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CHRISTIAN RELIEF & DEVELOPMENT ASSOCIATION

Training Programme

On

Primary Health Care Management Advancement

CCRDA

May 31st - June 10,1994
Hosanna

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CRDA and The Ethiopian Evangelical Mekane Yesus Church (EEMYC) Training Workshop in Hosana on Primary Health Care Management Advancement Program

May 31st to June 9, 1994

Background

The Christian Relief and Development Association (CRDA) is an umbrella organization for 91 churches and agencies operating in Ethiopia. Since 1993 it has embarked on a process of capacity building which involved human resources development through a series of planned training programs and workshops. This was in response to requests made by members whose program of relief was redirected toward development which necessitated wider substantive knowledge and skills in the management of development programs. Conscious of this, in 1993 CRDA designed and implemented 25 training programs and workshops covering agriculture, health, environment, water, children, gender, HIV/AIDS, income generating and financial management.

The planning process for 1994 involved needs assessment through mailed questionnaire to CRDA members and analysis of experience gained from the 1993 training and workshop activities.
Based on these findings, the main objective of the 1994 training activities is to promote genuine community based development efforts supported by CRDA members. Its aims are strengthening the capacity of the members by equipping their field workers with the requisite skills, knowledge, and attitudinal outlook for participatory socio-economic development at the community level. Three strategic approaches are outlined i.e a) decentralization of training, b) training of trainers (TOT) c) cost-sharing.

In line with the above stated objectives and aims of training and planned strategic approach, training and workshop programs work plan was drawn for 1994. Accordingly, Primary Health Care Management Advancement program was scheduled for the first and second weeks of June, 1994.

About 14 years have passed since the adoption of PHC as a global strategy for achieving Health For All by the year 2000. Global PHC review 10 years after Alma-Ata revealed enormous short comings in the implementation of PHC particularly management related weaknesses. The strengthening of the district health management system including management training of health workers operating the system was found essential. All measures addressed

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to rectifying this particular defect are expected to help accelerate the achievements of PHC. Strengthening PHC management capability at the local level is, therefore, an appropriate response to rehabilitate the devitalized PHC at the community level.

At present there is high prevalence of ignorance and confusion about PHC. Some define the scope of PHC to the activities of CHAs and TBAs and others define it in a broader sense providing general approaches for its implementation. There is a need for definition of specific tasks that should be accomplished in order to reach an acceptable level of performance. This can best be achieved by improving the knowledge and skills of those working at the community level. It is generally felt that CRDA has not been able to extend its training activities to field staff who work directly with communities. As part of the decentralization process, there is a need to develop a core staff adequately trained to design, organize and manage training at regional level. Such a process will ensure the attainment of a well trained staff at the community level to provide the technical and managerial leadership needed at the community level.

CRDA in collaboration with the Ethiopian Evangelical Mekane Yesus church prepared a Training of Trainers (TOT) workshop in Hosana as part of its human resource development scheme.

2. Goal and Objectives of the Workshop

2.1 Goal

The main goal of the TOT training workshop is to equip carefully selected participants with the necessary knowledge, skills and the dynamics of learning and teaching in order to develop competent groups of individuals at Regional level who could provide appropriate training for the field staff in their respective Regions.

2.2 Objectives

- to train 25 carefully selected Regional trainers to stimulate PHC activities in the Regions.
- to help trainees attain competence in PHC management
- to develop knowledge and skills in trainees to train other field staff in their respective regions
- to help participants acquire knowledge and skill in needs assessment, planning, organization, implementation and monitoring and evaluation of PHC programs.

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- to train participants to be able to provide technical and managerial support to PHC activities in their respective regions.

3. Strategies for training

- selection of participants who possess the ability to learn and the capacity to train others.
- utilization of competency based training. The training approach should provide ample opportunity for group interaction and sharing of experiences among participants.
- preparation of a workshop manual which provides basic information on the topics for discussion and guidelines for discussion groups.
- preparation of case studies relevant to PHC experience in Ethiopia and identification of certain basic questions capable of triggering discussions and solutions.
- organization of discussion groups with a good mix of varying experiences and academic preparations. Each group will select its chairperson and reporters for each discussion session and these officers will be responsible for representing the group during the plenary session.
- formulation of plenary session to create additional forum to share experiences of a wider constituency.

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Principles and Methods of Training

1. Introduction

Training of Trainers (TOT) is an approach used to reach the peripheral health workers who could not otherwise be reached through a centrally arranged training scheme. The only feasible approach is to train trainers who have better access to the periphery and have the academic preparation and experience to provide technical and managerial support to other health workers at the implementation level. Training those who are involved in the operation of the health system is part of a Continuing Education program.

Continuing Education in health is the term used to describe education given to health workers in the course of their work. There are many reasons why health workers need continuing education.

a) Health workers do not always receive basic training which is relevant or adequate. As a result it becomes essential to improve their knowledge and skills to close the performance gap created by irrelevant and inadequate training.

b) Health knowledge changes over time. Health workers, especially those in the remote rural areas, find it difficult to apply new skills when there is no way of learning about them. Updating the knowledge of health workers through workshops and seminars remains an important task.

c) Many health workers are initially trained for one job but field situations dictate that they involve in areas they have the least preparation and training. It is important to redress this shortcoming in order to ensure satisfactory performance.

It would, however, be erroneous to assume that continuing education will be a panacea for all performance gaps. Continuing education and training is mainly a solution to problems created by lack of knowledge and skills of the individual worker.

2. Strategies and approaches

Continuing education strategies vary. Two commonly used strategies are those known as ' the cascade and the mushroom'.

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The cascade begins at the top by creating a national 'body of knowledge' which is then passed down through the different levels of the training programs until it reaches the peripheral health workers. The problem with this type of training is that, the message gets more and more diluted and even distorted as it passes down.

The mushroom strategy starts at local level where there is strong leadership and community participation, with the hