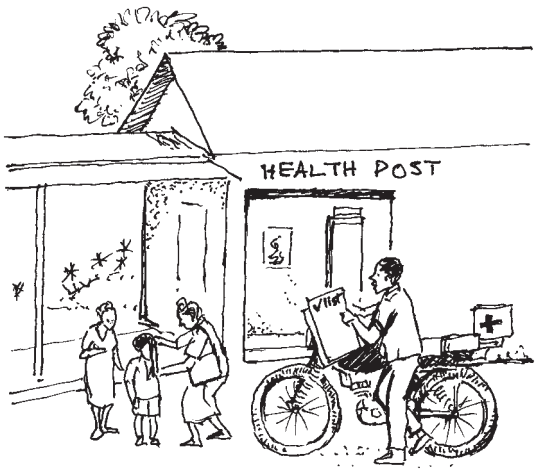
"Some have expanded and learned new skills in areas outside of their profession (ie nurses becoming prescribers, orderlies giving injections, sterilising equipment and changing dressings). Learning and practising new skills and taking on new responsibilities makes you feel more professional and that you're moving forward."

Ali, nurse and CEC member – Central

Provide supportive follow-up with health management teams (HMTs)

Early on, we realised that following up health workers after training is just as important as the training itself. For every learning activity, CECs identified expected outcomes or behaviour changes that should occur after that activity.

During regular follow-up visits, the facilitator, CEC or HMT member would check if there had been changes in practice. Some CECs developed checklists to observe specific practices or to discuss certain study or community assignments given during a training session. The CECs budgeted monitoring activities into their activity plans. These follow-up sessions are also a way of discovering problems (such as lack of supplies) that prevent workers from doing what they've been taught, and finding ways of resolving them.



"We prepare a plan of work to be a guidance for follow-up with district co-ordinators, supervisors and the CEC (usually by watching staff from what they were doing before and what they are doing now) to find out the impact of our training."

Mahmoud, radiologist and CEC member – Wete

"We collect evaluations from the departments annually to see what kind of improvements have been made over the year and what problems or failures persist."

Ashura, librarian and CEC member – Mnazi Mmoja Hospital

"People are happier with this approach in the long run, especially in the area of follow-up, since many may be involved in sharing the responsibility that makes all of their jobs easier ."

Saidi, CE Officer – Pemba

"Follow-up has been less than optimum…but when monitoring has been done with checklists and feedback to health workers, they have changed the way they practise to what they were taught."

Dr Moh'd, past ZMO – Pemba

Develop health learning materials and manuals

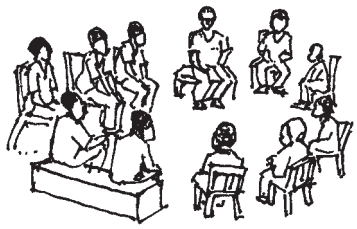
To help standardise how specific groups of workers would perform certain practices or procedures, the CECs developed and printed learning materials for training sessions. Those materials covering a series of sessions and those needing changes in current practice were particularly important. The CEU provided funding and support for producing the materials once draft materials had been tried and revised by the facilitators and CECs.

Examples of materials developed include 'English for Health Workers', 'Basic Acupuncture and Moxibustion', 'Orientation for Health Orderlies', 'Basic CPR' (cardiopulmonary resuscitation) and 'Guidelines for Resource Centres'.

"Management guidelines for cerebral malaria, meningitis, anaemia and heart failure have been drawn up with prescribers; the quality of care for these conditions is much improved."

Nassor, nurse and CEC member – Micheweni

Conduct zonal meetings[13]



There are too few of some types of health workers to conduct district sessions just for them (ie those working in laboratories, x-ray, pharmacies). The idea was proposed for them to meet every quarter on each island, and it was accepted. Meetings have included practical experience, agreements on best practice, discussions on professional issues and sharing ideas and resources. Each group submits quarterly and annual zonal plans to the CEU for direct funding.

Over time, other health worker groups (nurses, health officers, medical assistants) began conducting zonal meetings. These meetings often included professionals or organisations from outside of Zanzibar.

Laboratory technicians have standardised procedures and reporting of specific laboratory tests (especially for malaria and anaemia). They have also learned new procedures (HIV testing), and they have co-ordinated supplies and equipment through zonal meetings.

Health officers have developed guidelines for inspecting people who work with food and in services providing food, and for water and sanitation safety. They have learned more about community health education and school health. They've also discussed how health assistants can be upgraded to health officers, and other career issues.

> *"Everyone (x-ray technicians) used to do everything on their own, but now we know what each other is doing and we can help each other and work together as a team."*
>
> Makame, radiographer and CEC member – Mkoani

> *"Professional groups on the island have been able to come together to combine resources so that their services have expanded and improved."*
>
> Saidi, pharmacist and CEC member – Chake Chake

Organise national meetings[14]

As the zonal meetings progressed, the need arose for the two island groups to come together to discuss and resolve common issues. Proposals for national meetings were submitted to the CEU for approval and funding. Meeting reports, with a list of

13 A zone in Zanzibar is the island of Unguja or Pemba; it is similar to a region in mainland Tanzania.

14 'National' refers to Zanzibar only (Unguja and Pemba islands), not mainland Tanzania.

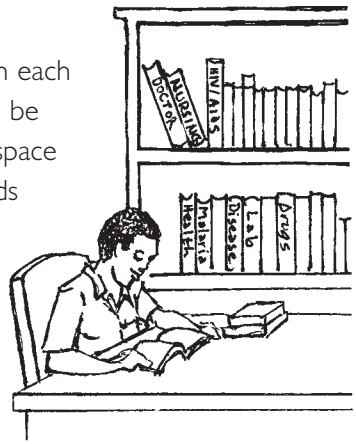
recommendations from the particular professional group, were submitted to the MoH for consideration.

As a result of these meetings, standards of practice, professional issues and ways of improving professional services have been discussed and approved. Recommendations have been formulated that have provided a basis for discussion in the MoH.

Radiographers recommended a list of safety devices for staff and supplies that would ensure better x-ray results. All were approved and obtained by the MoH.

Nurses developed a list of rights that started negotiations with the Ministry.

Establish and maintain resource centres



When the ***CEP*** started, only one health library existed on each island. Much of the material was old and too technical to be much use to the average health worker. CECs obtained space in each hospital and health centre, and they used ***CE*** funds to buy equipment for the resource centres (also used as teaching areas). Resource centre assistants were chosen and trained in setting up and managing the centres. Each year, the national health librarian visits each assistant to give support and to recommend ways of improving resource centre services.

CECs want useful and understandable health materials, but don't know what's currently available. The CEU provides current publication catalogues (ie from TALC, AMREF, WHO and ELBS) to the CECs to give them ideas and information on the price of books, newsletters, magazines, videos, slides and other learning materials. Each CEC chooses and submits a priority list of resources for general use and for specific professions that the CEU tries to provide (depending on the budget). Every two years, new orders for learning materials are submitted.

"We now have a library and health workers come here to read instead of sitting down and doing nothing."

Zuhura, midwife and librarian – Micheweni

"The new library is used by different kinds of workers in the hospital and even some recovered patients."

Baru, nurse and CEC member – Mental Hospital

Link and network within and outside the MoH

Initially, CECs asked doctors and other health experts from MoH programmes to conduct training sessions. When they began to know and understand each other's work, they discovered experts among themselves and began using each other as resources (eg nurses and medical assistants being taught family planning by MCH aides). Sometimes, the Ministry didn't have the expertise needed, so CECs approached other ministries, professional bodies, NGOs and other groups to help conduct their activities.

> *"One of the CECs' most important roles is to work with the MoH and other ministries and programmes in finding the most appropriate teachers and resources for conducting learning activities."*
>
> Abdulla, nurse and CEC member – Chake Chake

Ambulance drivers wanted more information on road safety, vehicle maintenance and first aid, so local police officers, mechanics and emergency nurses were recruited to conduct sessions.

> *"Now I can go to other areas of the country and know who to contact for help either professionally or personally."*
>
> Fatma, midwife and CEC member – South

Work with other health providers in the district

Most people seek the services of traditional healers or traditional birth attendants (TBAs) before visiting public health clinics. The CECs realised that for services to improve, traditional providers also needed ***continuing education***. Most of them were afraid to be identified, but the CECs did outreach work and planned ***CE*** activities just for them. This has resulted in more openness and sharing information between traditional and MoH providers that benefits patients. With more private hospitals and clinics, the opportunity for extending ***continuing education*** to other providers shouldn't be ignored.

> *"TBAs are not afraid to bring mothers to the hospital like they were before. They usually accompany the mother to the clinic and tell workers what has*

happened. They use the knowledge from seminars to treat and refer mothers earlier if problems occur. We sometimes follow up some mothers with difficult deliveries together."

Hamida, MCH co-ordinator and CEC member – North 'A'

*"Through **CE**, we have discussed issues with traditional healers and they now refer patients to the clinic for assistance. Presently, they feel very comfortable to come to the hospital with their patients and even do local treatments in the hospital. The relationship and co-operation is still very good."*

Mohammed, paediatric nurse and CEC member – Micheweni

Conduct community health education

Once CECs started making contacts outside the health facilities, they received requests from schools, village health committees, other ministries and NGOs to educate groups on a variety of health topics. This led to CECs building stronger links with teachers, village leaders and extension workers to help address various health problems.

The Mnazi Mmoja Hospital CEC taught CPR and first aid not only to their staff but to Red Cross volunteers, army medical staff and some private businesses.

Drug and substance abuse was taught in secondary schools and to young people not in school in some communities resulting in young people bringing in friends for detoxification.

Work with communities on health problems

The CECs have been able to detect health problems earlier and reach communities faster than MoH programmes. They have had regular contact with local health workers, traditional healers, village health committees, NGOs, school committees and other ministries; this has created a very reliable network for notifying each other when problems arise. In cases of emergency, CECs are flexible and can change plans and use funds to initiate action while informing MoH officials of the situation.

Requests for CECs to teach about HIV/AIDS and STDs in secondary schools led to further discussions with village, school and religious leaders on early teenage sex and its

problems (pregnancy, expulsion from school, STDs). They then planned ways to address the problem.

> *"**CE** has made staff aware of helping each other where and when problems arise. When dysentery broke out, they [CEC] came to help assess community problems and provide household information and education that shortened the duration of the epidemic."*
>
> Dr Hassan, DMO and CEC member – South

Generate income

To have more funds available to carry out ***CE*** plans and be less dependent on donors, the CECs began taking on new projects. In 1998, CECs in rural areas began contracting their services to a local NGO who asked them to work with communities to plan and organise annual 'Village Panorama' days that included games, plays, songs, a children's programme, health information, videos and group discussions. In 1999, they began selling mosquito bednets and insecticide from health facilities – with the option of paying by instalments. Half of the profits they make go towards community health projects ($0.20) and the other half goes to the CEC ($0.20) to pay for materials or expenses that can't be paid for by the CEU.

Since 1999, the CECs have sold over 5,000 bednets bringing an extra $2,000 to CECs, and also decreasing the risk of malaria for probably more than 10,000 people. Sessions on

treating nets with insecticide are held in health facilities where people can buy nets and insecticide by monthly payments.

Latrines and covers for wells have been built using profits from the sale of mosquito nets in some communities.

CECs have used profits to obtain supplies for learning aids and resource centres and to fund follow-up activities.

CECs have been a valuable and inexpensive resource for NGOs and researchers who want to be introduced to key contact people in a community or district.

To summarise, *CECs* have been able to:

- conduct district ***CE*** activities
- provide supportive follow-up with HMTs
- develop health learning materials and manuals
- conduct zonal ***CE*** meetings
- organise national ***CE*** meetings
- establish and maintain resource centres
- link and network within and outside the MoH
- work with other health providers
- conduct community health education
- work with communities on health problems
- generate income

How the CECs have developed

From the beginning, the CECs' role has constantly been changing as members' abilities, interests and relationships have developed. After ten years of working in ***continuing education***, the present roles and responsibilities of CECs are summarised in the box.

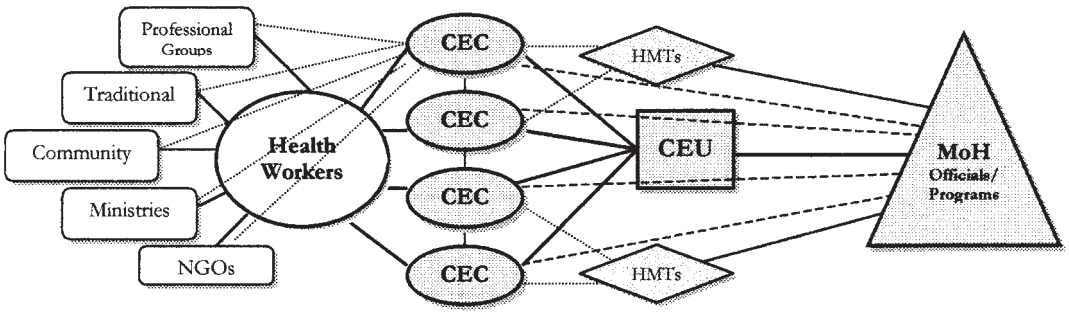
Roles and responsibilities of continuing education committees

1. Identify health and learning problems, then determine priorities.
2. Plan and organise activities to resolve priority problems.
3. Carry out activities according to plans.
4. Manage and administer ***continuing education*** activities, finances and materials.
5. Monitor changes in health workers' performance resulting from ***CE*** activities.
6. Evaluate the impact of ***continuing education*** on workers and the healthcare services they provide.
7. Explore other means of gaining support for ***continuing education***.
8. Involve others in resolving health and learning problems.

Notice that 'identify health and learning problems' in point 1 is not restricted to health workers or facilities. Since the CECs chose to extend ***continuing education*** into communities, others have become involved in improving the health situation by:

- creating supportive relationships among different types of health workers, among CECs, and among groups in the MoH and groups outside of the MoH
- sharing ideas, information, abilities and resources regularly to find ways of resolving health problems
- building people's capacity to plan, implement, monitor and manage ***continuing education*** activities that respond to health needs and benefit the people they serve.

The following drawing shows the connections built by the ***CEP*** (CECs and CEU). Notice that CECs now communicate directly with MoH officials and programmes instead of relying on the CEU to act on their behalf.



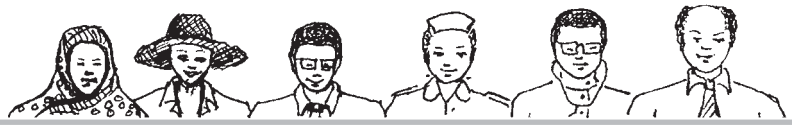
Without the CECs progressing as they did, the CEU would have had little to do. But the CECs actually grew more than we could have imagined. To deal with the growing number of activities, requests and demands from the CECs and MoH, we needed a different approach to managing the ***CEP***.

How the continuing education unit has managed

When the CEU started, we were new to this kind of situation (few funds, no policies or guidelines, only two people) and we knew that normal ways of continuing education wouldn't work. We thought that by using participation we could involve others, but didn't know any examples of others using participation in continuing education. So, with our limited resources and limited experience with participation, we decided to find people who were willing to help us develop ***continuing education*** by organising committees. Fortunately, many health workers in all areas were interested and volunteered to serve on CECs.

Even though the CECs started slowly, they soon realised what they could do and began to try new activities. The CEU needed new tools and systems to manage the growing programme. We used participation in all aspects of our work. This created an open, friendly and flexible working atmosphere. In responding to growing programme needs, the CEU presently carries out the functions listed in the box opposite.

As the CECs grew, so did the CEU. The unit that started with two officers now has four and also a zonal office on Pemba. The adviser left in 1995, but with SC UK funding the CEU has been able to continue its work.



Continuing education unit management functions

1. Providing technical assistance – effective learning and participatory approaches
2. Monitoring and reporting ***CE*** activities
3. Co-ordinating ***CE*** activities
4. Producing/obtaining learning materials
5. Financing and resourcing the ***CEP***
6. Influencing MoH policies related to human resource (personnel) development
7. Evaluating the impact/effectiveness of ***CE***
8. Networking with others involved in ***CE***

The CEU's main task has been to create and maintain a supportive environment for changing the way people learn and work. The programme builds people's capacity, responds to their needs, appraises and advises them and invites criticism and suggestions. The benefits have been felt by both the CEU and the health workers. They have supported each other in building a programme based on trust, respect and friendship!

In the CEU we had to develop new skills and talents to meet the demands of a growing programme. These demands included the need to gain more technical information (ie on human resource development, management, continuing education options) and also to develop and refine ways of communicating with and relating better to people. By learning new communication skills, we took on new roles and found ourselves wearing many different 'hats'. For example, we became:

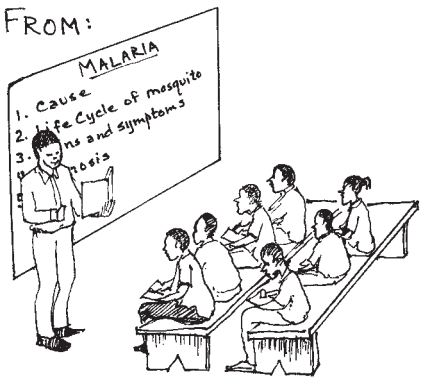
- **advocates** for the ***CEP*** and participation
- **facilitators** to bring out the ideas of others
- **critics** of bad practice, and the misuse and abuse of people or things
- **supporters** for those doing good planning and practice
- **students** of other people's creativity, innovation and initiative
- **advisers** who suggest alternative ways of doing things
- **negotiators** to bring two sides together.

Most of the time we found ourselves wearing several hats at the same time depending on the situation. By taking on these roles, the CEU has been guided by health workers on all levels to carry out the current CEU functions of:

1. Providing technical assistance and support

This assistance and support are not just for CECs, but for MoH programme trainers and other officials involved in training and development (HMTs, supervisors, in-charges,[15] department heads and managers). The CEU has provided education, information, advice and support to them by:

- Introducing, advising on and practising participatory methods and approaches (See **Practical Pointer 2**)



15 Refers to a group of health workers who are in-charge of health clinics.

- Conducting training and courses to promote better learning and meet learning needs (ie adult education methods, basic financial management, planning for learning needs and training of trainers)
- Reviewing plans and advising on better learning activities (other than workshops or lectures) by helping identify needs and target groups, planning activities (including more study and practice) suitable for the target group, finding suitable resources and recommending time frame and duration (See **Practical Pointer 3**.)

- Providing on-the-job training and advice on issues related to monitoring and follow-up of ***CE*** activities, reporting and finances, management issues, and solutions to urgent problems
- Informing health workers of decisions/changes in the MoH that affect them (ie new guidelines for practice and training, new initiatives or policies, new structures or personnel changes).

The CEU helped facilitate two six-week international training of facilitators (ToF) courses with participants from many sectors and most countries in the East Africa region.

"More MoH programmes are moving to the participatory methods, but there are different levels of participation. Most are still using lecture methods, but they use participation in planning, identifying needs and even in follow-up, so there is a change."

Dr Moh'd, past ZMO – Pemba

2. Monitoring and reporting *CE* activities

The CEU is responsible for collecting ***CE*** activity information from all CECs and MoH programmes every quarter and bringing it together in a quarterly report. Information collected includes the topic or type of activity, its objectives, who participated and who facilitated it, expected outcome or changes in behaviour, and costs. Also, information about changes in practice and behaviour resulting from previous activities is collected from the CEU's follow-up visits and then added to the quarterly report. Quarterly ***CE*** reports are brought together in annual ***CE*** reports that are distributed throughout the MoH. To collect this information, the CEU conducts the following quarterly activities:

- **CEC visits** – the CEU meets with each CEC at least once every quarter to:
  1) review and discuss the previous quarter's activities and progress report
  2) advise on methods or problems
  3) discuss follow-up activities and changes noted
  4) check costs and receipts
  5) discuss, advise on and approve the next quarter's plans
  6) inform of new changes in the MoH
  7) top up[16] funds.

  Each visit takes no less than half a day and CEC members are present throughout to verify and to contribute to discussions.

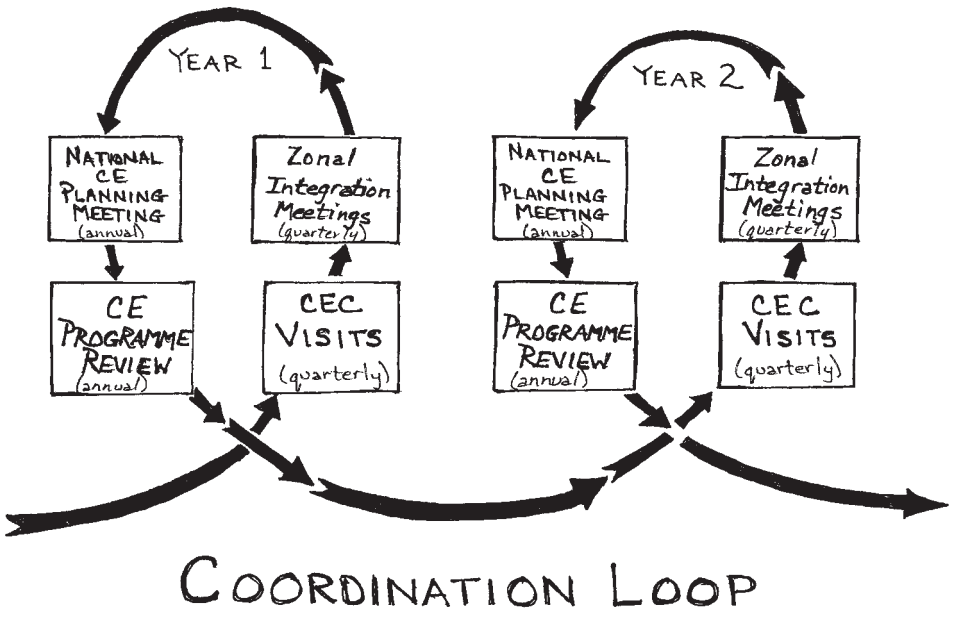
- **MoH programme integration meetings** – the CEU meets with programme managers or trainers and HMT representatives to review the past quarter's activities, to discuss issues arising from implementing training plans and to discuss and co-ordinate the next quarter's training and follow-up plan. Problems of timing, duration, target groups, teaching approach and topics are often discussed, as well as sharing resources and finding ways to monitor and evaluate changes which result from training. By the end of the meeting, HMTs have approved ***CE*** activity and follow-up plans for their district or zone for the next quarter. Both HMTs and the CEU are responsible for informing CECs of future events so they can make arrangements with programme trainers directly. Information gained from this meeting goes into quarterly ***CE*** activity reports.

16 This refers to increasing the balance of funds that remains from ***CE*** activities in this quarter up to the level that has been agreed for each CEC for each quarter's activities. It is also referred to as 'buying back' receipts that are acceptable from the approved budget activities. More detail in 5. Financing and resourcing the *continuing education programme*.

3. Co-ordinating the *continuing education programme*

Since the ***CEP*** operates on different levels and in many dimensions, the CEU found or created different ways to not only co-ordinate ***CE*** activities, but also to co-ordinate information exchange between health workers and the MoH. Various meetings are now held to exchange information among those involved in ***CE***:

- As mentioned above, there is district co-ordination with CECs during quarterly on-site visits.
- District, zonal and national programme co-ordination takes place at quarterly training integration meetings.
- These activities don't allow sharing between zones or allow CECs to input directly into programme training plans. And so the purpose of the annual ***CE*** planning meeting is to bring everyone together to let them discuss ***CE*** problems and future plans. At the end of the three-day meeting, the CECs, programmes, HMTs, donors and the MoH have a chance to review and discuss the previous year's successes and problems, to plan how to resolve them, to hear what CECs and programmes are planning for the next year, and to find ways to co-ordinate activities.
- When the new ***CE*** plans and budget have been finalised from the national meeting, a ***CEP*** review is conducted with MoH officials, HMTs and donors. They discuss the previous year's programme activities and the direction for the coming year. CEU and ***CE*** plans are reviewed, revised and approved as a result of this meeting.



COORDINATION LOOP

- The CEU also represents the ***CEP*** in other MoH meetings and affairs. We have contributed in departmental meetings, donor co-ordinating committees, programme reviews, policy and guideline development (on human resources, training), curriculum development (for community health nurses, HMTs), committees formed for specific purposes, and taskforces. We also bring concerns of health workers to the Ministry for consideration, especially to clarify personnel issues such as criteria and decisions for transfers, higher education or promotions, and differences between job descriptions, actual work duties and salaries.

  "By the CEU working with other MoH programmes, there has been reduced spending and less duplication of training activities. Also, improved co-ordination and monitoring of these activities have allowed for better allocation of the few resources available for training."

  Dr Uledi, Deputy Principal Secretary – MoH

  "The CEU, using participatory approaches, is a management co-ordinating tool. It co-ordinates between the workers and the Ministry. It plays a very important role."

  Dr Omar, Principal Secretary – MoH

4. Producing, obtaining and distributing learning materials

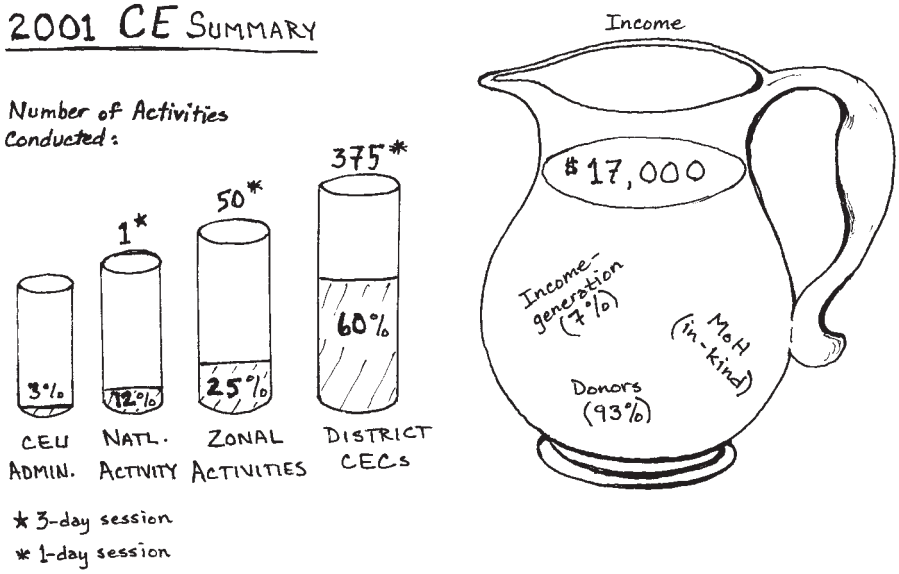
The CEU acts as a 'clearing house' for health workers to access current learning materials. This means that it searches for, enquires about, obtains, begs, subscribes to, reproduces and distributes materials requested by CECs for resource centres. It also revises, edits, advises on, produces and distributes learning materials developed from specific ***CE*** activities that can be used by other groups. It also develops, contributes to, reproduces and distributes MoH curricula, documents and reports related to ***CE***.

Resource centres have been established and maintained in all ten hospitals and health centres.

The CEU started the development of the community health nurse course and supported its implementation. It also contributed to the development of the international ToF course, the clinical teacher course and a number of HMT modules.

5. Financing and resourcing the *continuing education programme*

Soon after the CEU was established, a rule was made that its administrative costs would not be more than 20 per cent of the total budget. The other 80 per cent would be distributed for conducting ***CE*** activities, mostly to district CECs. Activities at district, zonal and national level increased, and more funds were obtained from other donors and from several income-generating schemes. The CEU opened its own bank account (and encouraged the CECs to open their own accounts, too) so funds could be monitored and controlled directly.



*In ten years, the CEU has never spent more than 15 per cent of the budget on **CE** administrative costs. In 2001, administrative costs were less than 5 per cent.*

*In 2001, over 95 per cent of the funds were used for **CE** activities in districts (where over 375 one-day sessions were conducted), in zones (where over 50 one-day sessions were held) and nationally (for one three-day meeting).*

*Donors contributed 93 per cent of the **CEP**'s operational costs in 2001; the other 7 per cent was produced by the CEU through the sale of bednets and consultancy services to NGOs.*

- **Funding CECs** – Allocating funds to CECs needed a new financing system. It is based on a CEC's average level of quarterly activity, its future plans and how much money is 'in the pot'. A limit (or ceiling) is negotiated with each CEC of how much money will be available for them each quarter to implement approved

plans. At the end of each quarter, the CEU follows up each CEC to review activities and expenses. If all is in order, expense receipts are bought back and the funds are topped up to their original amount. In this way, CECs do not have to refund the money remaining at the end of a quarter and activities can continue without having to wait for funding.

Most CECs have quarterly limits of between TSH 100,000 and 200,000 ($150–$200). The limits or ceilings are reviewed each year or when a CEC asks for them to be reviewed.

*If CECs cannot implement **CE** plans, the same funds and plans are used for the next quarter. Funds allocated for that quarter remain in the CEU account for redistribution.*

*The CECs, professional groups, MoH programmes, HMTs and other groups of health workers can submit proposals for additional **CE** activities to the CEU for funding.*

- **Funding zonal and national meetings** – Special working groups or professionals submit proposals to the CEU for funding their activities annually. If not enough funds are on hand, the CEU asks other donors to support these specific activities.
- **Donor support** – In the past, the CEU wrote proposals to support various ***CE*** activities at different levels and submitted them to DANIDA, GTZ, the Aga Khan Foundation, Action Health, VSO and UNICEF. Luckily, the donors had different financial years so when funds ended with one, they would continue with another. But for each organisation there were different reporting requirements. Over time, common formats for proposals, plans, budgets, and progress and financial reports were developed and agreed upon in order to satisfy everyone. In this way, transparency was assured through regular ***CEP*** reports and accounting which informed stakeholders how and where their funds were being spent.
- **MoH contribution** – Even though ***CE*** appears yearly in the MoH's training budget, it has not yet received any operational funds to support the programme. It does support ***CE*** in the form of salaries, office maintenance and transport, but the rest of ***CE*** is totally dependent on donors. To make sure that the ***CEP*** survives, we are working to establish a separate Ministry budget line for ***CE*** and to put ***CE*** in district health plans.
- **Income-generating activities** – Over the years, the CEU has raised extra funds for the ***CEP***. Recently, the CEU and CECs began selling mosquito nets and insecticide for a small profit of less than $0.50 per net which is divided between the CEC and community health projects.

*The CEU has helped facilitate two six-week training of facilitators courses and has provided consultancy services in planning, facilitation and community organisation that have earned money for the **CEP** and promoted participation.*

The CEU co-ordinates between a local NGO and CECs to organise a yearly 'Village Panorama' with village leaders for a day of health education and entertainment in certain communities.

The CEU co-ordinates and monitors the buying and distribution of mosquito nets and insecticide.

6. Influencing policies related to human resource development

By participating in various committees, taskforces, reviews and studies, the CEU has influenced MoH policies and guidelines that affect health workers' development and advancement. Also, through its unique approach, the ***CEP*** has influenced other organisations to review and change their policies. Examples of the CEU's influence have included:

- **The diploma course for community health nurses** – The CEU worked with the Zanzibar Nurses Association (ZANA) to develop the problem-based curriculum and to help gain affiliation status with AMREF and recognition of CHNs in the civil service. The CEU has provided technical support to ZANA throughout the implementation of two courses.
- **Health sector reform** – The CEU contributed to the first health sector reform processes in human resource development in 1995 and has participated in producing the current revised document. It has also contributed to developing HMT training modules.
- **Training guidelines** – The guidelines were developed in consultation with and through agreement between CECs, MoH programmes, HMTs and the CEU to give recommendations on better co-ordination and implementation of training activities on all levels.
- **Government of Zanzibar** – In 1995, the ***CE*** model was accepted by the Principal Secretaries who then adopted it as a national programme. The programme would be implemented through the civil service reforms to bring uniformity of ***continuing education*** in the public sector.
- **Other organisations** – The CEU has provided technical assistance to SC UK's education and health projects in Tanzania in adapting participatory approaches.

7. Ensuring the impact/effectiveness of *CE* is reviewed and evaluated regularly

It's important for any programme to know if its activities are making any difference or changes for the better. ***Continuing education*** is no different. It's important to know if health workers have changed how they work or provide services because of their involvement in ***CE*** activities, and if those changes have affected others.

It's not possible for the CEU to do this by itself, but it can make sure that evaluations are conducted by others on a regular basis. The CEU can organise and plan activities (terms of reference) and resources (human and material) for the evaluation to take place.

After the evaluation, the CEU reviews and revises the ***CEP*** priorities and plans with stakeholders so that recommendations to improve the programme are included.

8. Resourcing from and networking with others

The CECs developed relationships with district and zonal experts who would help with ***CE*** activities. At the same time, the CEU was busy linking up with national and international contacts that could provide technical and resource support to all aspects of the ***CEP***. Formal and informal contacts were made with various groups to find the most current information that could be used to develop the ***CEP***. Important linkages continue with:

- Local and national **ministries** – especially the MoH in Tanzania, and the Education, Civil Service, Water and Sanitation and Women and Children Ministries
- Local, national and international **special programmes and NGOs** – including HIV/AIDS/STDs, malaria, women's health, child and school health, diabetes, young people's health issues, and water and sanitation
- National and international **professional organisations** – nurses, radiology, laboratory, health officers, public health associations, physical therapy, mental health, traditional and alternative healing, and pharmacology
- Local, national and international **educational institutions and programmes** – in particular those concerned with distance education, adapting of modules and learning materials, accreditation and recognition of courses, and participation networks
- Local, national and international **donors** – including bilaterals (ie DANIDA, GTZ, Ireland Aid), multilaterals (ie UNICEF, WHO, UNAIDS), foundations (Ford, Aga Khan) and international NGOs (ie SC UK, ActionAid, CARE, OXFAM)

- Local, national and international **health education suppliers and publishers** – especially TALC, AMREF and Intermediate Technology
- Local and national **NGOs promoting health or participation**

Through the years, the CEU gained more experience in applying participation with different groups in a variety of settings. The participation used early on is not the same as the participation that is used now.

How participation has progressed

The CEU carried out its responsibilities using participatory approaches whenever possible. At first, we were cautious and worried because we weren't sure where this approach would take us. The methods we used at first were unfamiliar and uncomfortable; also we made lots of mistakes. But people were patient… yet also doubtful. Participation was also a new experience to them. With all of us trying new ways of relating, working and learning in ***CE***, our fears and doubts were shared but soon replaced with confidence and pride. The ***CEP*** has created a climate of teamwork and responsibility towards each other that has matured over the years. Our insights concerning participation have changed a lot from the early experiences, and so have our methods and approaches. (See more in **Practical Pointer 2**.)

A method

Initially, participation was seen as a **method** that would be used for better learning practices. Then we found that we could also apply these methods to other management activities, such as facilitating co-ordination meetings and monitoring visits. As the CEU gained more experience and confidence in these methods, we found other ways to use participation in our daily work and our relationships in the MoH.

An approach and an attitude

Participation soon became **an approach and an attitude** for working and relating with people on an equal basis. We became aware of barriers that discouraged people from sharing freely and tried to remove them. We tried to remove obstacles that prevented positive interactions with others. These included changing the office design and having an open-door policy so that people would feel comfortable in coming to the office to talk. It also included respecting people and treating them as equals, listening to what people tell you, doing what you promise, and trusting that people can take on new responsibilities when they are given adequate support.

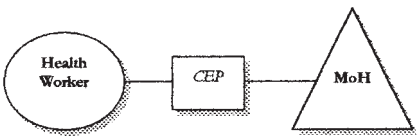
A way of life

And now participation has moved to a new level – as a **way of life**. We now look for ways of sharing participatory methods, attitudes and approaches with others. We've adapted these methods and approaches in our homes, our communities and even outside of Zanzibar. By sharing the basic principles of participation (respect, trust, sharing, equality, responsibility and tolerance) and nurturing them in others, both our lives and their lives change for the better. We've found that we have talents and strengths, we've made new friends and contacts, we've learned with others and we've had lots of fun doing it.

Summary of the growth of *continuing education*

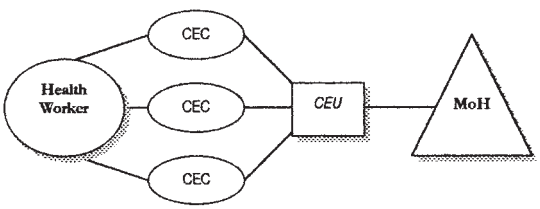
Using participatory approaches in ***continuing education***, the programme developed slowly, but it developed well. Below is a summary of the main events of the first few years of the ***CEP*** – it gives you an idea of the time needed to invest in 'people programmes':

Year 1



Collect information about the Ministry and its workers. Develop programme goal and objectives. Discuss ideas for programme goal with health workers. Identify staff in health facilities who want to work in ***continuing education***. ***CE*** volunteers make charter (rules) for their CEC. The CECs meet monthly with the CEU to: (1) determine staff learning needs; (2) analyse information; (3) decide learning priorities; (4) plan, carry out and review ***CE*** activities (including resource centres); and (5) keep activity and financial records for quarterly reports.

Year 2



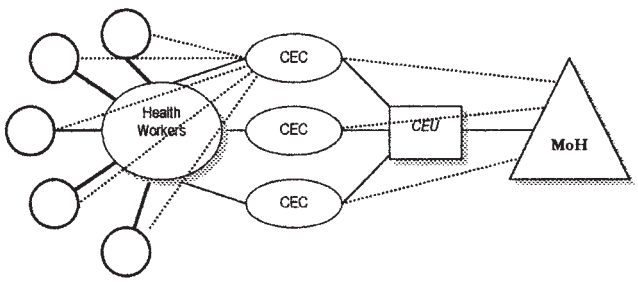
Continue regular meetings between CECs and the CEU. The CEU reviews plans and ***CE*** activities; produces quarterly ***CE*** activity progress and financial reports; finds more

funding and expert resources for CECs to conduct activities in districts; orders and obtains learning materials for resource centres; trains resource centre assistants; begins quarterly zonal ***CEP*** planning meetings; and begins professional zonal and national meetings (nurses, radiographers, laboratory staff). CECs ask for training in teaching so they can conduct their own activities.

Year 3

Continue quarterly meetings between CECs and the CEU to review plans and ***CE*** activities. Produce quarterly ***CE*** activity progress and financial reports. Conduct course for CECs on adult education techniques. Expand ***CE*** activities into communities in districts. Support new zonal and national ***CE*** activities for other professional groups and HMTs. Find more funds and expert resources for ***CE*** activities on all levels. Continue quarterly zonal ***CE*** integration meetings. Start of resistance to changes – improve documentation and accountability of CECs and the CEU. Conduct national ***CE*** planning meeting. Conduct ***CEP*** review. Begin providing input into MoH policies and guidelines. Create more interest in and acceptance of ***CE*** and its approach by others in the MoH – ask the CEU for technical support on participation and learning. CECs perform other activities for MoH and its programmes.

Year 4



Continue quarterly meetings between CECs and the CEU to review plans and ***CE*** activities. Produce quarterly ***CE*** activity progress and financial reports. Continue zonal ***CE*** integration meetings. Continue national ***CE*** planning meetings and ***CEP*** review. Find more funds to carry out ***CE*** activities on all levels. Continue to input into MoH policies and practices. Order and obtain learning materials for resource centres. Start the diploma course for CHNs and help its development and recognition. Establish greater linkages with educational and professional organisations within and outside of MoH to obtain better information and resources. With human resource department and civil service, look at alternatives that build ***continuing education*** into a recognised, long-term, career-advancing, human resource incentive.

The first two years of the ***CEP*** provided few results, but it has produced effects and benefits every year since then. The time invested at the start in working closely with the CECs produced benefits later on. The abilities and talents discovered cannot be taken away, but they can be built on when they are used with other groups and in other settings.

Continuing education has shown that health workers don't need expensive vertical programmes in order to learn. They can do it themselves when they are given an opportunity and are empowered to do so.

Changes resulting from *continuing education*

Participatory or people-based programmes are mainly concerned with changing attitudes and behaviours; as a result, effects are usually gradual, variable and unpredictable. Identifying changes (or effects) resulting from people-based programmes requires the use of different methods, indicators and evaluations. (See **Practical Pointer 4**.)

Monitoring, however, is the key! Changes in what people do and how they do it provides evidence of the ***CEP***'s effect. Those people who know what changes need to be made and those closest to the programme (health workers, facilitators, supervisors, HMTs, communities) are usually the best monitors. Their observations have been brought together from CEC reports, integration meetings and programme evaluations for this booklet. These reported changes in practice and 'soft indicators'[17] have been vital in the ***CEP***'s success in and achieving its goal:

> **To provide educational opportunities to all health workers in order to improve their personal and professional growth that will in turn improve the services they provide to the Zanzibari people, especially women and children.**

To see what progress has been made towards this goal, specific signs (or indicators) were checked regularly in the key areas of:

1) improving educational opportunities for all health workers
2) improving health services
3) improving personal and professional growth

17 'Soft indicators' refers to qualities that often cannot be measured, such as attitudes, perceptions, feelings, values, ways of relating, levels of control, involvement, etc.

4) influencing and advocating for ***CE*** – more specifically for ***participatory continuing education***.

The effect (or impact) of the ***CEP*** has not been easy to measure, but it cannot be denied. This section summarises achievements in the key areas and includes comments by those people who have been directly affected. Their views reflect their experience with ***CE*** and its effect on them, on their work and on their learning. Their comments also answer the following question that determines the success of any programme:

Are people who are using *CE* resources motivated to use them to provide options for learning, to improve their performance and to improve the health services?

Changes resulting from *CE*

1. Improving educational opportunities for all health workers

- 12 CECs in districts/hospitals
- resource centres in hospitals and health centres
- learning material production and distribution
- continuous district ***CE*** activities
- supportive follow-up after training sessions
- professional and co-ordination meetings on zonal and national levels
- affordable and accessible

2. Improving health services

- better relationships with and services for patients
- better support and co-operation between workers
- more interest in work and taking on new responsibilities
- better community relationships

3. Improving personal and professional growth

- networks and linkages
- CHN diploma course
- promotion and recognition within MoH
- discovering personal abilities and talents
- benefits from using participation
- change of status (formal and informal)

4. Influencing and advocating for *CE* with

- Ministry of Health
- Government of Zanzibar
- other organisations

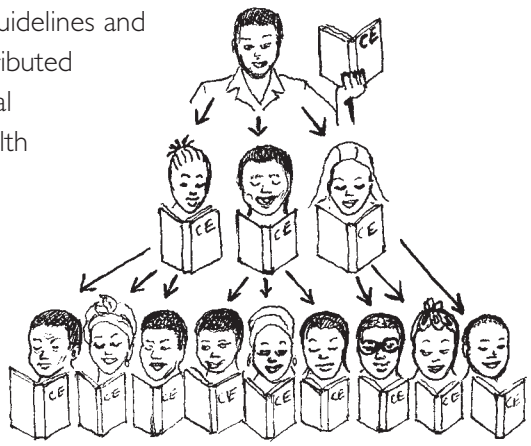
1. Improving educational opportunities for all health workers

Achievements

1) **12 CECs** established and maintained in districts and hospitals with members who volunteer time to organise regular ***CE*** activities based on needs and interests. Activities and CEC membership are for any interested health worker. Adult education, problem-solving methods and learning on-the-job or near your place of work are promoted in clinical and community settings.

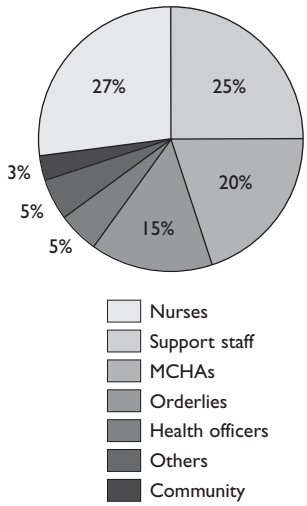
2) **10 Resource centres** established and maintained in each hospital and health centre for people to study independently and access reference materials.

3) **Learning materials** included courses, guidelines and surveys developed, produced and distributed by CECs and the CEU for district, zonal and national activities. Appropriate health materials (most in Kiswahili) were and still are often shared with groups so that ideas, information and practices that multiply learning effects can be exchanged.



2001 CE district participants

N = 2,200

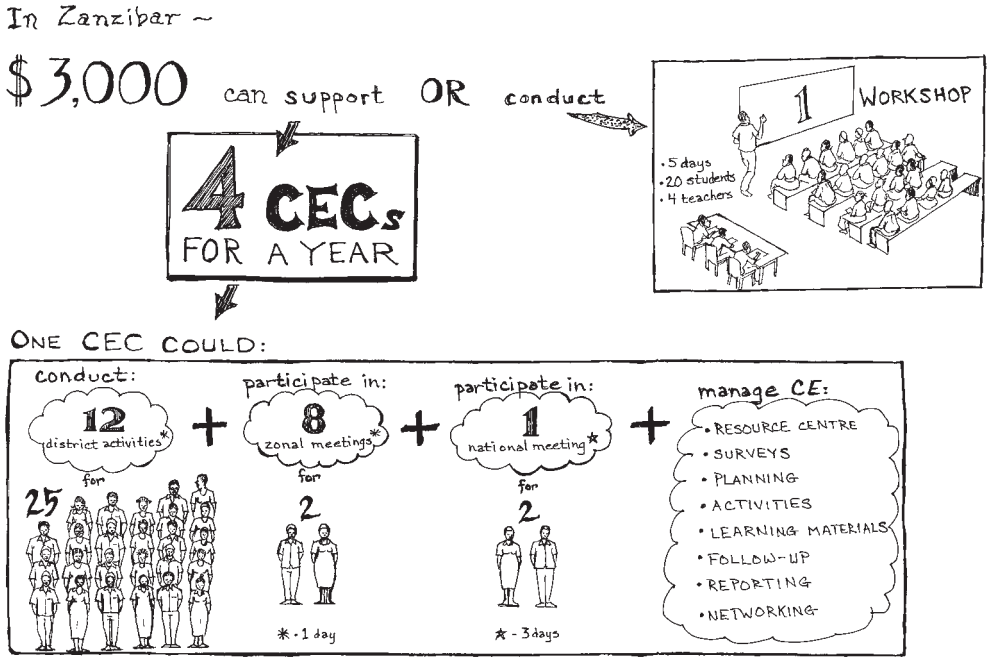


4) **District activities** – In 2001, CECs conducted more than 375 learning activities (an average of 2.5 sessions per month per committee). Ninety-five per cent of sessions were conducted in health facilities and 5 per cent in communities. Over 2,200 people participated – almost half were nurses and MCHAs; 40 per cent non-professionals (orderlies, support staff); 5 per cent health officers; and 5 per cent doctors and medical providers, laboratory, x-ray, pharmacy and physical therapy staff. Seventy students and community members also participated (3 per cent). The average health worker attended two district ***CE*** activities per year.

5) **Supportive follow-up** has been provided by CECs and/or DHMTs after training to clarify and discuss how to put training into practice and how to improve the work situation.

6) **Zonal and national meetings** have been held quarterly for specific groups (radiographers, laboratory staff, nurses, health assistants, medical assistants, pharmaceutical staff). In 2001, 50 zonal meetings were conducted (Pemba – 30, Unguja – 20) for 250 professionals. One three-day national meeting was held for 62 participants to plan ***CE*** activities for 2002.

7) ***CE* is affordable and accessible to health workers** – In 2001, around TSH 16 million (less than $17,000) was used by CECs and the CEU to carry out more than 375 district activities, 50 zonal meetings and one national meeting for more than 2,500 participants. Thus CE is inexpensive and easily accessible to most health workers.



Value of *continuing education*

"The spirit of co-operation among health workers allows CECs to use their money for many activities for many workers."

Zuwena, nurse and CEC member – Mnazi Mmoja Hospital

"Training opportunities were mainly for doctors and nurses, but now the programme has expanded to benefit all groups of workers in the Ministry."

Dr Uledi, Deputy PS – MoH

*"We gain more knowledge and experience from **CE** activities to use in our work. We get more ideas and practice that helps us. We have access to learning and knowledge that wasn't there before."*

Ame, health officer and CEC member – Central

*"**Continuing education** educates all groups of workers. It helps people find their needs and suggest ways to solve them. It provides specific activities for specific groups of workers to meet specific needs. It deals with many topics."*

Awesu, pharmacist and CEC member – Mnazi Mmoja Hospital

*"**CE** has been a way to evaluate yourself and how you are practising. Are you doing what others are doing? Staff that haven't received training for many years are reminded of how to do their work."*

Said, pharmacist and CEC member – Chake Chake

*"Workers attend **CE** because they are interested in learning and books, not because they are looking for money. Attendance in **CE** activities is increasing even though money is not available to pay them."*

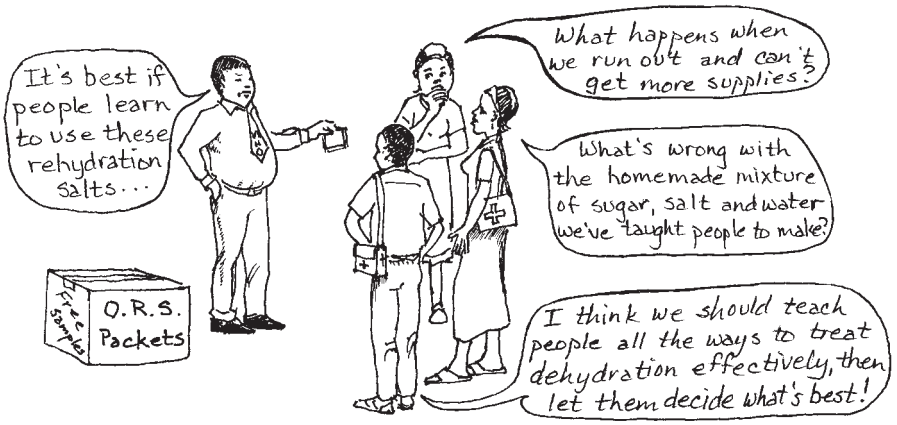
Maryam, midwife and CEC member – Mnazi Mmoja Hospital

"We are helping health workers understand how they might do their job better or improve their results with what is available. This may include improvising, and educating some to do things they are not qualified for but yet are expected to do. Utilising whatever is available (funds, facilitators, resources) in a careful way was a major breakthrough to us."

Jaku, CHN and CEC member – South

*"**CE** has given us new ideas and options for treating and managing patients. Usually in workshops we're taught only one way of doing things when we know there are other ways available (eg boiling water to make it safe when there are other ways to treat water – chemicals, sun and settling, etc) that are cheaper and just as good."*

Azan, DHO and CEC member – South



*"CECs are using local resource people to review and refresh health workers. There are many trained and qualified professionals in Zanzibar and **CE** is a way of having them share their knowledge."*

Moh'd, health officer and CEC member – Chake Chake

*"**CE** has facilitators around almost all the time who can follow up and can be asked other questions by health workers because they are here with us."*

Khalfan, nurse and CEC member – Mkoani

"The initiation of health workers being tutors for other staff is a very big success. Finding practical solutions to their work problems allows everyone to learn."

Dr Uledi, Deputy PS – MoH

*"We know which activities were successful and those which need to try another way of reaching the goal. We know who has attended other training and when they return we arrange for them to share their information with others in future **CE** activities without being paid money in a workshop."*

Masoud, nurse and CEC member – Wete

"Professionals from all over the island get together regularly to discuss issues related to their profession and plan action to do together so that others may benefit."

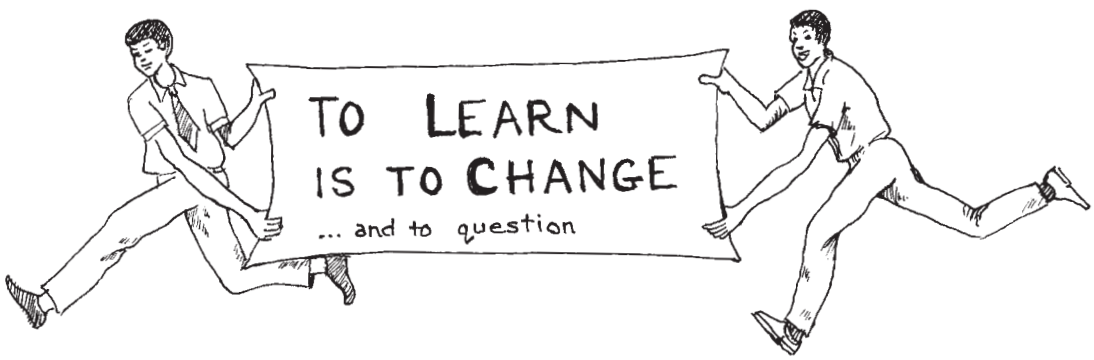
Abdulla, zonal health officer – Unguja

*"We get other ideas from other CECs when we attend zonal meetings. We can try what other CECs are doing in **CE** and in their work."*

Juma, lab staff and CEC member – Mkoani

*"With this approach to **continuing education**, you're in the field, you take your problem, you sit down, you solve your problem according to your own situation, with what you have in that situation. So I think this is more practical and beneficial."*

Dr Omar, PS – MoH

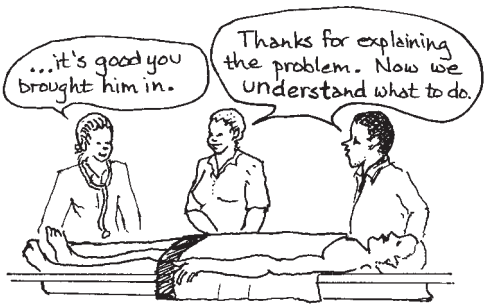


2. Improving health services

Better relationships with patients and better services

"Staff are more polite to the patients who are coming to the hospital. They discuss with them, they involve them, and in this way the relationship between the patients and service providers has improved tremendously."

Dr Moh'd, past ZMO – Pemba



"People are working more appropriately and properly. They follow standard treatment guidelines and are able to treat many cases properly and know when to refer. They are able to keep better patient records and know the importance of keeping them. They also care for and use drugs and equipment better."

Dr Selele, past ZMO – Unguja

"We are getting referable patients from clinics, TBAs and healers. We know these people, what training they've had and what services they can provide to patients. They also know when and where to refer patients for the right treatment. When we receive a patient, we know they've been managed a certain way before coming to us."

Abdulla, nurse and CEC member – Wete

"Referral rates from health clinics to the health centre have increased by 100 per cent, but the referrals were almost all appropriate. Referrals for severe anaemia cases and recognition of pregnancy problems have particularly improved."

Zuhura, midwife and CEC member – Micheweni

"Some prescribers are refraining from giving drugs to every patient, but give health education instead when appropriate."

Moh'd, nurse and CEC member, Micheweni

"Some workers are being trained for responsibilities they were not hired to do. But because of the shortage of qualified staff, they had no alternative. It is important for workers to know how to do the job when someone else is not there."

Sharifa, CEO – Unguja

*"Nurses are now able to take histories and examine patients to better diagnose them and prescribe proper treatment, where before **CE** they were not doing that. Even MCHAs have been included."*

Saada, midwife and CEC member – Micheweni

"Workers were afraid to even give first aid to patients if a doctor wasn't there. But now, services can still be provided. In this way, if a prescriber is not there, an MCHA can prescribe. If an MCHA is not there, a prescriber can give MCH services."

Dr Yusuf, DMO and CEC member – North

*"Most training takes health workers out of the workplace for long periods of time so that no or few services are being provided to people. With **CE**, they receive training at the workplace and services are not interrupted."*

Dr Moh'd, past ZMO – Pemba

"Diagnosis has improved, even treatment. Of course with that, it has raised the satisfaction of the patients. If the patients or the community are satisfied with the services we provide, and the technical people are satisfied, then I think that is a very big effect."

Dr Uledi, Deputy PS – MoH

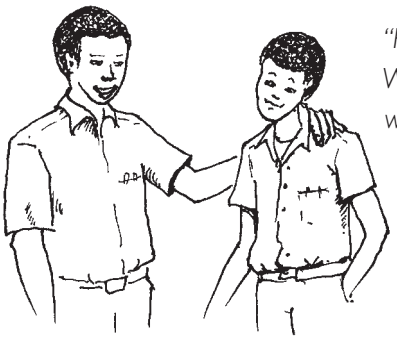
Better support and co-operation between workers

"By learning and trying new approaches in dealing with people in training sessions and at work, relationships have developed and improved between workers. We trust each other's skills and abilities."

Omar, nurse and CEC member – North 'A'

*"Before **CE**, we used to work in each department separately without knowing each other and what they were doing. But now we know what each other is doing and we can help each other."*

Mahazei, nurse and CEC member – Mnazi Mmoja Hospital



"Relationships between staff have changed. We don't see 'big bosses' anymore. We work more as a team that includes all staff members. We consult each other when we have a problem."

Fatma, MCHA and CEC member – Vitongoji

*"Before **CE**, most workers acted differently to us. But now that we have different responsibilities with them through **CE**, we're more interested in them and their work. They felt we didn't know anything before and that we had low standards, but now they see that we have high standards and they respect us more. We probably respect them more, too."*

Ali, CHN and CEC member – Mkoani

*"We now know many health workers in the district, zonal and national level that we didn't know before. We've gone to other areas of the country for **CE** activities and know who to contact when we need help. We were never able to move from the workplace before."*

Mahmoud, nurse and CEC member – Mental Hospital

More interest in work and taking on new responsibilities

*"Workers are given more work and professional responsibilities in addition to their ordinary duties as they become capable through **CE**. They see it as a way of advancing. They feel better about getting the extra responsibility and attention and recognition from their fellow workers and being listened to by their superiors."*

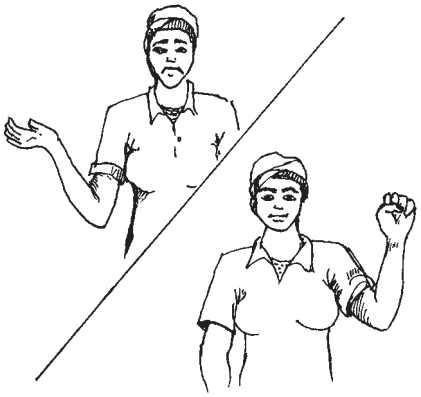
Sharifa, CEO – Unguja

"Orderlies now sterilise equipment, admit patients, give injections and stitch and dress wounds, and do it very well. They feel more professional and that they are moving forward."

Issa, nurse and CEC member – Mkoani

"Before, we would not think of work after working hours, but now, we find that when we return home at night, we keep thinking of how things should be done the next day."

Salma, MCHA and CEC member – Urban



"Staff are more motivated, interested and responsible in their work. They don't wait for the Ministry to decide for them. ***CE*** *has changed the attitude of staff from the custom of waiting for superiors to always tell you what to do."*

Salum Seif, past health co-ordinator – Pemba

"Workers have become confident in giving their services, decision-making, management and administration. Before, they would wait for orders. But now, they can solve most of the problems related to their work themselves."

Dr Uledi, Deputy PS – MoH

Better community relationships

Achievements

1) **Community education and action** – CECs work with village health committees and other community groups to provide information on current health problems. Plans

are developed in follow-up meetings for resolving the problems through community efforts. Issues have included malaria, dysentery, teenage pregnancy and early sexual behaviour, substance abuse by young people and HIV/AIDS and STDs.

2) **School health education** – CECs work with school and teachers' committees on health issues, eg HIV/AIDS and STDs, teenage pregnancy, water and sanitation, and prevention of malaria, worms and other conditions common in young people.

3) **Awareness of better community health** – through health education and projects, communities have become aware of relationships between disease and unhealthy practices. People feel since they have changed the way they behave, death and disease have decreased in their communities; for example, they have started to use latrines and clean water, and to change unsafe sexual behaviour.

*"We have built relationships with people in the community, schools, MoH programmes and traditional sector through **CE** activities. By looking at health problems in the community, we've been able to initiate actions to deal with them."*
Ali, CHN and CEC member – Mkoani

*"Through **CE**, we've discussed issues with traditional healers, circumcisers and bone-setters and they now refer patients to the clinic for assistance. They feel very comfortable to come to the hospital with their patients and even do local treatments in the hospital. The relationship and co-operation is still very good."*
Mohummed, nurse and CEC member – Micheweni

"From doing training with TBAs, they are using better techniques to prevent problems, like using sterile cutting equipment and knowing when to transfer mothers having difficulties."
Hamida, MCH co-ordinator and CEC member – North 'A'

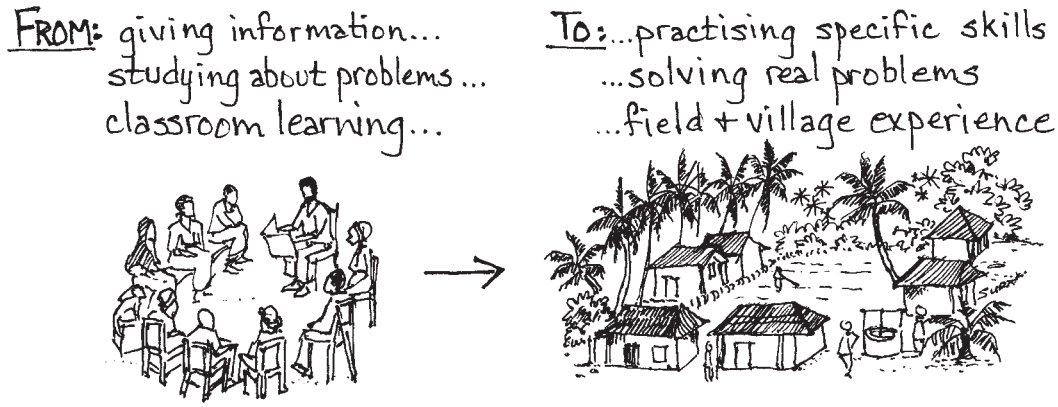
"All staff can provide health education to the community according to their position. This helps bring health awareness to the community."
Ame, DHO and CEC member – Central

"Our interest is to get to the people right in the villages and these CECs are there now. So these are the right organs/instruments to use to make health services extend as far as possible. These are committees who have proven able to reach communities faster and more efficiently."
Mkubwa, past financial officer, PHCSP – DANIDA

*"**CE** can react faster in responding to sudden health problems that arise by informing health workers and communities. Hospital administration informs **CE** and MoH programmes when a problem arises so that appropriate measures may be taken."*

Dr Mkoko, ZMO and past CEC member – South

The focus of continuing education has been changing



3. Improving personal and professional growth

Achievements

1) Networks and linkages formed with:
   - **local experts in and outside of the MoH** for educational sessions and community projects. These include traditional healers, community leaders and religious leaders, extension workers and business people
   - **other ministries** for collaboration and co-operation in human resource upgrade programmes and expertise. The Civil Service Commission and the Ministry of Education have been especially useful
   - **professional boards and organisations** representing nursing, radiology, laboratory, pharmaceutical, medical, and public and environmental health workers
   - **various NGOs and other organisations** to address specific conditions, issues or specialties either locally or internationally
   - **health and education institutions** for obtaining expertise, recognition, information on learning material, and other possibilities of learning leading to advancement.

2) **The CHN diploma course** has provided advancement and recognition for 36 nurses.

3) **Promotion and recognition** of health workers who have shown remarkable talents in carrying out ***CE*** activities. The MoH has promoted some workers, sent others for further training and delegated new responsibilities to others.

Discovering personal abilities and talents

*"I have less fear of teaching now because of the experience I've gained in **CE**. And I've learned skills in financial management."*

Issa, nurse and CEC member – Mkoani

"I can organise meetings and various training sessions now and can determine if they've been successful or not. I'm not afraid of working with or saying things to others because we're working as a team."

Haji, nurse and CEC member – North 'A'

*"**CE** makes us feel useful, motivated, and satisfied, knowing we're contributing to others' development as well as our own. We are highly committed to this work. Since there's no money in it, we must be motivated by knowing we are helping others. We're more confident in doing things and feel we are accomplishing something important."*

Amina, matron and CEC member – North 'A'

*"Before, I used to feel shy around Ministry officials. But with **CE**, I've gained courage to speak with higher-ups."*

Makame, radiographer and CEC member – Mkoani

*"**CE** has forced us to improve our English and standard of writing since our reports, letters and proposals would be read by others."*

Ashura, librarian and CEC member – Mnazi Mmoja Hospital

*"Before **CE**, we didn't know our rights of what should be provided for us (ie protective equipment, high risk precautions, special allowances) and now we are receiving them. We got results from our requests because we did it as a group, not as individuals."*

Fatma, midwife and CEC member – Mnazi Mmoja Hospital

"We are proud of the work we are doing. We used to do work alone; but now, by sharing with staff and other members, we have grown from sharing, and have gained pride and respect for each other and our work."

Khamis, radiographer and CEC member – Mnazi Mmoja Hospital

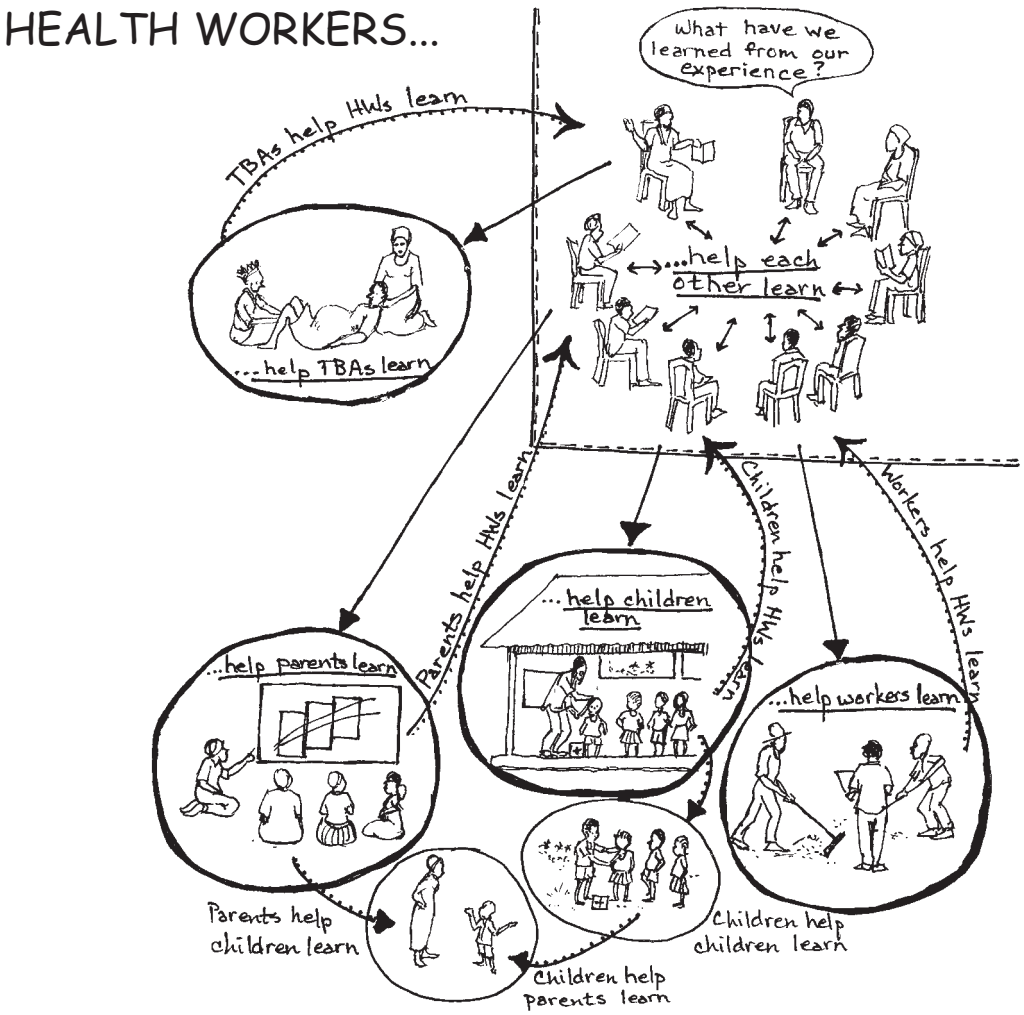
Benefits from using participation in *CE*

*"We have the freedom of deciding some things ourselves. We have a chance to plan, implement, evaluate and fund our **CE** activities without problems. We have never been able to do that before."*

Suleiman, nurse and CEC member – Mental Hospital

"All have benefited from the approach and have gained facilitation skills. We use it in our meetings and our work. We try to use these skills in other situations and new work."

Maabad, medical assistant and CEC member – Urban



"We work as a group and a team. When we work in a group, we can always get something from others, so it is better. We learn from each other. I feel happy because we share the work together. No one knows everything. So when we come together, we can share with each other our ideas, plans and thoughts."

Abdulla, nurse and CEC member – Chake Chake

"We are now able to plan proposals from problems identified in our areas and find solutions to them."

Ali, nurse and CEC member – Wete

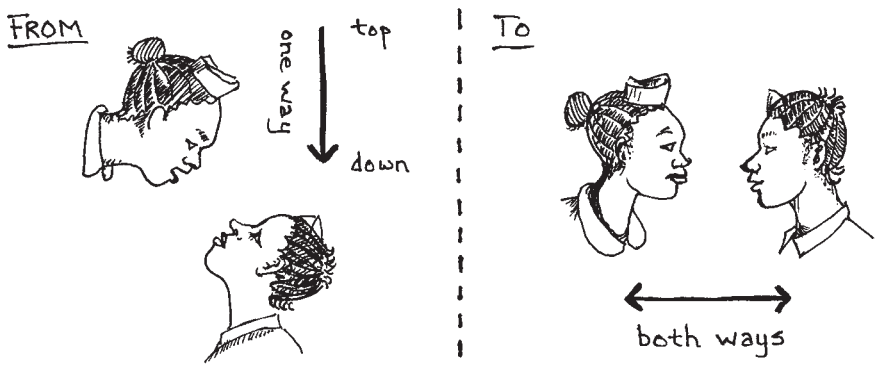
"This participatory teaching method allows people to share ideas, not teaching where someone stands over you and says 'do you understand?'. This method helps me in my work. I use it in solving problems rather than directing others. It was difficult at first, but now I think it's easier because it benefits everyone involved."

Amina, matron and CEC member – North 'A'

"Everyone has a chance to say what they want. People are free to plan and express their concerns, fears and worries. ***CE*** *is not commanded by one person, so anyone can call a meeting when someone feels something needs to be done."*

Khamis, physical therapist and CEC member – Chake Chake

Participation aims to change



"When the CEU comes to visit, there is dialogue to try to find solutions to problems. There is enough time for discussion to solve the problems and share some of the work in solving the problems. We feel they are part of us."

Maua, orderly and CEC member – Vitongoji

"The CEU has given a spark to the CECs – to initiate CECs in the beginning, to think of different ideas for learning, to explore how they might go about it, to stimulate CECs to try new ways of helping people learn and informing us of changes that are occurring in the MoH."

Bakari, nurse and CEC member – Mnazi Mmoja Hospital

Change of status from *CE*

*"I've represented the CEC at meetings with people I normally would never have met with in my normal work. I thought meetings were only for big senior people and didn't know the value of meetings in planning and organising together. But with **CE**, I've gained courage to speak up in big meetings and have become familiar with people in other areas who have given me new ideas and information."*

Awesu, pharmacist and CEC member – Mnazi Mmoja

*"Workers are willing to work on **CE** because they now feel the Ministry values their ideas and contributions. The Ministry supports their ideas with funds and opportunities to gain more knowledge and skills that weren't there before."*

Abdalla, radiographer and CEC member – Chake Chake

*"We've been called on frequently by officials for information or requests concerning training issues; this wouldn't have happened before **CE**. It is a form of recognition and reward that Ministry officials would want to meet with us."*

Mahmoud, radiographer and CEC member – Wete

*"Some of us have been asked to teach students and help develop curriculum at the health sciences college because of our work in **CE**."*

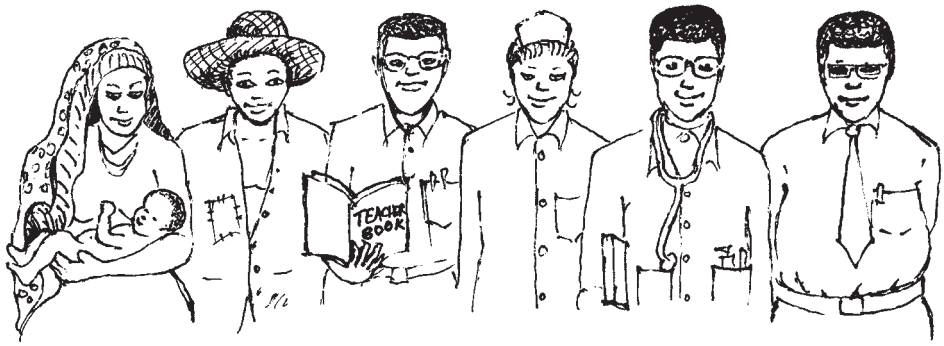
Naifa, nurse and CEC member – Mental Hospital

*"Because of **CE** involvement, two MCHAs started working better which gave them knowledge to pass interviews to go for outside training in Japan."*

Khatti, district MCH co-ordinator and CEC member – Central

*"The little money for **CE** has helped improve living conditions somewhat, but we know there's something more to get out of **CE**. We've seen that others have been recognised and given new jobs and responsibilities or advancement through their involvement with **CE**. They would not have been noticed or considered otherwise."*

Issa, CEO – Unguja



We've all benefited from continuing education!

4. Influencing and advocating for *continuing education*

Ministry of Health

In addition to what's been mentioned, the ***CEP*** has been able to influence other areas in the MoH, such as:

- **Co-operation and collaboration** among facilitators/trainers

  "Other programmes have joined in and they are now using the same approach. They participate in the planning and I think this gives us a very good result in the sense that utilisation of resources is more effective than before."

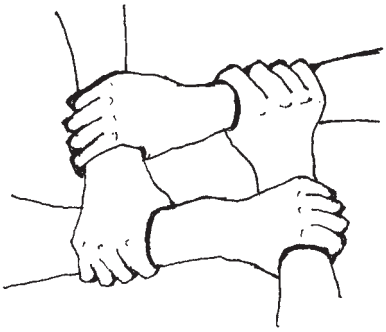
  Dr Uledi, Deputy PS – MoH

  *"**CE** provides opportunities for donors to work in an integrated way with the MoH and health workers at the district and zonal level. Things are quicker and you achieve the results in a better way because you hear from people in the field."*

  Talaa, past project officer, PHCSP – DANIDA

  "We received support from some MoH programmes to do some training (in the district), so now workers have become more familiar with their programme and their work in the Ministry."

  Dr Yusef, DMO and CEC member – North 'A'



"One of the (HMTs') roles is the co-ordination of training activities. We are to make sure that all groups of workers are involved in training activities. ***CE*** *and its approach have allowed us to plan in an integrated way for the benefit of all health workers. The CECs have relieved us from some of the training activities and we have time for other business now beside just following training."*

Dr Moh'd, past ZMO – Pemba

"Many programmes and trainers see the importance of planning and integrating training. They even challenge each other's plans during integration meetings (before it was only the CEU). Supervisors now do approach the ***CE*** *team for help in the areas where weaknesses have been discovered. They try to reach agreements in conducting and co-ordinating their activities."*

Dr Selele, past ZMO – Unguja

- Lessons learned from putting **MoH initiatives into practice**

  From the beginning, principles of participation and decentralisation have been built into the programme. The ***CEP*** shows what can happen when workers are responsible for solving problems and taking care of resources – and those in authority allow them to be in charge.

  a) **Using participation in *CE*:**

  "The acceptance of this participatory method of training is a revolutionary turn in the Ministry. Staff have created a big force which supports the ***CE*** *committees and the* ***CEP****. They know they have an alternative. It has served as an alternative to traditional training methods… and it has brought back hope. People now have hope. They changed their attitude to work and learning and that has reduced dependence and feelings of frustration. People are willing to discuss and explore new ways of doing their work. It has raised their awareness. They feel confident in their work. They feel they are part and parcel of the Ministry."*

  Dr Omar, PS – MoH

  "The majority of health workers have not only accepted and are satisfied with the programme, but they also have high regard and expectations. It's popular and encourages self-improvement."

  Dr Uledi, Deputy PS – MoH

*"**CE** is a way of moving away from formally structured workshops… to move towards a more integrated and flexible form of on-the-job training and supervision that involves all levels of health workers."*

Chris, past country director, SC UK

*"**CE** is more practical and problem-oriented. Because of that, it is more interesting to the health workers. They ask questions and come up with suggestions. It shows they know better and more about the work in their situation than you or a facilitator. We often learn more than the participants."*

Dr Selele, past ZMO – Unguja

*"Workers are interested, enthusiastic and very ambitious about **CE**. They don't think about allowances for the work they do – they do it in addition to their regular MoH job. They don't get tired. They decide what time they will work and for how long; even on weekends or after working hours. Some have shown great initiative in organising training activities."*

Sharifa, CEO – Unguja

b) **Decentralising *CE*:**

Because health sector reform is in transition, the ***CEP*** has concentrated on building the capacity and awareness of local health workers to manage and control small-scale programmes. Many workers know a lot about participation and management skills that allow them to work with others in resolving identified problems.

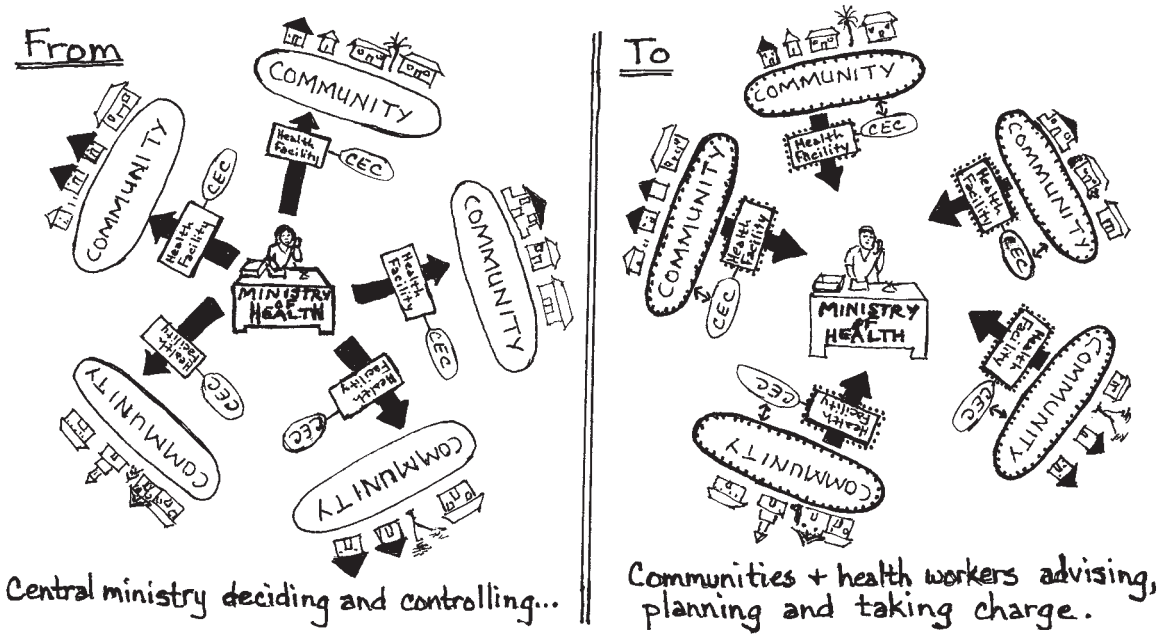
"There has been improved and more efficient communication between health workers, the CECs and the Ministry."

Dr Omar, PS – MoH

"Decentralisation is possible. People in the MoH had fears of whether people on the lower levels would be able to plan and decide what needs to be done. The CECs have shown that this is possible. This participatory approach has empowered people at the lower level to plan and implement and even monitor the activities. This is an important lesson the ministry has learned. This has enabled us to delegate power to the lower levels because people are responsible – we can trust them."

Dr Moh'd, past ZMO – Pemba

Decentralisation aims to change



*"The CECs and DHMTs work together to make each other's work more effective and efficient. As health sector reform progresses, the CEU can hand over funds directly to districts to carry out their **CE** plans."*

Issa, CEO – Unguja

*"The **CE** officers have made a very close follow-up with CECs and have done an excellent job of making CECs aware of their responsibilities. Before, the CECs didn't know anything about keeping funds or records. But when you go there, you find money is being sent and records are being kept, so you know it will satisfy people who give money. Maybe they've been better trained or maybe the methodology used was more acceptable, but in this respect, money has been utilised the way it was meant for. I wish others had such a commitment."*

Mkubwa, past financial officer, PHCSP – DANIDA

Government of Zanzibar

A UNDP report on civil service reform recommended that all ministries use the ***CE*** model. As a result, the Government (Principal Secretaries) agreed to adopt the model in all its ministries.

"People from outside the MoH have visited and have been impressed by our activities such as our reporting and library. This outside recognition makes us feel like we have built something good."

Zawadi, midwife and CEC member – North 'A'

*"Even people from outside the Ministry have recognised **CE** and have recommended that it be adopted as a model for the Government of Zanzibar. That recommendation was accepted by the Principal Secretaries last year (1994), so this model will be adopted as a national programme. We are very proud it was the MoH that started this programme. There is no turning back. There is still a bright future for this programme in this and other ministries."*

Dr Omar, PS – MoH

Influence on other organisations involved in *CE*

*"As VSO, we came not as a donor but as facilitators. If we hadn't had the structure of **CE**, it would have been hard to co-ordinate our work. It has guided us on how to continue work and help with training and follow-up. The advantage of it all is they don't need doctors from the West or expatriates to run their **CE** scheme. They know how to do it themselves now."*

Dr Ginny, VSO and CEC member – North 'A'

*"We feel that the **CEP**, having been set up using this participatory approach, is beginning to make a difference – this despite the lack of resources and problems such as low salaries, and people having to do jobs other than those they are trained or qualified for. And when given an opportunity to participate in defining what the problems are and what the solutions are, and given some control over them, a difference will be made. One of the outstanding successes is that motivation has improved tremendously and they believe in what they are doing. Many other organisations and government services could adapt this approach and have similar sorts of success. It has shown potential solutions to problems that are common in all sectors."*

Chris, past country director, SC UK

*"**CE** can be a way of breaking the big problems of lack of sustainability and of imperialism of the donors."*

Dr Moh'd, past Pemba manager – GTZ

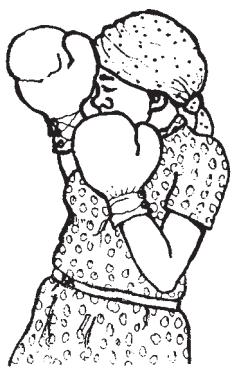
Continuing education is achieving its goal and giving workers opportunities to control their own learning and work situations… but acceptance of ***CE*** did not come easily.

Challenges encountered

There will always be disagreement and conflict between people. Especially when competition (for power, resources, rewards and influence) or change threatens existing conditions. Not everyone sees change as positive. This is particularly true in participatory programmes that aim to change the way people normally think, work and learn. (See more in **Practical Pointer 2**.)

For some people, conflict or challenge is so stressful they try very hard to avoid it. But in Zanzibar, conflict forced the ***CEP*** to plan, focus and unify its efforts, and to carefully consider its options (Plan A, B or C)[18] before confronting the issues. The challenges the ***CEP*** has faced can be categorised into three main issues:

- narrow views and misunderstanding of continuing education
- difficulties of introducing the new concept of participation
- opposition to the principles of participation.



This section should not change your mind about ***CE***. It should give you ideas and insights so that you will not experience the same problems the ***CEP*** had. Each issue will be dealt with later, but first, let's look at how difficulties and conflict can be used to build and strengthen a programme rather than threaten it. The first steps in defeating any challenge are to know and understand where the challenge comes from (its source) and what its argument and concerns are, and then to look at possible options for dealing with it.

18 For example, having back-up or alternative plans should original plan fail.

Dealing with difficulties

Differences between people are natural and should be expected. When people work together, differences can lead to arguments, disputes, competition and confrontation. If these are ignored or not resolved, they can create greater difficulties or conflict.

> *"There are always problems when change is proposed. This might be just because the thing which is coming is new or because of collision between people. These collisions might have negative impact on anything you are planning."*

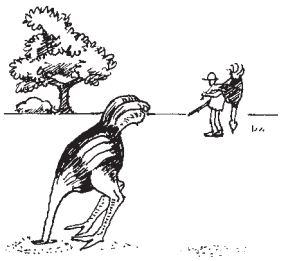
Difficulties (conflict, collisions, obstacles, challenges) can create positive or negative effects depending on how you react to them (see box below). Managing difficulties badly can create hostility, divide workers, disrupt services and damage the organisation.

To manage a difficulty properly, you openly recognise it, agree on how to resolve it, and make adjustments based on the agreement. Everyone wins. Everyone has heard everyone's views and everyone agrees with the solution, so harmony and unity can return to the situation. To be able to create this win-win situation, you need to be confident and assertive so that you can deal with challenges and difficulties positively.

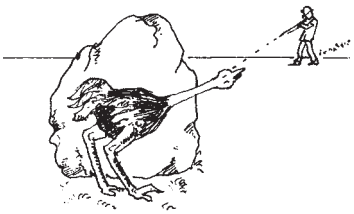
Responses to challenges and conflict

Response	Creates	Leads to	Results in
Aggression	not OK feelings	tension turned *outwards*; anger, blaming, hostility	winner–loser
Passivity	not OK feelings	tension turned *inwards*; accepts, lets things happen	winner–loser
Assertion	good feelings	defends rights without offending others; can say 'yes' or 'no' with confidence*	win–win

*Confidence builds each time you are assertive and defend yourself



People can react to difficulties in various ways. Some choose to ignore them, hoping they'll go away without causing trouble. They refuse to recognise problems by 'sticking their head in the sand', staying still and keeping quiet. By not seeing the problem, they don't have to act; their thoughts about the difficulty and awareness of it are buried deep. Unfortunately, ignoring difficulties won't make them go away – it just makes someone an easy target for hurt or abuse.[19]



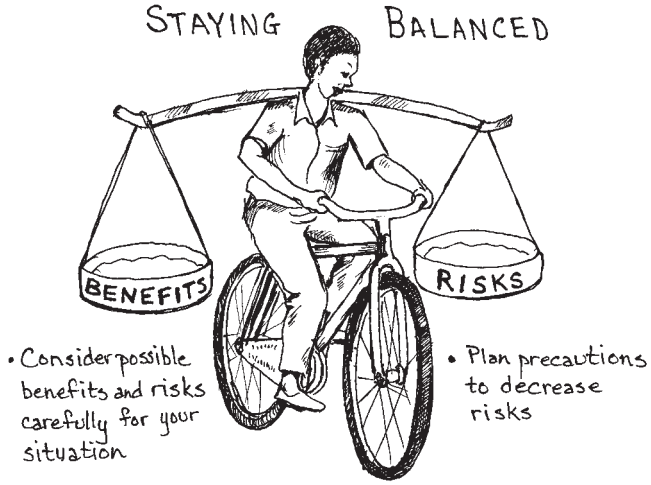
On the other hand, some people are very eager to solve problems but they don't think before they act. Their commitment is so strong that they haven't thought about what might happen as a result of their actions. By acting impulsively they are caught unaware and may also become easy targets for hurt or abuse.

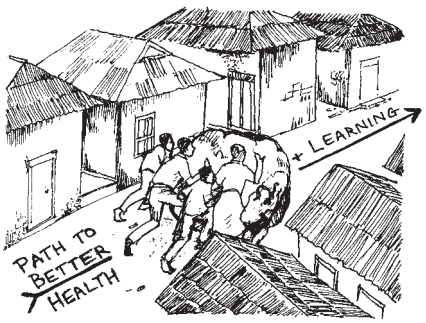
Don't take unnecessary chances. However, when the danger is clearly greater if you do nothing, don't be afraid to try something if you feel reasonably sure it will help. Both action and inaction can be dangerous if you have not carefully considered and weighed the risks and consequences.

Taking on a challenge

When starting something new, plan a course of action, but also plan for difficulties that might result from those actions. Identify the possible benefits and risks (advantages and disadvantages) of each step and each situation. The risk of taking a particular step must be weighed carefully against the risk of not taking that step (What might happen if we take action on this issue? What happens to health workers and the programme if we don't? Is it worth taking the risk because of the benefits?). Caution is as necessary as courage. If confrontation or conflict with powerful people is involved, take extra precautions. Be sure to carefully consider the balance of risks and benefits and make informed, purposeful decisions. Use your own best reasoning, judgement and common sense to identify the causes and issues that need to be challenged – choose your battles wisely.

19 'Abuse' refers to being ridiculed, discredited and made fun of; even ending your job or service.

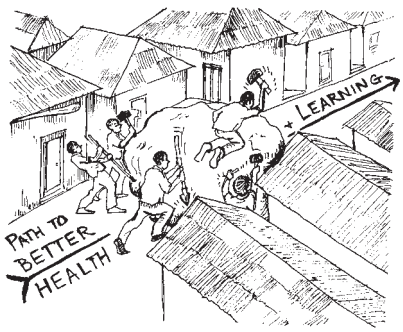




Smaller obstacles can be removed or overcome when people work together.

When you have made the decision to confront a specific issue, don't do it alone. By joining together with others who share the same commitment, breaking down obstacles becomes easier and less threatening. People with different strengths and talents can share the work of overcoming obstacles in a unified team effort. You are also less likely to experience severe reactions when acting as a group as opposed to one person acting alone.

When people work together and achieve some success in moving an obstacle thought impossible to move, a major transformation occurs. One small success or forward movement can build the momentum people need to tackle other issues and obstacles that were also thought impossible to change. As confidence and teamwork builds, obstacles fall apart.



Large obstacles that stop progress need more talent and strength to remove or work around them.

Let's now look closer at some of the ***CEP*** 's struggles (see box opposite). The issues the ***CEP*** dealt with could become problems for others starting up a new ***CE*** programme. Here are some suggestions on how to avoid these difficulties so that ***CE*** programmes start off well and operate with fewer obstacles.

Difficulties encountered

- Narrow views and misunderstanding of continuing education
  …among health workers
  …among supervisors and managers
  …among decision- and policy-makers
- Difficulties of introducing the new concept of participation
  …to health workers with little or no experience in participation
  …that is time consuming and repetitive
  …into existing training activities
  …into groups
  …that confronts realities and has an unpredictable, uncertain future
- Opposition to the principles of participation

Narrow views and misunderstanding of continuing education…

…among health workers

Workers have rarely been provided with skills that help them read better, study, or question the way things are done – either through their basic education or ***CE*** experiences. Since few health workers have received higher education, most do not understand what ***CE*** is or what its possibilities are. Most saw it as workshops that represented a holiday and extra money from very little effort. This common view made it even more difficult to introduce ***CE*** with its different approaches and incentives. Innovation and other motivations were needed to change health workers' expectations and experiences of ***CE***; and even now, some people still don't accept ***CE***.

*"Professionals are quite aware of **CE**, but other workers are just starting to become aware of the benefits of **CE** – and it's not just the money."*

*"Some people are after money and say they haven't been involved in **CE** because they haven't gotten any money. They won't participate unless they get money – even if the activities are during work hours and convenient to others. This has nothing to do with the approach, just the person who wants more money."*

*"Due to poor living conditions and low salaries, health workers are occupied with getting extra money to live. Most have second jobs to supplement their government income. They don't have a lot of time to get involved in **CE** activities unless money or other MoH rewards are available."*

...among supervisors and managers

Some supervisors and managers think that staff getting together to discuss work problems (and having a good time doing it), can't really be learning. They see ***CE*** activities as unimportant and a waste of time and money if they don't meet their expectations or ideals of training.

"Some people who don't like it [the approach] are bosses. They are afraid of it. But the lower people like it because they can work on how to solve their problems without the boss. This is why bosses get nervous when people meet."

*"There's been no real support from hospital leaders for workers to participate in **CE** activities."*

*"Some leaders think **CE** is a waste of time. They don't pay attention to what is being done so they think people are 'playing'. They don't have interest to observe what is really going on, so they assume work is not being done. They may be jealous because they think the CECs are making lots of money doing this. We need to inform them of what we are doing and maybe involve them in some of the activities."*

…among decision- and policy-makers

No clear training policies or human resource policies exist that clarify ***CE***'s role and purpose and direct its efforts. Therefore, officials give conflicting views and messages that create confusion and misunderstandings, which frustrate efforts and progress.

> *"There needs to be better understanding between the **CEP** and the Ministry regarding issues of recognition of health workers' involvement in **CE**, accepting new work responsibilities and upgrading. If they have attended many sessions, it's obvious that they will need a sort of promotion and this has not yet been worked out. This has been an area of disagreement. How can this type of learning – rather than sending them away for long courses – promote staff?"*

Difficulties of introducing the new concept of participation…

…to health workers with little or no experience in participation

Helping people realise they have strengths and power they can use to change their situation isn't easy, especially when they see themselves as uneducated, useless and having no skills. In the past, first reactions to participatory learning ranged from indifference, curiosity, suspicion and opposition to acceptance. The CEU continued trying to expose people to participation and involve them in different participatory situations and activities. Once people became familiar with the approach and saw its effects, more became involved. Despite efforts to involve people on all levels, there are still those who do not want to participate – but that's their choice.

"People may be reluctant or hesitate to join something in the beginning. Be patient. As they see results, they will want to join in. Don't give up."

"I doubt whether the concept of participation was well understood by the senior officials; a good understanding was very important to giving support at all angles during the initial stages of the ***CE Programme****. Naturally, some still don't grasp the concept."*

"Some will resist, some will be reluctant and some will be undecided. But the important thing is to base programme decisions on what the majority want."

…that is time consuming and repetitive

Building the capacity of CECs to learn to solve problems in a questioning, step-by-step way is very important. But it's also tedious and involves considering the needs of each group, making frequent visits and being flexible. Systems are needed for managing different aspects of the programme so that each group's needs and progress can be followed. The initial investment in the programme established a foundation of core values and practices that are still operating and supporting growth.

"Everything is difficult in the beginning so people will need lots of encouragement."

"People may think it is easier to plan alone and that this approach will take a lot of time. But it's easier and faster if plans are accepted by people. If you involve them from the start and they accept the approach, they feel they are a part of it; then you see results faster. The difficult part is to get people to try to understand and accept it."

…into existing training activities

Introducing the new concepts was and still is difficult. Changing people's attitudes to accept different ways of learning is a never-ending struggle. Some people will always believe learning can only take place in classrooms, in workshops using lectures. They are not comfortable with other ways of learning they are not familiar with, and they quickly judge them as inferior. However, by exposing people to other methods, they can experience the benefits and limitations of each method, and then decide which is best for their particular situation.

The problem with participatory learning is:

- it's too informal and relaxed
- classes don't begin on time
- instructors dress too casually
- instructors use crude expressions
- it takes too much time
- lots of words are misspelled
- lots of straying from the topic
- material is not always covered
- wrong information is discussed
- too much noise and laughter

"Some people who are not used to this approach feel it takes up a lot of time and limits the input because too much time is spent getting participants to bring out their views. Maybe it doesn't give enough time for teachers to do what they want."

"Some people want lectures and don't want to do group discussion or solve problems. They want new ideas to be given to them. They think facilitators are not prepared and that they want ideas from them. It is a new approach, but they are continuing to try. The more we try, the more they will accept."

"The personality of the teacher influences the learning and can be a cause for people not learning. Make sure all teachers are voluntary and that they are ready, interested and want to be teachers. They should not be appointed."

"Make sure participants are voluntary and they are interested. Learning and changes occur for those who are willing."

...into groups (CECs, HMTs, MoH programme trainers)

Group functioning and dynamics are as variable as a group's members. Differences in personalities, opinions, motives and abilities provide many opportunities for disagreement and miscommunication. Group members have learned democratic principles and communication skills for dealing with difficulties that threaten cohesion

and harmony. Sometimes, the CEU has acted as referee for those experiencing growing conflict, or as a sounding board for them to try out their opinions and ideas. By resolving problems together, everyone has learned ways of managing conflict through discussion and negotiation. As group members change, so do the personality, dynamics and problems of the group.

"Some of the active CEC members are transferred to other places so we have to find new people to work with. We don't have a lot of spare time to start up new members."

"Some CEC members were not seriously committed to ***CE*** *at first. Some of those have left, but some still remain and we try to let them find their way."*

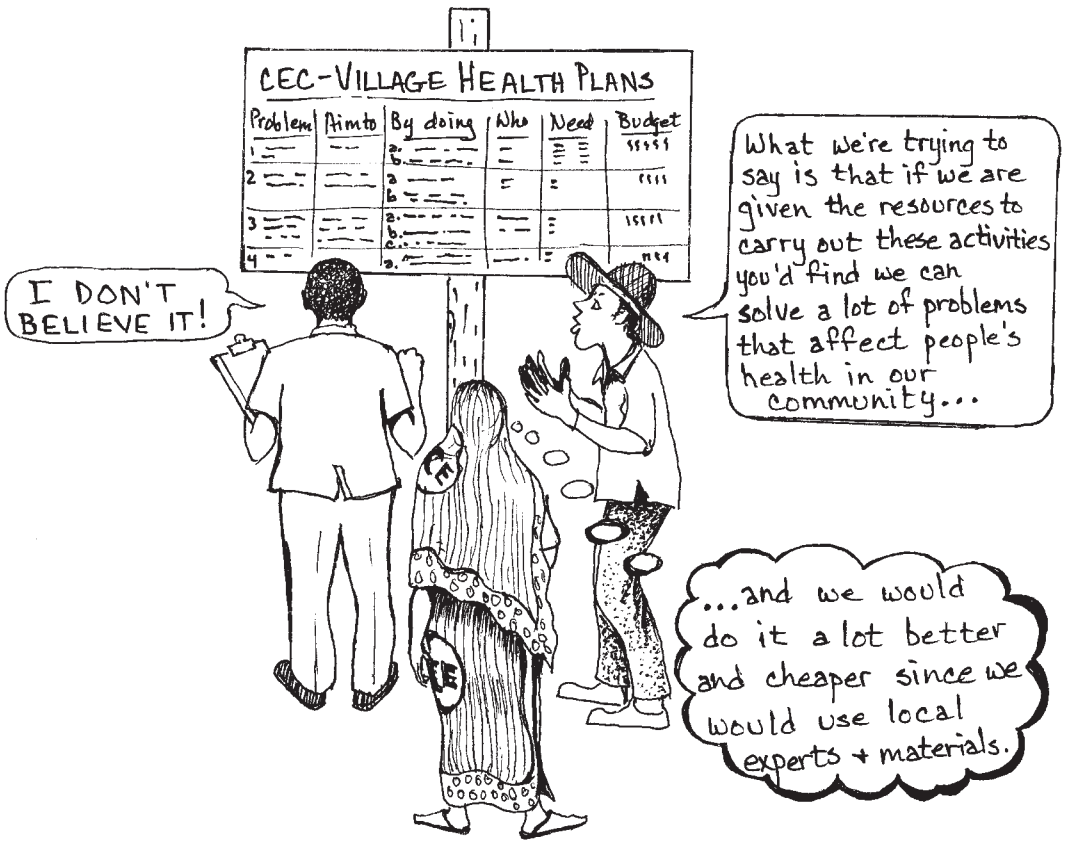
"We have had CEC members quit because they felt the committee was no longer helping them. Some expressed poor communication as a reason. They would travel far to show up for a meeting, but the chair had left without cancelling the meeting. Others said their ideas were ignored and never considered. And some said the CEC was too authoritarian and dominated by a certain member who made the decisions regardless of what the committee wanted."

"Rotation and changes in composition of CEC members would help. More representation from periphery staff, rather than hospital or management staff, would decrease chances of some people dominating the CEC."

…that confronts realities and has an unpredictable, uncertain future

To work in people-centred programmes you need to be willing to confront and admit truths about your reality or situation. Only then can effective actions be taken. Discovering real causes of people's problems doesn't happen quickly and may be upsetting and risky. People's response to problems and their actions cannot be forced or prescribed. They initiate actions gradually, unpredictably and uniquely and the actions may succeed or fail. Few organisations have the flexibility to respond to this kind of process. Most organisations base their work on results and success. They have biases, fears and rules that limit how much they trust local people to control their own initiatives.

"Before you do anything, listen to people… then you can find out where to start. They will tell you what is going wrong or what the problems are and their causes. It's up to us [health workers] to work with them in finding the right people to change our situation for the better."



Opposition to the principles of participation

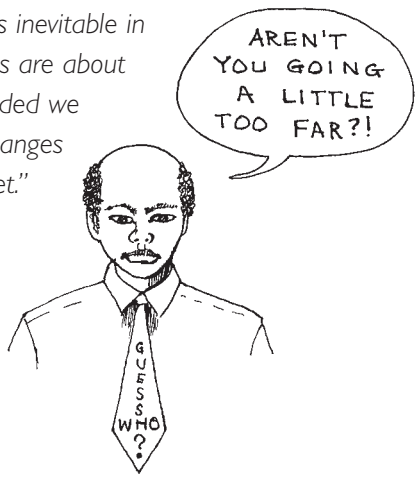
Some people will always oppose the whole concept of participation and will work hard to keep power, control and resources where they are. When people act superior and arrogantly, and show contempt for those they consider to be beneath them, this creates an environment of mistrust, suspicion, disrespect and dishonesty among workers. Workers who show initiative and innovation are often treated with disapproval and they are ridiculed until they become frustrated and stop trying to change things. It's not easy dealing with these people – but you will.

"This approach takes the power of those on higher levels and gives it to people on lower levels to decide what they want and don't want. People on higher levels are used to doing that, so they may feel that it is taking their power. It takes control of some resources from leaders and gives to others who they may not be able to control."

*"Some don't like the approach because they don't trust people. They don't believe that people on the district level could do what they are doing. That's why they wanted to scrutinise every bit of the **CEP** to see that it wouldn't work."*

The best way to respond to opposition and its effects is to use tactics directly opposite to those being used. So, be trusting, respectful, open, direct and truthful; and admit mistakes and provide information freely and in writing. These efforts may not change the opposition's minds, but they show that the ***CEP*** practises what it teaches and that there's a different way of working.

"There is no concern about the participatory approach, but it has brought us into a bit of conflict. But I think conflict is inevitable in a project that is challenging the norm. If our projects are about bringing about changes, and if changes weren't needed we wouldn't be here, then we have to accept that if changes are to be made, some people are going to get upset."



"There have been people high at the Ministry level who were and still are opposed to the whole participation concept and prefer the traditional educational methods. They definitely have their reasons, but it seems that they are in the minority and their arguments are outweighed."

Avoiding pitfalls

In anything we do, there may be unexpected difficulties or 'pitfalls' that can cause serious problems or delays. To start a new ***CE*** programme off well, the ***CEP*** suggests you consider the following issues and plan early how to deal with them. Experience shows that a programme can fall into deep difficulties and delays unless decisions are made early on in order to find the best ways to approach and overcome these issues. The ***CEP*** learned these lessons the hard way.

Avoid pitfalls by planning early to:

- Keep people on all levels informed and aware of ***CE***
- Secure enough time and funding
- Use participation that empowers people – not manipulates them
- Provide supportive follow-up
- Make ***CE*** compulsory
- Expand the scope of ***CE***
- Get ready to learn … and expect the unexpected!

Keep people on all levels informed and aware of *CE*

Continuous efforts to discuss and share information and concerns about the programme with key officials and workers need to be established and maintained. If ***CE*** is to progress successfully, key officials and workers need to have a clear understanding and awareness of the programme's purpose and direction.

*"Educate all those staff, especially senior Ministry officials, on the concept of the **CEP** so they understand and grasp the participatory approach. They have to know the whole concept of the programme and what role they need to play. This must be*

*done to ensure the viability and sustainability of the **CEP** on the district, zonal and national levels."*

"From the onset, we actually need to have full support and co-operation from high authorities, staff, donors and others if the programme is to be successful. You need to convince the big bosses to like what you want to introduce. If they don't want it, how can you continue? They may agree with it in words, but may cause problems in doing."

*"Have discussions and dialogue with those concerned. Don't hide anything from them. Try to compare the costs and benefits of the **CEP** with other training programmes. Try to involve them as much as possible."*

Secure enough time and funding

Whenever projects are dealing with people gaining control over their lives, support should be committed for a minimum of 10–15 years. Changes are gradual and variable. People need regular encouragement to try new ways and to keep the momentum going. Ensuring that ***CE*** is established within the MoH human resource system is a long-term investment. If you take the short-term view of ***CE*** (less than five years), the result could be few lasting changes and disappointed, frustrated workers.

"Whenever you're talking about a programme that deals with changing some people's attitudes, you need more time to see results. The output should be looked at as a long-term product."

Dr Omar, PS – MoH

*"To reach a stage like this programme has reached and just say 'no, no more **CE**', would be a very big blow to the programme and to the workers who now have faith. It might even result in the collapse of services and collapse of morale, which would be a very negative effect."*

Dr Uledi, Deputy PS – MoH

You also need to explore different options for funding. To be sustainable, most of ***CE***'s operational budget should come from the Ministry or Government, but that's not always possible. The table opposite shows the ***CEP***'s experience of different funding sources.

CEP's experience of different funding sources

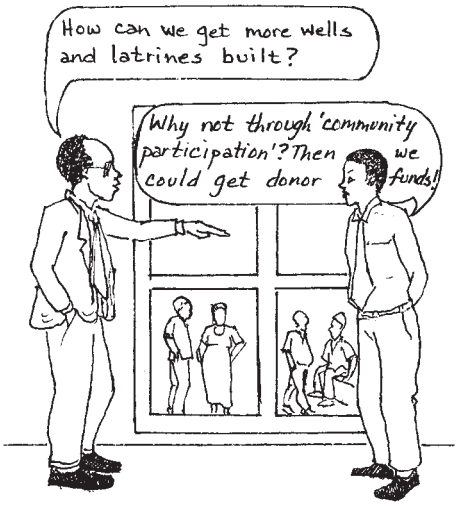
Funding source	Lessons learned	Advantages	Disadvantages
MoH and health sector reform	There should be a separate ***CE*** budget line in both the central Ministry budget (to support the CEU) and the district health plans (for funding CEC plans).[20]	• Shows commitment by the Ministry and Government to develop workers' capacity through local means. • ***CE*** activities will be sustained through annual funding and MoH policy support.	Allocation of ***CE*** budget may not be paid out due to other MoH priorities.
Donors	At first, most donors were hesitant to support ***CE***. They now co-ordinate and integrate training with CECs and HMTs. Adjustments to proposals and reports can be negotiated to satisfy everyone's requirements.	• Funds are given directly to the ***CEP*** to carry out activities. • Support for district training activities in primary healthcare and CBHC is available. • Many donors are interested in capacity-building and participation programmes.	• Puts limits on how funds can be used and what topics can be covered. • Delays in receiving funds cause delays in activities. • There is little interest in funding administrative, non-professional or hospital ***CE*** activities.
Income-generating activities	a) International ToF course b) CECs selling treated mosquito nets c) Contracting out services.	• There is full control over how ***CE*** funds are allocated and spent. • It is beneficial to people's health in communities. • It develops links with NGOs, communities and other ministries.	Workers are still expected to carry out their full-time job, ***CE*** activities and extra work with little or no reward.
Fees, tuition or cost-sharing leading to job enrichment[21]	This idea is still under consideration. Until MoH policy clarifies human resource requirements and ***CE***'s role in staffing development, it will be difficult to proceed.	• This is a policy that provides clear criteria and requirements workers must fulfil to advance. • Workers decide direction and rate of advancement by enrolling in courses. • By paying, workers are investing in succeeding. • Scholarships or grants from donors/NGOs for specific courses or workers could be an incentive to improve performance. • The ***CEP*** will use the fees collected to expand and improve options.	• Few workers have extra income to pay for courses. • The CEP will need support to meet the demands and requirements for organising quality educational programmes, and implementing and supervising them.

20 Being part of the training budget line doesn't work. In Zanzibar, there is intense competition between ***continuing education***, the basic health institution and higher institutional training budgets, and ***CE*** usually loses. A separate line for ***CE*** will give legitimacy to the programme and build donor confidence to give funds directly to the MoH for ***CE***.

21 'Enrichment' refers to techniques that change work conditions and experience to meet workers' needs and increase their job satisfaction and motivation, resulting in better work performance.

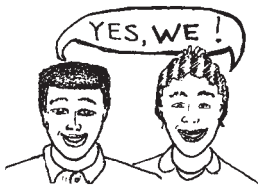
Use participation that empowers[22] people – not manipulates them

Different approaches to participation produce different results (details in **Practical Pointer 2**). The empowering approach enables people to take charge and be responsible for their lives. To achieve this, leaders and organisations need to be prepared not to manipulate and impose decisions, but to hand over control and resources to others, and be responsive to new, unexpected ideas.



"Africa must refuse to be humiliated, exploited and pushed about. And with the same determination, we must refuse to humiliate, exploit or push others around. We must act, not just say words."

Julius Nyerere, *Freedom and Development*, Oxford University Press, Dar es Salaam, 1973, p. 371



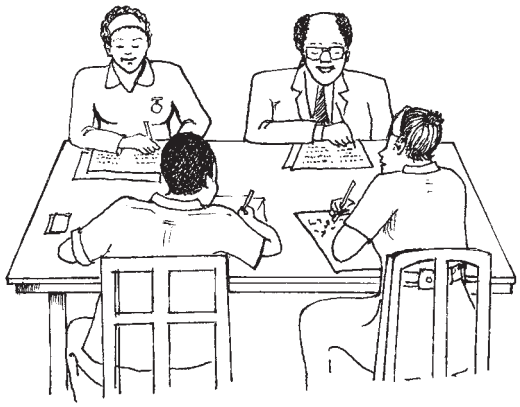
Empowerment can happen when the foundations or the **Three Pillars of Participation**[23] are adapted into work and other situations.

Pillar 1 **Our attitudes and behaviour** need to change – We need to stop controlling and providing answers for people and start relating to others as partners and sharing freely and equally with them. When we struggle together to find practical solutions to problems, we need special talents to help others learn to change things.

> *"This concept aims to empower people, so people in the hierarchy should be willing to allow this to develop or happen by providing technical input, funding, encouragement and willingness to share [information, resources, feedback, etc]."*

22 By 'empowered people' we mean those who have acquired awareness, understanding and relevant capabilities to demand and manage actions or changes responsibly, using their own initiative and control.

23 Adapted from Robert Chambers' concept in *Whose Reality Counts?* Also, see **Practical Pointer 2** for details on the Three Pillars of Participation.



"Certain qualities are needed to be helpful to health workers: being truthful, without biases, not being selfish, being co-operative, working as part of the team, having a friendly personality and medical background."

"People are equal – there is no boss. Everyone accepts what somebody is saying and we listen, decide together, accept mistakes and give constructive ideas. We've become patient, because it's a little bit hard to help people to grow. When we find a problem, we struggle together. We've learned to be tolerant, because working with groups we find different attitudes and behaviour."

Pillar 2 **Participatory methods and approaches** are used by workers to express, share and extend their knowledge, confirm and analyse information, judge situations, weigh options, act together to improve conditions and be accountable for the results.

"We use participation in everything we do. We found this approach is more effective because health workers are interested and involved. They become committed to the situation and if there are achievements, they will be theirs. By addressing their problems and interests, you will be more successful in your programme."

Pillar 3 **Sharing and exchanging** information, experiences, knowledge, opinions, food and other resources is promoted. These exchanges create a culture of openness, generosity and honesty, and form alliances and partnerships which then influence other people's ways of relating to and working with others.

"We work as a team here and everyone is clear of what is going on. In that way, we know what is happening, and right or wrong, we are responsible for it."

"We've developed a network within the Ministry that provides us with encouragement, support, direction and feedback when times get tough."

Provide supportive follow-up…

…for health workers Any training or ***CE*** activity that doesn't provide follow-up to participants is a waste of time and money. The aim of training is to improve health services, but if monitoring and follow-up are not done, no change will be seen. Co-ordinating follow-up visits of training activities among supervisors, CECs and HMTs will result in changes in workers' performance. This performance can then be monitored on a regular basis. Tools can be developed from training plans (checklists, assignments, outcomes, procedures, etc). These tools can then provide a focus for discussing areas where support is needed to put learning into action.

"Gaps in the transition from people attending training to putting it into practice still exist. Follow-up and monitoring should continue if we want to plug that gap."

"When we do follow-up, we look for and praise good practices we see happening. When we see workers not doing things they're supposed to be doing, we suggest and encourage them to do it the way they were taught. Some aren't doing this because they don't have the equipment or supplies. So we discuss how it could be done differently or find ways of getting the supplies to them."

The only way forward is to take one step back...

and reflect often on where we've been and where we want to go.

…for facilitators Those who conduct training and ***CE*** activities also need supportive follow-up. Regular meetings are needed with CECs and MoH programme trainers to discuss more effective ways of learning and follow-up, and to resolve issues causing problems for co-ordination and sharing resources.

"Instead of putting ideas in people's heads during training, we try to bring out their ideas."

*"The **CEP** follows up everything very well – the plans, the money. They look at our programme and suggest changes or correct errors. They try to educate and direct us and correct us well to do the **CE** activities properly according to what we can do. They are interested in what we are doing. They don't force us to do something. They change our attitude by sharing their ideas."*

Make *continuing education* compulsory…

…for promotions, salary increases or obtaining recommendations for further career education. Begin to work with civil service and human resource departments at the start of the programme to establish procedures and criteria for advancement through ***continuing education***. Special attention should be given to distance education, career paths for advancing all groups of workers, and upgrading basic education qualifications.

> *"**Continuing education** should be compulsory. A policy should be developed where **CE** will be part and parcel of salary increment and upgrading of staff and those sent for further training. Now it's just taken as an activity. It's not given importance in evaluation of the work performance and upgrading of the staff. It should be valued and graded accordingly. Increments should be given through **CE** activities that a person has participated in."*
>
> Mkubwa, past financial officer, PHCSP – DANIDA

> *"Efforts should be taken to liaise with the civil service department to see that the model is adopted nationally. This will not only enhance the security of the programme, but will also bring uniformity in the public sector."*
>
> Dr Omar, PS – MoH

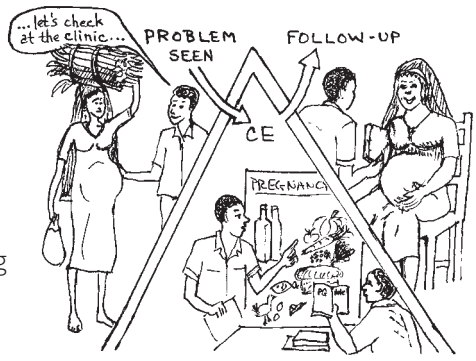
Expand the scope of *continuing education* by…

…making it available for all health workers

Continuous efforts need to be made to include all groups of workers in ***CE***. Analysing records to see who did not participate can lead to discussions of how ***CE*** can address their needs in the future.

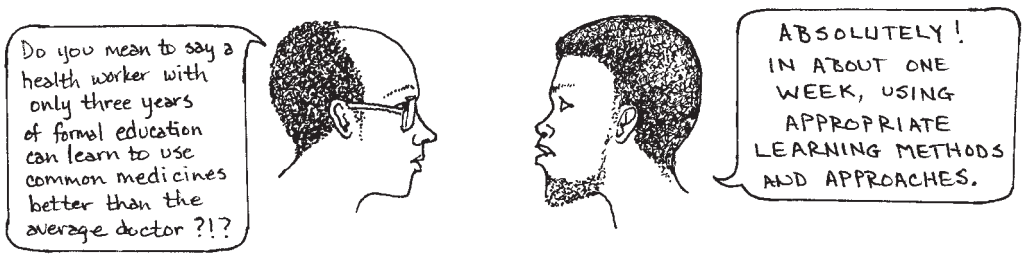
…providing better learning through improved methods and co-ordination

Efforts are needed on a regular basis to provide trainers and facilitators with more technical support and feedback to conduct problem-solving activities based on experience. This includes helping them analyse situations and problems, identifying learning priorities, accessing current resources, developing learning materials and following up changes in working conditions and service provision.



…reviewing job descriptions and practice procedures

Job descriptions are the basis for workers to know what is expected of them and what their limits are. To be useful, they need to reflect what workers are actually doing, not what they should be doing. ***CE*** must work closely with supervisors and human resources to ensure workers know their job, and receive orientation and regular updates about the work they're expected to do. Then, guidelines and modules can be developed on standards of practice. In this way, supervisors can better monitor workers' performance and recommend training to bring practice up to standards.



…supporting the *CEP* with resources to meet these challenges

The CEU has more and more responsibilities and therefore needs more qualified staff and resources. One way to achieve this would be to recruit a full-time person to be on the DHMT to facilitate ***CE*** and human resource functions in the district. Other ideas include…

"The heads of the CECs and CEU should get special lessons, short courses or on-the-job training on management issues that can help us do this kind of work better [educating, reports, statistics, evaluation]."

"The CEU needs to be supported in terms of technical support, staffing and material support to help them be closer and give technical support to the CECs and MoH."

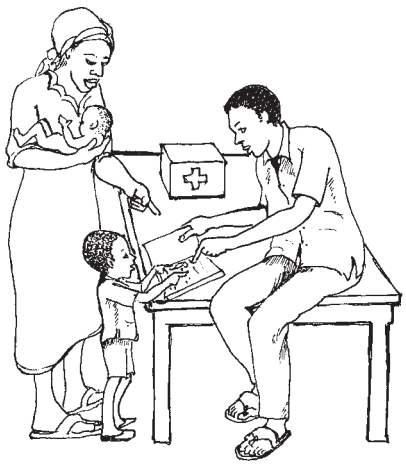
Get ready to learn …and expect the unexpected!

When participatory programmes start gaining momentum, new ideas and activities multiply… and amazing things start happening. These are often experiences or outcomes that could never have been predicted or expected. Surprises and miracles can happen. By opening up and learning from these experiences, you often learn more than those who are intended to learn, especially about yourself. Such surprises and discoveries make working and learning with others exciting, challenging and fulfilling.

Reasons for starting *continuing education*

Workers take interest and pride in working professionally

Health services improve when health workers know what they're supposed to do and they have the competence and resources needed to do it. Forming social and professional links with colleagues, experts and other organisations assures that standards of practice, current trends and information, and supportive consultation are available. Workers gain confidence to act and react to resolve health problems in any setting within the limits of their training… and to share their knowledge willingly with others.



*"**CE** is a positive step forward in helping health workers realise the potential of resources in themselves."*

*"**CE** provides opportunities to put up-to-date information into practice and standardise healthcare services."*

*"**CE** is trying to work with people to make positive and lasting changes in their work or life situation through participation. When you find there is a problem, health workers and people are able to implement plans based on actual needs in their areas. They can be flexible to respond to unexpected situations."*

It's more economical, practical and effective than traditional training

*"**CE** gets workers to think to find the best solutions to their problems. They can tell you what they are doing and why, and can explain themselves. Often training and education does not allow people to think – this one does."*

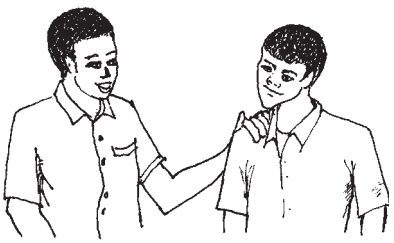
*"As compared with other training methods, **continuing education** is feasible, less expensive and cheaper to implement, more sustainable and more effective because you are involving people who are tackling real problems in their workplaces."*

Learning …

that helps develop

- self-reliance
- problem-solving skills
- initiative
- ability to use books

will prepare health workers to act more or less **independently**

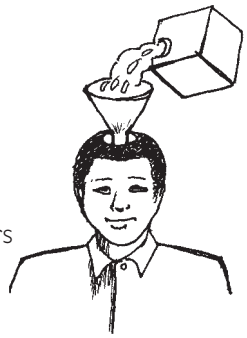


Training …

that emphasises

- memorising facts
- obedience
- filling out forms

creates health workers who need lots of **supervision**



Workers take responsibility for their own learning and development by choosing from various *CE* activities

Personal learning and development is a major concern to most organisations. ***CE*** is a way of addressing these and other issues through various learning activities that are organised on-the-job or in the workplace. ***Formal*** and ***informal*** opportunities are established for workers to contribute to, participate in and take charge of decisions that affect learning and career advancement. Workers can continue to learn through:

- Studying and learning on their own
- Participating in meetings, courses and training whenever possible
- Teaching others… keeps you studying and learning
- Asking questions… of anyone you think you can learn from
- Helping people less able than yourself to ask for help or encouraging them to speak for themselves.

"Workers are free to choose the topics they want to learn about and then organise a time to teach each other."

"People gain confidence by attending classes, learning from each other and on their own."

"Teaching others provides opportunities to expand your own learning."

*"Since the main responsibility of health workers is to share our knowledge, we need to know how to do that well. **CE** has given us all the chance to share what we know. We've discovered that opportunities for teaching and learning are anywhere and everywhere."*

"A very good thing about adult education is that we can learn what we want to learn – what we feel would be useful to us in our lives."

Julius Nyerere, *Freedom and Development*,
Oxford University Press, Dar es Salaam, 1973, p. 105

Workers like *CE* and enjoy its benefits

CE provides an enabling and empowering environment where people can develop equal and democratic relationships. When people learn to trust, respect and share with each other, the result is freedom of expression, tolerance of others, options for action, decisions by agreement and team spirit.

"Workers get to know each other. They meet regularly to share ideas and knowledge and learn together different ways of solving problems. They are working together and trying to change the way they work and live."

"We feel free to express ourselves in front of each other and in groups. There is less fear to contribute our ideas. We feel safe with each other."

Where to go from here?

We hope our experience of ***continuing education*** in Zanzibar has provided some ideas and motivation for starting or getting involved in your own ***CE*** programme. Don't expect the same results or problems. Different circumstances have different needs and solutions. As long as your ***CE*** programme is people-centred and is improving people's health and well-being[24] by using empowering participation, you'll be moving towards success.

The following **Practical Pointers** provide more information on continuing education, participation, better learning methods and monitoring and evaluation. The ***CEP*** found what worked for health workers in Zanzibar by searching and trying things out and making mistakes. If these pointers work here, they could work almost anywhere… with some adaptations.

The section after **Practical Pointers** contains information on **Useful Resources for Continuing Education** that the ***CEP*** has used for obtaining advice, guidance and resource materials. These resources provide a continual link with global networks trying to keep health workers in remote areas up-to-date with current trends and professional practice. The support and resources (mostly free or low cost) they provide are essential to any continuing education programme's success. Get in touch with them today…and let us (the ***CEP***) know how we can help you more.

> *"Anyone who wants to start a programme using participatory approaches should be confident that it is possible. Even though we hesitated at first, we have done it. We have seen lots of achievements through this approach, but be prepared for the consequences and drawbacks. I would suggest that if you want to do this, go to the people who have experience in these things so they can share, ask questions, get clarification and so on. We are really willing to share…"*
>
> Sharifa, Saidi and Issa, Continuing Education Unit, MoH – Zanzibar

24 Well-being here means good quality of life, such as having health, social relationships, basic services, freedom of choice, peace of mind, satisfaction, security, fulfillment and basic living standards.

Part II
Practical Pointers

Practical Pointer 1: Basics of continuing education

People have different perceptions, experiences and expectations of continuing education (CE). Its potential for meeting and expanding human resources is underdeveloped and unimpressive considering the number of workers and professionals who are in need of continuing education.

What happens after someone has completed an education or training course? Does learning stop? For many workers, especially those in rural areas, it does. Their chances for gaining new information, exchanging views on work and professional issues, or advancing career options are few under present CE trends.

Existing CE programmes are too expensive, ineffective and inappropriate to meet the dynamic and expanding needs of most workers. More ideas and efforts are needed to develop CE programmes that are not only responsive, practical, relevant and accessible to workers, but are also cheap, rewarding and enjoyable! Allowing workers to take charge of their own continuing education can make this possible.

Continuing education…

…is a tool for stimulating workers to keep learning while working on-the-job!

…provides education in a recurring way over a person's working life.

…aims to change practices so that they improve the effectiveness and efficiency of individuals and organisations.

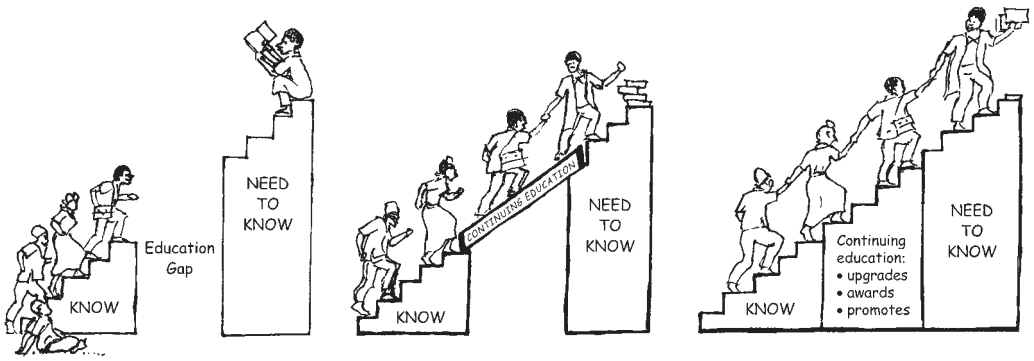
…should be an essential and compulsory part of human resource planning in any organisation for it to achieve optimum effects.

Why the need for CE?

People keep learning throughout their lives. Opportunities to explore and develop personal and professional potential are vital for improving services being provided and job satisfaction. CE provides diverse opportunities in the workplace for workers to develop and improve the way they work.

What can CE achieve?

CE can bridge the gap between 'what workers know' and 'what they need to know' to perform work and responsibilities better.



It can also provide incentives for workers to receive promotions, salary increases or career advances by participating in accredited CE activities.

Who is CE for?

Any worker interested in learning how to do things differently, solve problems and improve existing conditions. **CE is for anyone… and everyone.**

Who is responsible for CE?

Learners, mostly. They are responsible for reaching their learning goals. Without interest, self-direction and a strong drive to improve oneself, continuing education is pointless.

But **supervisors, managers and decision-makers** also have a role to play. They can create conditions and opportunities for workers to learn to accept new responsibilities and challenges, and support them in working wisely and independently.

Ways to achieve CE

There are a variety of CE options for health workers to learn more about their work and discover new ways of doing it better. Learning methods that stress problem-solving, trying new experiences in different settings and exchanging knowledge increases workers' interest, confidence, commitment and self-reliance.

CE activities can be organised into **formal** or **informal** options. There are advantages and disadvantages to both, and CE can adapt either method to meet particular needs and conditions.

Formal learning includes courses that have **set curricula and structure** for fulfilling requirements to gain an **award or recognition**. It usually takes place in **classrooms**. Teachers **lecture** to students for a set period of time. Formal learning focuses on **memorising** theories and facts with some **practical experiences**. Students must meet set criteria and standards during the course to continue studying. **Examinations** are used to evaluate students' knowledge and determine whether they are qualified to receive an award. The most common formal learning options are:

- full-time institutional courses
- short-term or refresher courses
- distance education
- research projects.

Informal learning takes place **anywhere**, but mostly in settings where the learner works – clinics, schools, community. **Learners plan together with supervisors** what needs to be learned and how they will learn it. Informal learning focuses on **problem-solving, active experiences, providing guidance, and sharing** with others. Evaluation is in the form of **supportive supervision** to help learners put what has been learned into practice. Informal learning options include:

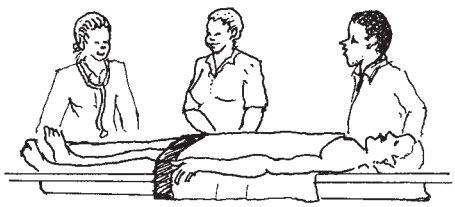
- enquiry, self-study or discovery, and independent research
- visits from experts, advisers and colleagues
- meetings with other health workers and professionals to discuss and solve work-related issues
- exchanges with or study tours of other health facilities to learn new procedures and practices
- meeting and learning opportunities provided by other groups or programmes involved in health-related activities
- educating others in work, clinical, classroom or community settings
- practising and accepting new tasks and responsibilities
- attending training, ward rounds, in-service sessions, workshops, seminars, etc, whenever possible.

Qualifications or credit can be gained from informal learning when criteria is predetermined and approved by accrediting bodies (professional bodies, civil service, etc).

In summary, continuing education provides workers with regular and frequent opportunities to acquire the capabilities identified as important to perform their work better (for example, knowledge, understanding, access to information and new skills).

Opportunities for learning through continuing education are limitless and can bring many benefits to workers, the work and the organisation.

Some ways of obtaining continuing education



Continuing education benefits workers by:

- picking up where basic education left off. It can guide and support new graduates in the transition from school to work
- not being restricted to one way of learning. It can use elements from both formal and informal education
- being limitless in range and scope. It can cater to any worker, whether doctors, nurses, radiologists, traditional healers or farmers
- being flexible and adaptable to any sector or situation
- never finishing. CE continually changes its priorities and needs. As learners achieve one skill, they are ready to learn another
- bringing a sense of accomplishment and pride in work well done. With added confidence, workers are willing to take on new challenges and responsibilities.

- using participatory approaches that coach workers in communication, negotiation and 'people' skills not usually taught in basic education courses. Through on-the-job experience and supportive supervision, workers learn to work with each other and with communities in resolving problems
- meeting human resource needs by upgrading staff from their present positions to posts that are lacking, using established criteria
- providing an alternative to institutional education for gaining basic or advanced qualifications and meeting course requirements while working on-the-job.

For more information…

…on continuing education, contact organisations found in **Useful Resources for Continuing Education** (following **Practical Pointers** section) and your local civil service or training and personnel departments within ministries and organisations.

Practical Pointer 2: Basics of participation

Since the early 1980s, people's participation has been promoted as the approach that brings success and lasting results to community and development work. When participation is done right, it empowers and transforms people and organisations by shifting control and power to the people most affected. The experience of practising participation in the Zanzibar Continuing Education Programme has revealed many valuable insights into the use, and abuse, of participation. These are the lessons we've learned about participation.

What is participation?

There is no definitive definition, but by providing a few descriptions, some common and essential traits of participation can be noted.

Participation…

…is a family of approaches and methods that enable rural people to share, enhance and analyse their knowledge of life and conditions in order to plan, act, monitor and evaluate together.

…gives people at the grass-roots level access to their key resources – power, knowledge and skills – by setting up appropriate structures and relationships in society.

…enhances people's capacities as individuals and groups to improve their own lives and to take greater control over their own decisions.

…is when people choose logically, emotionally and physically to commit to establishing, implementing and evaluating both the overall direction of a programme and its operational details.

Essential traits…

From these descriptions, we can summarise what participation can achieve through various methods and approaches. For people to become empowered,[25] they:

- **acquire and develop relevant competencies** (knowledge, skills, awareness, analysis) and confidence in understanding and changing their conditions
- **are involved and consulted** in decision-making processes, delivery of services or evaluation of a service

25 When people acquire awareness, understanding and the relevant capabilities, they are able to demand and manage actions and changes responsibly through their own initiative and control.

- **reach consensus** to take action – by discussing together and formulating a plan for action, then carrying out and sustaining their decision
- **control power and resources** by determining the direction and priorities of their development and employing mechanisms for managing and regulating their progress
- **accept responsibility** for, and challenges resulting from, actions and changes
- **determine if actions have made a difference in equity and well-being**[26] by monitoring and evaluating progress and changes resulting from actions.

To really empower others, **those in control must be willing to give up and hand over responsibilities that affect people to the people**.

Who is participation for?

- People with little or no control or power over decisions that affect their well-being
- People who have power and control over decisions that affects others and their well-being.

Through participation, the way people relate and work together shifts or reverses normally accepted practices. Centralised authoritarian, standard decisions are dispersed to local areas for people to control and to be accountable for decisions and initiatives.

Elements of participation

For optimum results and relationships in participation, there are some guiding principles or foundations to be considered. Chambers refers to these as the **Three Pillars of PRA**.[27] When the pillars interact, they reinforce each other and build on each other's effects, giving greater support and strength to achievements.

Pillar 1: Behaviour and attitudes

What we are and how we interact with others are fundamental attributes for learning and action. If we acted differently with people, outcomes would be different. By assessing our own values and actions, we can identify behaviours that

26 Well-being refers to good quality of life, such as having health, social relationships, basic services, freedom of choice, peace of mind, satisfaction, security, fulfillment and basic living standards.

27 Chambers, R (1997) *Whose Reality Counts?*, Intermediate Technology Publications, London, 1997, pp. 104–106 (PRA – Participatory Rural Appraisal).

hinder relating well with others and learn new ways of relating. In participation, we need to act in assisting others to gain the necessary capabilities to solve identified problems.

Pillar 2: Methods

Participatory tools have evolved and expanded to enable people to reverse normal ways of thinking and doing things. Various methods allow people to express, share and extend their knowledge and validate information for better analysis of situations and actions.

Methods can be created to meet the growing learning needs of people as they progress. As they become capable of doing one task, methods for learning the next step need to be ready. There's no limit to the different methods that can be used to increase people's capacity in learning to:

- **identify needs and priorities** (through mapping, modelling, observing, listing, counting, comparing, ranking, scoring, producing diagrams, investigating and estimating)
- **analyse and plan** (through processes that rank and score problems, preferences, opportunities and priorities for action)
- **monitor, evaluate and research** (by using methods to compare progress and changes after actions, or to watch for specific signs of change on a regular basis and document results)
- **facilitate, educate and share with others** (developing methods that enhance exchange of ideas, information and experiences with others).

Even though participatory methods make up a small portion of the total work done in development work, they can set the general feeling and atmosphere of how people relate and work together.

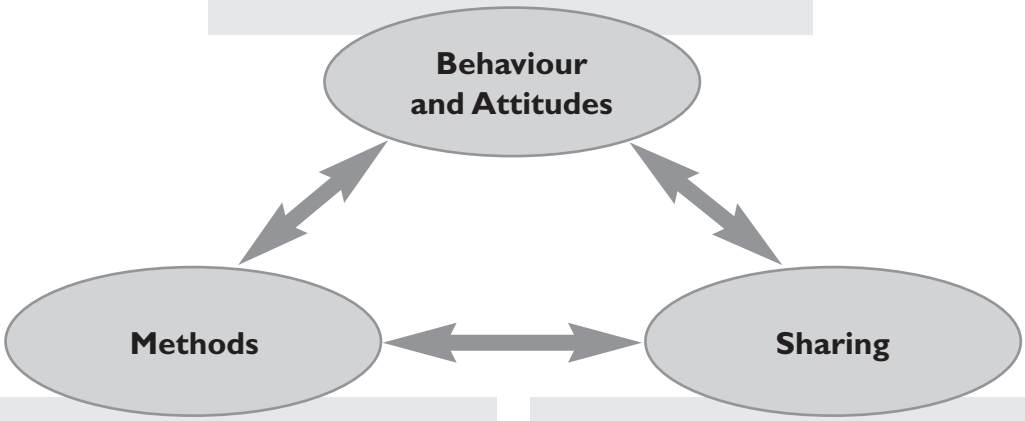
Pillar 3: Sharing and partnership

A culture of openness, transparency and generosity spreads when people willingly share whatever they possess. Sharing information, innovations, errors, examples, adaptations and resources builds new relationships and gives others ideas and encouragement to try something new. From these initial exchanges, alliances and partnerships can form among those with similar purpose and interests to combine resources for greater and longer lasting results.

Three Pillars of Participation

'People with Power' learn to:

- 'hand over the stick'/the control
- trust that they can do it
- use their own best judgement at all times
- sit down, listen, learn, respect
- unlearn
- embrace error and mistakes
- facilitate
- not rush – be relaxed
- ask them
- have fun
- be nice to people



'People without Power' learn to:

- interview
- map
- model
- rank
- score
- analyse
- produce diagrams
- present
- plan
- observe
- list
- compare
- count
- estimate
- act
- monitor
- evaluate

Together, people:

- share knowledge, ideas, facts and enquiries with each other
- exchange experiences of living, resources, food…
- facilitate and communicate experiences through training, working, media, and exchanges on all levels – local NGOs, government, universities, donors, etc.
- form alliances and partnerships

Through the activation of these **participatory pillars** and essential traits, major shifts in current thinking and conventional practice can occur. There will be changes in individuals, in organisations, in the work and how it's done, and in commitment and responsibility for actions and the well-being of others. As the pillars interact, changes will begin to unfold.

What hinders participation?

Reasons for participation not working well are many and diverse. Stumbling blocks will always exist but shouldn't stop attempts to try participatory approaches. The following tips can help avoid common mistakes that hinder people's involvement and participation.

- **Imposing and dominating** – is the most common mistake made in participation. By considering ourselves superior, either consciously or unconsciously, we send people messages telling them what they ought to think and how to do things. These messages of superiority can be sent verbally (lecturing, interrupting, criticising, preaching, shouting down and manipulating until they see things our way) and non-verbally (body language, facial expressions, hiding behind desks, type of dress and accessories) and cause great damage. We've all done it… and are aware we still do it… but try to do it less often!
- **Starting from scratch** – this is another major reason for failure of participation. Instead of determining what is already being done, what groups already exist and what structures are already in place, some facilitators think they have to start afresh with new groups, activities or initiatives instead of building on what already exists, what can be adapted and what they're comfortable with.[28] Making adjustments within accepted practices, groups and structures is easier than starting from the ground up and the changes made are more likely to be sustained.
- **Rushing** – all too often, we are more concerned about completing a process or method than taking the time to learn about people and their concerns, which damages our sincerity and credibility as facilitators. Common courtesies, good manners and a relaxed, friendly atmosphere go a long way in building rapport, showing interest and earning people's trust. The time spent in explaining who you are, why you've come and what you can and cannot do establishes early what

28 We all know of instances where villages have functioning health and school committees and yet malaria committees, diarrhoea committees and HIV/AIDS committees are formed, sometimes with the same people! Each may have different leadership and management requirements creating sources of duplication, inefficiency and conflict.

they can expect and what they'll get out of it – which saves time in the long run! It's difficult to know how much time participatory processes will take, so flexibility and willingness to pursue the matter until it's resolved (which may require returning on several occasions) are much better than rushing to finish on schedule. **The more the rush, the less time and opportunity for consultation** and the greater the imposition of our views on project plans and appraisals.

- **Routines and ruts** – often we use a particular method with different groups of people, and it becomes very easy to fall into the habit of doing it the same way each time – or falling into a rut. There is no one way or right way of using participatory methods and it's our responsibility to create and invent fresh approaches so we avoid making a routine of processes. Also, if a process has been successful, we might repeat it until it becomes a routine without flexibility. The danger is that the method might become standard in practice and responses. There is no perfect recipe or formula for participatory tools – they're all open to adaptations and revisions.

- **Using 'foreign' languages** – people's participation is better achieved when the language they're most familiar and comfortable with is used. English and French are used for the benefit of outsiders, but they're an obstruction for those with a different first language like Kiswahili. Another hindrance regarding language is using too technical or trendy words without full explanation or description. It's much better to avoid these unless they're really necessary.

- **Biases** – due to pressures of time or convenience, participation often involves those who have the time or are better off, who are usually the privileged or elders (men mostly). Unless carefully considered and offset, differences between sexes, ages, vulnerable or marginal groups and occupations are easily overlooked. We assume[29] one group can speak for all diverse groups. Our own biases towards people (do we relate to people differently because of their colour, sex, language, educational background, religion, accent, status or age?) need to change for us to be effective in contributing to the equitable development of all people.

- **Taking without giving** – during participatory activities, people give up lots of time and information that are extracted for research or planning purposes. Even though they may enjoy the processes, they may never see the researcher or planner again. So what happens to the information and how will it be used? Who owns it? And who benefits? Providing people with explanations of information,

29 As my daddy taught me, never **assume**: it makes an **ass** out of **u** and **me**.

updates on how it's being used and ownership of information produced gives back some of the information that was taken. Remember, common courtesy, good manners and transparency (not to mention sound ethical practice) go a long way in building trusting relationships.

- **Raising expectations that can't be met** – all too often, participation has been used for appraisal, planning and action purposes requiring long periods of intense and engaging activities that build people's hopes and expectations that some future action will be taken. Again and again, organisations and outsiders have not responded or have failed to honour their pledges, resulting in disappointment, low morale, frustration and hesitancy to join future development or participatory processes.
- **Avoiding conflicts** – whenever changes occur, there's always going to be resistance, challenges and conflicts. It's a normal part of working with people. However, facilitators who are not comfortable with confrontation, arguments and disagreements and try to avoid them will lose credibility, trust and respect. Those who try to avoid conflict usually impose their views when it gets uncomfortable, to put an end to negotiations – and their views dominate. Even though it can be difficult, people expect good facilitators to allow all sides of an argument to surface so that people struggle to find an agreement that everyone can accept; and then they can move forward together.

Other tips may surface as you begin putting participation into practice and you'll be able to add to the list we've started here. Be sure to create opportunities where you can share your experiences of how to remove stumbling blocks to participation so more people will want to become involved.

Are there differences in how participation is practised?

Like any other method or approach, participation can be done badly and *is* being done badly on a growing scale.

Over the years, participatory development and learning has spread with alarming speed across continents, countries, professions, organisations and communities with different interpretations of participatory values, concepts, methods and behaviours among practitioners and facilitators. This rapid spread, especially imposed from the top down through prescriptive methods and actions, has brought bad practice. Many practitioners/facilitators are not equipped with the necessary skills, faculties and attitudes to deal successfully with the complexity, variety, imprecision, uncertainty and conflict that true participation brings.

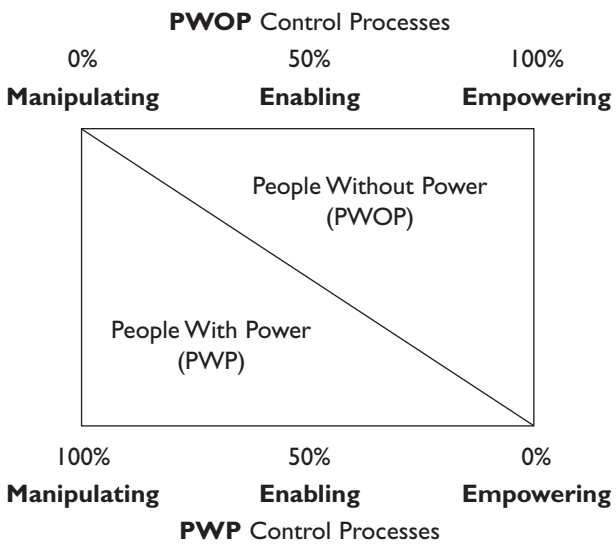
The range of participation in practice extends from total control and manipulation of people at one end of the scale to empowered, self-reliant, responsible people at the other. **Participation that controls and manipulates** tries to maintain existing conditions and is adverse to change. **Participation that empowers** creates conditions that enable people to control and change their circumstances.

People with Power (PWP) over others (decision-makers, facilitators, educators, outsiders, bosses, managers, supervisors and those in higher positions) decide the type of participation that is used. They create, direct and set conditions for people to learn to take control of their development. The degree of handing over these responsibilities to people determines whether participation is being used or abused, and will produce dramatic differences in the results.

People without Power (PWOP) (workers, beneficiaries, insiders, those in lower positions, vulnerable groups, etc) need opportunities to learn to take charge and be accountable for decisions and actions through participatory values, methods and processes.

Types of participation

The following tools demonstrate the range of participation and the different conditions and effects each one can create. The degree (percentage) that **PWPs** or **PWOPs** control participatory processes determines whether participation is manipulating or empowering.



What kind of participation is being used?

To determine how participatory your programme, activity, project, intervention or organisation is, and to see who controls which participatory processes, the following exercise can be a guide. It can be done individually or as a group.

Instructions

1. Look at question A and decide what percentage of control People Without Power (PWOPs) have over each process from a to j in your project, programme or organisation. Mark the spot on the graph that best corresponds to the percentage decided until all of the 10 processes have a score.

   [ie, in the first process 'identifying needs', PWOPs had been involved in doing surveys, assessments and planning, but the activities were organised by PWPs. So we might give this process a score of 60% and mark it on the graph (see example).]

2. When you've completed all the questions and the graph has been marked, look below the graph to see in which condition (manipulating, enabling, empowering) the marks most often appear. This is the type of participation that's currently being used.

   [It's common for a combination to exist since some processes show better progress than others. This tool can identify processes where participation is weak so that action can be taken.]

3. Add up the scores from the 10 processes for a total, then divide by 10 to find the average score.

   [Congratulations if your average score is greater than 50. You're working in several areas in enabling and empowering people to gain control over their lives.]

A To what extent do PWOPs control the processes of:

a) identifying needs?

b) analysing findings?

c) planning?

d) budgeting?

e) implementing?

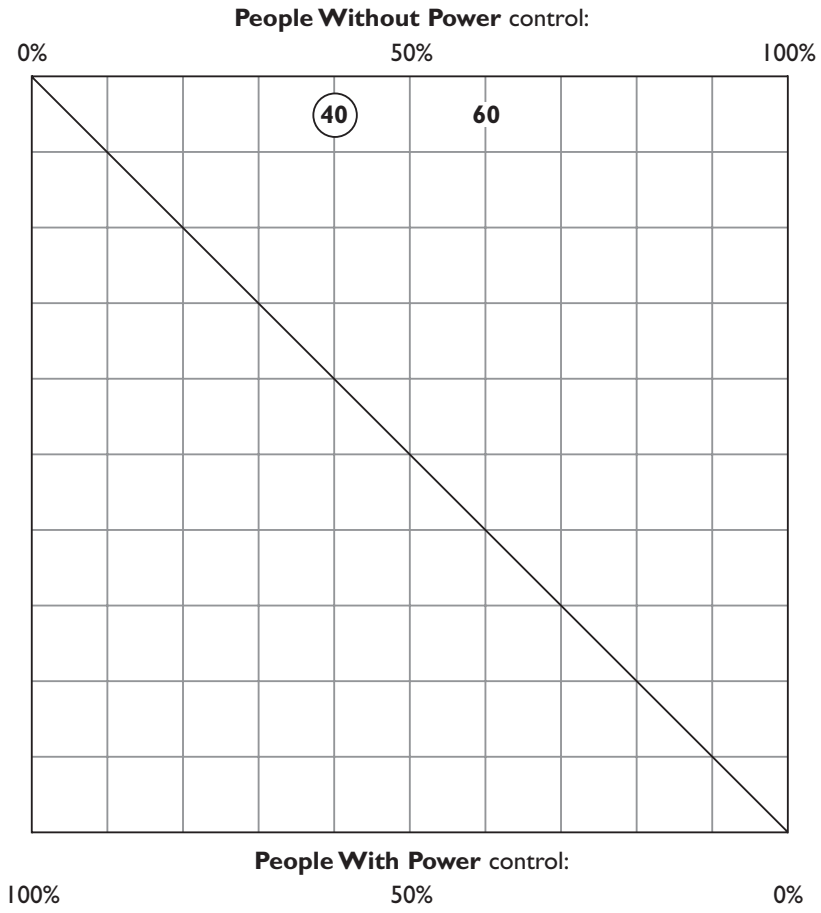
f) monitoring/follow-up?

g) evaluating?

h) training and educating?

i) managing resources?

j) decision-making?



B To what extent do PWPs control the same processes (a–j)?

4. Look at question B and decide what percentage of control People with Power (PWPs) have over processes a to j. Mark the spot on the graph that best corresponds to the percentage decided and encircle the score (see example on graph). Repeat steps 2 and 3 to see what condition exists and calculate the average score. Scores should be considered separate from question A.

Are conditions different or the same between questions A and B? When average scores for questions A and B are added together, do they equal 100%? If not, this can act as a discussion point between workers to determine what the real situation is.

So what kind of participation score and condition mostly exist in your situation? Are you happy with the results? If not, the next section can be used as a guide for making changes in behaviours and attitudes in order to improve conditions and further participatory processes.

Three approaches to participation and their effects

Type of approach	Manipulating	Enabling	Empowering
Aim	• Keep control and order • Maintain status quo • Resist change	• Create opportunities to meet and exchange ideas • People work together to accomplish tasks	• Equip people to control their lives • Transform people and organisations
General approach	• Authoritarian • Dictatorship • Centralised • Rigid top-down control	• Teamwork • Capacity-building • Delegation • De-concentration • Sharing power and control • Selective involvement – ad hoc	• Democratic • Humanistic • Consensus-building • Decentralised • Controlled by the people
Strategy	• Product more important than process and people • Output is paramount • One-way communication: top-down directives and orders	• Stimulate and develop interests or abilities of individuals and groups • Encourage interaction and networking • Free exchange; two-way communication; feedback • Build on strengths and downplay weaknesses	• Aims of people and organisation the same • People regain control and power over lives • Challenge injustices, inequities, corruption • Open communications: top-down, down-up, sideways • Systems responsive to people
Basic assumptions	• People are tools to do tasks • Needs of organisation are supreme • Rules are to be strictly enforced without question • Change leads to chaos, conflict and confusion	• People want to develop and learn through work and others • People can be trusted to make sound decisions • Organisations can change to accommodate the needs of the people and still fulfill their purpose • Rules need to be reviewed in light of the changing circumstances • Change is inevitable – it is a sign of growth and provides new challenges	

Type of approach	Manipulating	Enabling	Empowering
How workers are viewed	• Can't be trusted • Require strict supervision and control • Lazy; no initiative • Ignorant; know little about doing things properly • Cowardly; won't stand up for anything • Passive-aggressive tendencies; sabotage plans through non-action	• 'Diamonds in the rough' – many talents but need some polishing • Afraid of trying something new • Need to be shown and given direction • Trustworthy and dependable, until proven otherwise • Suspicious and cautious of abilities and motives	• Equal – as colleagues • Respected • Know and accept strengths/weaknesses • Capable; can be trusted without reservation • Responsible and accountable • Self-reliant: take care of self and others • Dependable: do what they say they'll do • Resource when needed
How bosses are viewed	• Have the answer to everything • Don't make mistakes • All-knowing; all-seeing • Not to be questioned • Know what is best • Superior in all respects	• With suspicion and caution initially regarding their capabilities and intentions • Willing to listen • Defend: speak up for colleagues • Direct; honest; don't mix words • Admit mistakes – sometimes • Afraid to give up power and control	• Equal – as colleagues • Respected • Know and accept strengths and weaknesses • Capable; can be trusted without reservation • Responsible and accountable • Self-reliant: take care of self and others • Dependable: do what they say they'll do • Resource when needed
Effects on the work and the workers	• Frustration; low morale • Lack of commitment and loyalty • Work gets done; little regard for accuracy or quality • Wait for instructions; little initiative or creativity • 'Punch the clock' mentality; don't think of work after hours • Isolated from others; few opportunities for interaction • Respect reserved for superiors and higher-ups	• Renewed interest in work; energised • Profusion of initiatives and ideas • Willing to try new ways of working and accept failures or successes • Use experiences to learn and change • Relationship-building – both personal and professional • Form formal and informal networks • Develop outside linkages	• Enthusiastic; energised • Take interest in others and their work • Committed to the work and the people • Concern for quality; doing it right and well • Eager to pursue new challenges and responsibilities • Have outside interests and social causes • Recruit, advocate for and encourage others in their efforts

continued overleaf

Type of approach	Manipulating	Enabling	Empowering
Effects on the work and the workers *continued*	• Blame others	• Respect and appreciate those who act the same way towards them	• Respect and support everyone • Take initiative and follow through • Are responsible and accountable for actions
Methods of working	• Directives; orders • Instructions • Rules and regulations • Fear and intimidation • Threats • Punishment and punitive measures • Fines and penalties	• Committees; group discussions; formal and informal meetings • Problem-posing and problem-solving approaches • Dialogue and negotiation • Voting, agreements and consensus-building • Guidelines and procedures resulting from agreements • Positive reinforcement: praise and compliments • Personal and professional incentives and benefits • Rewards and recognition for good performance or achievements	
Learning and training	• Spoon-feeding; passive teaching; lectures • Regurgitation of facts • Facts have little to do with real-life situation • Topics determined by superiors • Evaluation of acquired knowledge only; skills and attitudes rarely assessed • Once training is done, no efforts are made to follow up to see if changes have resulted from the training • Only those with proper teaching qualifications know how to teach	• Active teaching: group discussions and practicals • Teacher decides what is the right answer • Students participate in some activities, but they must be controlled • Topics approved by superiors and manuals provide necessary content and criteria for training • Evaluation of acquired skills and knowledge • Follow-up rarely done to determine changes in performance resulting from training • Learn from each other, but the expert has the final word	• Active teaching: learn through experiences of doing and discussing • Open-ended dialogue • Everyone educates each other and learns from their experience • Topics selected by group priorities, needs and interests • Sessions continue until everyone is clear on what is expected and their considerations are addressed • Evaluation in the form of follow-up support; what problems are there in implementing changes? • Everyone is qualified to educate others

Indicators of empowering participation

When true participation is working, there will be changes in personal values and actions, and changes in the **system** (organisations, operations, procedures, etc).

When participation has been done well, it has often brought **personal change** for those who facilitate it – a personal **transformation**. They have found new pleasures, satisfaction, insights and interests. Their conversion to participatory approaches becomes a way of life that's evident in any interaction with people.

Indicators that show that conditions in **systems** are changing[30] through empowering participation include:

- **Behaviour** – Respecting, trusting, listening to, learning from, handing over, enabling and empowering, and encouraging others to do the same
- **Trust, error and truth** – Trusting others to exercise responsible judgement. Rewarding truthfulness and honesty. Encouraging them to 'fail forwards'. Acknowledging and reporting error. Valuing unpalatable truths as opportunities to learn and do better
- **Accountability** – Shifting from being accountable only to superiors, to workers being accountable downwards and laterally for their performance
- **Management** – Instituting and supporting democratic and participatory management
- **Reversals of power** – Learning to enjoy giving up the normal exercise of power by bosses and workers learning to enjoy accepting and exercising more responsibilities
- **Disbursements** – Refraining from and resisting pressures to disburse large sums fast. Changing procedures, values, indicators and rewards to stress quality, participation and sustainability
- **Diverse experience** – Deciding where and how best to work. Seeking a mix of locations, posts, responsibilities and experiences in the interests of learning, improving judgement and seeing what works best.

30 Adapted from Chambers, R (1997) *Whose Reality Counts?*

In conclusion…

…when true participation happens, major shifts and reversals in normal tendencies take place in individuals and organisations. The following table summarises some of the changes participation can bring (adapted from Chambers' ideas).

Expected reversals when participation empowers

	From normal tendencies of:	To making shifts towards:
Approach	People with Power who: dominate instruct extract and exploit	People with Power who: facilitate listen empower
Views towards development	Things first – Men before women Professionals set priorities and targets Implement using manuals, 'sacred texts', expert instruction Technology transferred in set packages Simplify and standardise No disbursement unless targets met	People first – Women before men People, especially the marginalised, set priorities Individual responsibility – use your own best judgement Technology transfer – baskets of choices Complex, complicated, unpredictable Sharing progress and what works
Administration	Centralised, conformity, controlling Ritual, formal procedures Secrecy and suspicion Punitive management	Decentralised to district, community level Diversity, innovation, individualism, constructive dissent Enabling conditions, transparency and trust Incentives, recognition of achievements
Modes of learning	From above Passive, teaching by lecturing Classrooms, meeting rooms Stresses acquiring knowledge and passing tests	From below Interactive and practical experience Discovery and reaching own conclusions Workplace, field, community Focus on personal learning needs to become self-reliant
Monitoring and supervision	'Rural development tourism'[31] Standard procedures, activities, checklists	Rapid and relaxed, but not rushed Supportive follow-up Participatory appraisal methods
Evaluation	Questionnaires, surveys, measurement and statistics	Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA) methods
Analysis and action by	Mainly professionals, advisers, outsiders	Mainly local people, insiders

31 Chambers' term that describes how local staff plan and orchestrate brief, scheduled rural visits for urban-based outsiders (VIPs, superiors, officials) for purposes of showing 'successes' and leaving 'tourists' with a good impression, but it does little to inform them of the real situation and its challenges.

Practical Pointer 3: For better learning

Every day, people are challenged by changing situations at home, work, market, school, etc. It is essential they develop moral, spiritual and mental **capabilities to socialise, adapt and survive** in these dynamic environments. For people to be able to survive and adapt effectively, they must possess the **power to learn**. As people exercise new abilities in solving problems and making changes successfully, the results have widespread and lasting effects on individual, community and national development.

The value of learning is often underestimated. Greater attention and effort in providing better learning and educational opportunities that meet people's changing needs are vital.

What is meant by learning?

Learning is a daily and lifelong process that enables people to be aware of factors affecting their situation and find ways to adapt to the new conditions. People take appropriate actions or make changes when they have gained the necessary knowledge, skills, attitudes and resources to solve current problems. Put another way, learning is concerned with *the growth of* ***knowledge and awareness****, the awakening of* ***understanding*** *and the acquisition of a variety of* ***skills and competencies*** *to survive and thrive*.[32]

Learning = awareness + knowledge + understanding + skills + attitudes + resources + competence = **Action and Change**

How learning occurs influences **what** is learned. The **method** and **relationship** between teacher and learner, can either increase one's confidence or increases feelings of frustration. Methods and approaches that are *active, practical, stimulating, relevant and fun* make for better learning.[33]

Why do health workers need to know about learning?

Health workers' first job is to teach and help others to better understand and resolve problems affecting their health. Skills that help health workers observe, understand and explore ways of improving people's lives and health are essential. Unless they have learned these and other practical health education and problem-solving skills, their efforts will have little value and show few results.

32 'Training: A Process of Empowerment', *Bernard van Leer Foundation Newsletter*, Number 55, July 1989, p. 1.

33 For more ideas on these methods, refer to *Helping Health Workers Learn*.

Unfortunately, most of us teach the way we were taught, which did little to encourage us to **see** (*observe*), **think** (*understand*) and **act** (*explore*) in the struggle to overcome causes of ill health. Its ways are so embedded that we may not know or trust other ways of learning.

For us to become effective educators and facilitators, we need to learn new ways and skills to make learning more meaningful, useful and adventurous for ourselves, and others.

Ways to strengthen learning

To increase people's capacity to learn, activate as many body senses as possible during learning sessions! Methods and processes that involve **physical and mental activities**, and **challenge accepted values and ways** of doing things are more likely to be remembered and adopted into use.

Sense organs needed for learning

- **Eyes** – for seeing, observing, looking things up and reading
- **Ears** – for hearing and listening to others
- **Mouth** – for sharing, discussing, asking, consulting and tasting
- **Nose** – for detecting odours and smells
- **Skin, hands and body** – for touching, feeling, doing, practising, experimenting and experiencing
- **Brain** – for processing, analysing, reasoning, recalling, reflecting, searching for answers, adding emotions to incoming information from other senses, responding, and reacting to information.

Some learning methods that stimulate and challenge many senses include:

- research and self-study
- role-plays
- dialogue and discussion
- problem-posing or searching questions that encourage thinking, analysing and problem-solving

- trial and error experimenting
- hands-on practice and experience.

Learning to think, explore and solve problems is best done during practise and experience. But some classroom learning is helpful, especially if approached in an active, explorative and realistic way. The trick is finding a balance of educational methods that brings learning to life – and life to learning!

Learning versus education

The purpose of learning and education is the same: **to gain or access the necessary resources** (*knowledge, skills, attitudes, awareness and understanding*) **to meet life's needs and responsibilities**. Education is one of many tools that can assist learning.

Learning occurs when people change (*values, attitudes, actions, conditions*) after completing certain processes or steps. Steps leading towards change include seeking information, reflecting, analysing and deciding on a course of action, and then acting. Learning occurs anywhere, anytime, about anything, and for everyone.

Education is the main tool for learning. It organises the structure and framework for people to gain knowledge and related skills. It sets criteria for course content, teacher and student qualifications, when and where teaching will take place, and standards to achieve awards.

But not all education facilitates people's learning!

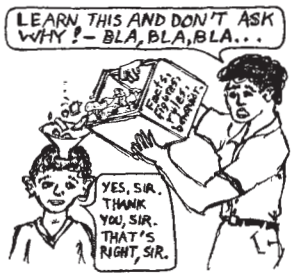
Different approaches to education

Different approaches to education have different effects on those learning and what is learned. The way people are educated can either break down or build up self-confidence and self-reliance. The educational approach determines if people really learn.

In *Helping Health Workers Learn*, David Werner (1991) talks about two different kinds of educational approaches: **education of authority** and **education of change**.

Education of authority is characterised by traits such as:

- the only way to learn is to be taught by someone who knows more than you
- teachers are the authority and are not to be questioned
- students listen, memorise, follow and obey



- stronger students are rewarded and the weak left behind
- the emphasis is on following rules, being on time, and behaving like others
- order and control are maintained using authoritarian measures (fear, belittling, threats, punishment, whipping, etc)
- teachers provide the approved knowledge and students receive it; ideas are put into students' heads without thinking or understanding.

Advantages: big groups can be taught in a short time; teachers can manage the class; and many subjects can be covered at one time.

Disadvantages: low degree of understanding due to lack of opportunities for questioning or discussion; no sharing or exchanging views; teachers act superior resulting in bad relationships with students; passing tests is most important – information is forgotten after the test; develops short-term memory, but does little for reasoning and thinking.

Education for change aims to promote:

- learners' capacity to observe, criticise, analyse and figure things out for themselves; learning is more important than teaching
- exploring, discovering and thinking of innovative ways to meet needs and solve problems
- expressing, questioning, sharing and discussing ideas, views, information, solutions, etc
- learners and teachers relating equally
- co-operation, not competition, among learners, and looking for answers together
- active learning methods, practice and experience for better understanding, reasoning and judgement.

Advantages: everyone contributes in solving problems and meeting needs; learners feel free to contribute; people are respected, trusted and treated equally; there are no limits on subject material – it is open-ended according to needs and interests; information is understood by learners, remembered and put into practice; people work together; it's interesting, adventurous and active; it challenges one's values, beliefs and practices.

Disadvantages: it takes time to reach a conclusion that everyone will agree to; only a few subjects can be covered; group work can be noisy, dominated by some or boring;

some feel threatened expressing themselves; facilitators are dependent on learners to contribute information.

These two approaches are at distant ends of the education spectrum with various approaches in between. The chart that follows has summarised 'Three Approaches to Education', that include the ***authoritarian*** *approach* at one end, the ***change*** *approach* at the other, with the ***enabling*** *approach* in between. This can help us determine which approach we are using and what areas need changing. As educators and facilitators, we need to critically examine the way we teach and determine where we fit on the educational spectrum for better learning to occur.

Three approaches to education

The chart overleaf gives a summary of three approaches to education described in *Helping Health Workers Learn*: **authoritarian** (manipulating), **enabling** (progressive) and **change** (empowering). When compared with the different participatory approaches in **Practical Pointer 2** (pages 100–114), many similarities can be seen in the kind of conditions that exist when a particular approach is used.

The educational approach one uses will have a lifelong impact on people's desire for further education and their attitude towards learning. By providing education that enables people to become capable of self-direction, confident in problem-solving, able to work with others effectively and aware of the power and responsibility they possess to change conditions for the better, then we have truly facilitated learning.

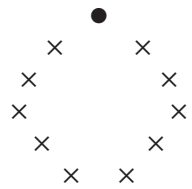
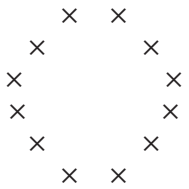
The human mind is made to think and explore. It grows stronger with exercise. But it grows weak, lazy or resentful when limited to 'clearly defined tasks'.

Three approaches to education

Areas of difference	Authoritarian/ Manipulating	Progressive/ Enabling	Change/ Empowering
Function	To conform	To reform	To transform
Aim	Resist change Keep social order stable	Change people to meet society's needs	Change society to meet people's needs
Strategy	Teach people to accept and fit in to the social situation without changing its unjust aspects	Work for certain improvements without changing the unjust aspects of society	Actively oppose social injustice, inequality and corruption. Work for basic change
Intention towards people	Control them – the poor and working people	Pacify or calm them – especially those who protest or revolt	Free them – from oppression, exploitation, corruption
General approach	Authoritarian (rigid top-down control)	Paternalistic (kindly top-down control)	Humanitarian and democratic (control by the people)
Effect on people and the community	Oppressive – rigid central authority allows little or no participation by students and the community	Deceptive – pretends to be supportive, but resists real change	Supportive – helps people find ways to gain more control over their health and their lives
How students (and people) are viewed	• Basically passive • Empty containers to be filled with standard knowledge • Can and must be tamed	• Basically irresponsible • Must be cared for; need to be watched closely • Able to participate in specific activities when spoon-fed	• Basically active • Able to take charge and become self-reliant • Responsible when treated with respect and as equals
What students feel about the teacher	**Fear** – teacher is an absolute, all-knowing boss who stands apart from and above students	**Gratitude** – teacher is a friendly, parent-like authority who knows what is best for the students	**Trust** – teacher is a facilitator who helps everyone look for answers together
Who decides what should be learned	The Ministry of Education or Health in the capital	The Ministry, but with some local decisions.	The students and facilitators together with the community

Areas of difference	Authoritarian/ Manipulating	Progressive/ Enabling	Change/ Empowering
Teaching method	• Teacher lectures • Students ask few questions • Often boring	• Teacher educates and entertains students • Dialogue and group discussions, but the teacher decides the right answers	• Open-ended dialogue, in which many answers come from people's experience • Everyone educates each other
Main way of learning	PASSIVE – students receive knowledge Memorisation of facts	More or less ACTIVE Memorisation still basic	ACTIVE – everyone contributes Learning through doing and discussing
Important subjects or concepts covered	• Rules and regulations • Obedience • Much that is not practical or relevant – it is taught because it always has been • Unnecessary learning of big words and boring information	• Desirable behaviour • How to make good use of government and professional services • Integrated approach to development • Simple practical skills often of little use	• Communication skills • Learning and educational skills • Organisational skills • Innovation and self-reliance • Use of local resources • Local customs • Critical analysis and social awareness • Confidence- and esteem-building • Human dignity, equality and rights • Methods to help weak grow strong
Flow of knowledge and ideas	School or health system ↓ Teacher ↓ Students One way (top-down)	School or health system ↓ Teacher ↓ Students Mostly one way	Students ↔ Group leader ↔ School or health system Both ways
Area for studying	The classroom	The classroom and other controlled situations	Life is a classroom

continued overleaf

Areas of difference	**Authoritarian/ Manipulating**	**Progressive/ Enabling**	**Change/ Empowering**
How the class sits			
Class size	Often large Emphasis on quantity, not quality, of education	Often fairly small, to encourage participation	Often small, to encourage communication and learning by doing
Attendance	Students **have to** attend	Students often **want to** attend because classes are entertaining and they will earn more if they graduate. Incentives are given	Students **want to** attend because the learning relates to their lives and needs, and because they are listened to and respected
Group interaction	**Competitive** (co-operation between students on tests is called cheating)	**Organised and directed** by the teacher. Many games and techniques are used to bring people together	**Co-operative** Students help each other. Those who are quicker assist others
Purpose of exams	Primarily to weed out slower students Grades are emphasised Some students pass; others fail	Variable, but generally, tests are used to pass some and fail others	Primarily to see if ideas are clearly expressed and if teaching methods work well No grades Faster students help slower ones
Evaluation	Often **superficial** – by education or health system. Students and community are the objects of study	Often **over-elaborate** – by education or health experts. Community and students participate in limited ways	**Simple and continual** – by community, students and staff. Students and teachers evaluate each other's work and attitudes
At the end of training, students are given…	• Diplomas • Irregular, police-like supervision	• Diplomas • Uniforms • Salaries • Supportive supervision	• Encouragement to work hard and keep learning • Supportive assistance when asked for
After training, health workers are accountable to…	…their supervisor, the health authorities, the government	…mainly to the health authorities, less so to local authorities and the community	…mainly to the community, especially the vulnerable, whose interests they defend

Changes needed for more effective learning

It's time to critically evaluate whether education is fulfilling its purpose, and if not, what changes can be made so that it does.

Learning, and in turn wisdom and good judgement, can only develop through a combination of experience and education provided in a variety of settings. Some of these are best suited to universities, some to practice in the field, and others to new forms of learning that combine elements of both. The key is to make **people** (*how they live, think and understand their situation*) the main focus of our duties as educators and facilitators.

The following suggestions reflect changes that need to be made in education in order to create new learning environments that foster appropriate development and learning:

1. Shift people's views of education and learning so that…

- listening, considering, discussing, dealing with conflicting views and negotiating solutions becomes the norm
- freedom of expression, sharing and tolerating different views become standard practice
- challenging existing values, opinions, customs and practices becomes less threatening
- those who have learned to express feelings and assert themselves, defend others or initiate changes aren't resented, intimidated or discriminated against.

2. Shift from conventional to empowering education by…

- limiting lectures and making interactive learning the key (learning from and with peers)
- providing as much direct, hands-on experience as possible in settings similar to real life
- both teachers and students becoming facilitators to contribute to each other's learning
- changing curricula so that they include topics in empowering others, facilitating change and learning, communication skills, etc
- valuing the individual – their personality, strengths, diversity, creativity, arguments and comments.

3. Shift from being teachers to facilitators who…

- can admit personal limitations and biases regarding people and educational preferences
- are willing to change values and ways of working with people to help them learn and solve problems for themselves
- trust, respect and treat people equally
- understand human nature and accept that learning and working with people is unpredictable, complex, diverse, uncertain, dynamic and can bring conflict
- have skills in communicating and working with groups, community organisation and accessing local resources
- build others' interest, initiative, confidence, wisdom, awareness, common sense, independence and self-reliance in meeting their learning and educational needs
- provide the stimulus or act as a catalyst for others to learn and change.

Planning for people-centred learning

Helping Health Workers Learn provides very useful information about starting participatory or people-centred learning. In Zanzibar, this book guided us during the initial stages of the ***Continuing Education Programme***. The area of the book that was particularly useful was the chapter 'Planning a Training Program'. We adapted this chapter to set up ***CE***. Our version of the ***CE*** planning process is summarised below. These steps have been effective and successful for the ***CEP*** and may guide others to start people-centred education programmes or courses.

Suggested steps for planning effective learning programmes

1. **List the main problems** that affect people's (or health workers') work, health and well-being.
2. **List the main subjects or interests** people (or workers) want to learn more about.
3. Compile lists. **Determine which problems and interests are most important to the people** (or specific workers). From this list **determine which problems and interests can be solved through education or learning** activities.
4. From agreed list, **determine top priorities**, generally (for all) and specifically (for selected workers).

5. From priorities, **decide ways problems might be addressed and what specifically should be emphasised**. To do this, consider local factors, available resources, probable strengths and limitations of targeted health workers and what is necessary for them to work better.

6. **List areas of knowledge and abilities health workers will need** to solve priority problems. Arrange these into groups or subjects (or objectives) for active, problem-solving study.

7. To determine the length of each learning activity, **consider how much time may be needed** for each subject or study area. For each subject, try to **balance learning methods** between **discussion-type sessions** and **practice**. Also seek a balance between treatment and prevention, learning skills, physical work and play.

8. Make a **rough plan** for each course or activity. Each activity plan would include problems to be addressed, objectives, activities for specific target groups, learning method or process, time frame, resources needed (human and material), expected behaviour changes, plans for follow-up and proposed budget.

Problem	Objectives	Activities	Target group	Method/ process	Time frame	Resources	Expected behaviour	Follow-up plans	Budget

Practical Pointer 4: Monitoring and evaluating a *continuing education programme*

When the Zanzibar ***Continuing Education Programme*** (***CEP***) began, it realised ordinary methods of monitoring and evaluation didn't reflect the participatory nature of the programme. Determining changes in people's behaviour and health problems resulting from ***CE*** activities needed different ideas, indicators, methods of collection and analysis than those commonly used.

Since little information was available at the time, we developed and evolved ways of determining how well ***CE*** was being done and how well the ***CEP*** was achieving its goal using participatory approaches in monitoring and evaluation. Lessons learned through the ***CEP***'s experience may help others to better monitor and evaluate their own continuing education activities or programme.

Evaluation and its methods

Many people are afraid of evaluation because they think of it as complicated research conducted during a limited time. But it can also be simple, continuous and improvised. There are many approaches to and purposes for evaluation that aim to answer the following questions:

- What was the activity, project or programme trying to accomplish? What were its goals, objectives and plans?
- What has been accomplished so far?
- What has been done well?
- What difficulties or problems have been encountered?
- What recommendations can be made to improve how things are going in reaching the goal?

Deciding on the kind of evaluation to use, consider **what** is to be evaluated, **why** it is being evaluated, and **who** is most suitable to do it. When participation is part of the programme, consider these kinds of ongoing evaluation processes:[34]

- **Continual evaluation**: occurs throughout the project or activity. It is less structured, often spontaneous, and involves questioning and reflection among workers when needs arise.

34 Adapted from *Helping Health Workers Learn*.

- **Follow-up evaluation**: is based on the results or effect of an activity after it has been completed. It tries to determine how successful an activity was in causing specific changes or effects.
- **Periodic evaluation**: takes place at certain times during a project or activity (*ie once a week, mid-year, mid-term*). It reviews the overall progress of the project or particular activities at agreed or pre-determined intervals.
- **Final evaluation**: takes place at the end of a project or activity before the next one begins. It can address the strengths and weaknesses and how the project/activity can be improved next time.

Over the course of the ***CEP***, all of these methods have been, and most still are being, used to monitor and evaluate the effectiveness of ***CE*** activities and the ***CEP***.

Getting started

Monitoring began when the Continuing Education Unit (CEU) began visiting Continuing Education Committees (CECs) on a regular basis. Each visit's activities were documented and used as progress notes. Once CECs started up ***CE*** activities, reports were submitted. From these activity reports (*of information CECs decided was important to include*), key areas or **indicators** were identified and compiled by the CEU into a reporting format guide for CECs and Ministry of Health (MoH) programmes to follow. Currently, monitoring ***CE*** activities is done through quarterly **CEC visits and activity reports**, **zonal *CE* integration meetings and plans** from MoH programmes and Health Management Teams (HMTs).

As ***CE*** expanded its scope, the ***CEP*** realised other tools were needed to determine how well the programme was meeting the needs of health workers and the Ministry:

- The annual ***CE* Planning Meeting**, where CECs, HMTs, MoH programmes, MoH officials and donors review the previous year's ***CE*** activities, critique each other's proposed ***CE*** plans and methods, and recommend improvements for the coming year
- Another tool is the annual ***CE* Review Meeting**, where MoH officials and donors meet with the CEU to 1) review and discuss programme objectives and activities, 2) recommend direction, priorities and improvements, and 3) approve ***CEP*** plans for the coming year.

Methods of evaluating CE

The ***CEP*** used, and still uses, the following methods to evaluate how well activities are being done and how well the programme is meeting its objectives:

- **Continual evaluation**: is used during ***CE*** sessions and activities, ***CE*** planning, meetings and informal discussions.
- **Follow-up evaluation**: is conducted on a regular basis after ***CE*** activities or training (*by CECs, HMTs, facilitators or supervisors*) to see if participants are practising what was taught. If not, support is given to overcome difficulties preventing expected behaviours.
- **Periodic monitoring**: is carried out quarterly and annually (*by the CEU*) with CECs, HMTs, MoH programmes, officials and donors to review, prioritise, plan, manage, co-ordinate and follow-up ***CE*** activities on all levels.
- **Final evaluations**: have been conducted at five-year intervals to assess how well the ***CEP*** is meeting its objectives and if the objectives and approach taken are meeting the needs of the Ministry. The 2002 evaluation was carried out using participatory methods and ***CE*** workers.

A word about examinations

These are rarely used in our ***CE*** activities. Written tests only reveal the knowledge someone has gained, not whether they have gained skills in thinking, practical procedures, planning and organising, communicating, problem-solving and relating to others. This is why continuous monitoring and follow-up visits are so valuable and necessary in determining changes in workers' behaviour and performance.

Key areas to consider in evaluating CE programmes

Some of the key areas or **indicators** the ***CEP*** has used to monitor and evaluate its activities have evolved over the years. Initially, indicators dealt with the number or **quantity** of activities, participants, etc (*quantitative indicators*).

As workers' skills and attitudes started changing, so did the **quality** of work performance, services provided and working relationships. To capture these changes, *qualitative indicators* were added to ***CE*** reporting guidelines.

CE monitoring reports include **quantitative** and **qualitative indicators** to evaluate activities.

Measurable (quantitative) indicators used in *CE* include the number or percentage of:

- *CE* activities conducted in districts and zones and at national level
- health workers and different professionals groups participating in *CE* activities at different levels
- hours, days, weeks spent on *CE* activities at the different levels
- costs per activity and participant
- types of *CE* activities conducted (*sessions, workshops, community projects, administration, resource centre, etc*).

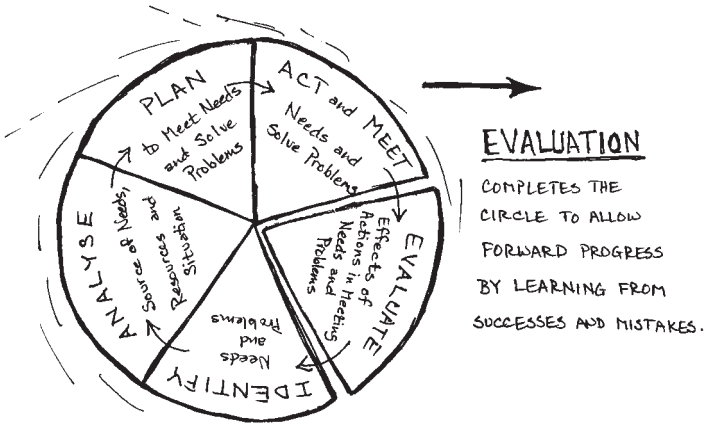
Human (qualitative) indicators that reflect *CE*'s influence and impact include:

- changes in workers' attitudes and actions regarding themselves and others
- how needs and problems are identified and decisions made in solving them
- how well *CE* activities relate to health workers' needs, interests and problems
- actions or changes in meeting needs through initiative, innovation and self-reliance
- examples of health workers helping each other or others
- how resources are shared and distributed
- the extent to which those involved in *CE* serve as good role models, share their knowledge and treat others as equals.

Let principles of participation guide evaluation planning

By using participation in the monitoring and evaluation of *CE* activities and the programme itself, we've learned:

- to keep monitoring and evaluation activities simple, friendly, logical and continuous. If more information is needed, it can be added later
- regular follow-up, monitoring and evaluation is vital for people to move forward and learn from their successes and mistakes.



- It's better when all those involved in ***CE*** are also involved in its monitoring and evaluation. In this way, assessing, reflecting, criticising and revising are built into the routine and regular work patterns of ***CE*** workers and programme partners.
- Careful planning and consideration are needed in using monitoring and evaluation methods that support and assist constructive problem-solving, rather than focus on negative findings (ie build on strengths and successes rather than dwelling on weaknesses and mistakes).
- Evaluating participatory projects properly requires new ideas and methods for **monitoring** regularly. Monitoring provides a continual supply of data and information showing how people are benefiting, the processes and dynamics exercised, and the different relationships formed between workers. All these are important in people's learning and in determining ***CE***'s effectiveness.
- And last, but not least, the **long-range impact of any educational programme can never be fully measured or known**. A seed planted through ***CE*** may not produce fruit for many years – but that doesn't mean it is not growing or taking root. Only **time**, **sensitivity** to subtle changes in people and conditions, **patience** and **being open** to the unexpected and unpredictable, will reveal ***CE***'s true potential.

Useful Resources for Continuing Education

References

Werner, D and Bower, B (1991) *Helping Health Workers Learn*, Palo Alto: The Hesperian Foundation.

Werner, D (1985) *Where There is No Doctor: A Village Health Care Handbook*, Palo Alto: The Hesperian Foundation.

Chambers, R (1997) *Whose Reality Counts? Putting the First Last*, London: Intermediate Technology Publications.

Hope, A and Timmel, S (1992) *Training for Transformation: A Handbook for Community Workers, Books 1, 2 & 3*, Zimbabwe: Mambo Press, 1992.

Lankester, T (1992) *Setting Up Community Health Programmes: A Practical Manual for Use in Developing Countries*, London: Macmillan Press Ltd.

Organisations/Publishers/Suppliers

The Hesperian Foundation, PO Box 1692, Palo Alto, California 94302, USA.

Teaching Aids at Low Cost (TALC), Box 49, St Albans, Herts AL1 4AX, UK.

BookAid International, 39–41 Coldharbour Lane, Camberwell, London SE5 9NR, UK. www.bookaid.org (previously Ranfurly Library Service)

Healthlink Worldwide, Cityside, 40 Adler Street, London E1 1EE, UK. www.healthlink.org.uk or e-mail: info@healthlink.org.uk

Intermediate Technology Development Group, Myson House, Railway Terrace, Rugby CV21 3HT, UK. www.itdg.org

AMREF, Wilson Airport, PO Box 30125, Nairobi, Kenya. (suppliers in Uganda and Tanzania) www.amref.org

World Health Organisation Publications, 20 Avenue Appia, CH-1211, Geneva 27, Switzerland. Tel: 41-22 791 94 56, Fax: 41-22 798 88 91, e-mail: publications@who.ch

ITDG Publishing Ltd, 103-105 Southampton Row, London WC1B 4HL, UK. www.itdgpublishing.org.uk

ELBS (English Language Book Society Editions), Harcourt Brace Jovanovich Ltd, Foots Cray High Street, Sidcup, Kent DA14 5WP, UK.

Macmillan Press Ltd, Houndmills, Basingstoke, Hampshire RG21 6XS, UK. www.macmillan-press.co.uk (suppliers in Kenya, Uganda and Tanzania)

Ministry of Health, Continuing Education Unit, Ministry of Health and Social Welfare, P. O. Box 1421, Zanzibar, Tanzania. Email: issah73@hotmail.com

OXFAM, 274 Banbury Road, Oxford OX2 7DZ, UK. www.oneworld.org/oxfam/

Save the Children UK, 17 Grove Lane, London SE5 8RD, UK. Tel: 020 7703 5400, Fax: 020 7793 7630. www.savethechildren.org.uk (offices also in Kenya, Tanzania, Uganda, Rwanda, Burundi and Democratic Republic of Congo)

Newsletters/Journals

SCN News: a periodic review of developments in international nutrition – UN Sub-committee on Nutrition, http://acc.unsystem.org/scn/publications/html/scnnews.html or e-mail: accscn@who.int (twice a year; free)

Sexual Health Exchange – Royal Tropical Institute, PO Box 95001, 1090 HA, Amsterdam, the Netherlands. e-mail: exchange@kit.nl (quarterly; free)

Safe Motherhood – WHO, Maternal Health and Safe Motherhood Programme, Division of Family Health, 1211, Geneva 27, Switzerland. e-mail request: abouzahrc@who.ch (three times a year; free)

TDR News – WHO, Special Programme for Research & Training in Tropical Diseases (see above). www.who.int/tdr or e-mail: tdr@who.int (three times a year; free)

Essential Drug Monitor – WHO (see above). e-mail: medmail@who.int (three times a year; free)

Action Against Infection – WHO, CDS Information Resource Center (see above) (monthly; free)

Population Reports – Johns Hopkins School of Public Health, Population Information Program, 111 Market Place Suite 310, Baltimore, Maryland 21202, USA. www.jhuccp.org/pr/index.shtml or e-mail: poprepts@jhuccp.org (quarterly; free)

International Family Planning Perspectives – Alan Guttmacher Institute, 120 Wall Street, New York City, New York 10005, USA. www.agi-usa.org (quarterly; free on request in developing countries)

Health Economics and Financing Exchange – London School of Health and Tropical Medicine (request from nicola.lord@lshtm.ac.uk)

Child Health Dialogue – Healthlink Worldwide, Cityside, 40 Adler Street, London E1 1EE, UK. www.healthlink.org.uk or e-mail: info@healthlink.org.uk (quarterly; free)

AIDS Action – Healthlink Worldwide (see above)

Africa Health – FSG Communications Ltd, Vine House, Fair Green, Reach, Cambridge CB5 OJD, UK. e-mail: info@fsg.co.uk (six times a year; free)

Passages – Advocates for Youth, 1025 Vermont Avenue, NW, Suite 210, Washington, D.C. 20006, USA. www.advocatesforyouth.org or e-mail: info@advocatesforyouth.org (quarterly; free)

Network – Family Health International, PO Box 13950, Research Triangle Park, Durham, North Carolina 27790, USA. www.fhi.org

Challenges: Sexual and Reproductive Health – International Planned Parenthood Federation, PO Box 759, Inner Circle, Regent's Park, London NW1 4LQ, UK. www.ippf.org

A Life of Learning is written for everybody involved in continuing education. This ranges from decision-makers at ministerial level, to trainers and fieldworkers. It is not a 'cookbook' full of recipes for success, but it starts as a travel journal of people working together in order to improve their capacity, and their ability to help and serve their communities. It ends with a few chapters of 'practical pointers' and useful resources.

Central is the participatory approach. This book recognises that much of our work takes place in an environment with very limited financial resources. Rather then becoming desperate at the enormous problems, it emphasises a resource that rarely appears in budgets: our own people.

The book describes the experience of Zanzibar, a small island state of about one million people off the East Coast of Africa. In common with large parts of Africa, Zanzibar has been experiencing a lot of economic, social and political troubles in recent times, against the backdrop of the AIDS pandemic. This book shows that, even in troubled times, with very limited resources, a group of open-minded and determined people can make a real difference for the better through continuing education.

The work is based on a continuing education process in the health sector. It can, however, be used in any basic service provision sector, for example, education, NGOs and other civil society organisations, and the private sector. It is hoped that both decision-makers and fieldworkers will find this book inspirational in finding new ways of learning.

02 0631

Save the Children
17 Grove Lane
London SE5 8RD
UK

TEL: +44 (0)20 7703 5400
FAX: +44 (0)20 7708 2508
www.savethechildren.org.uk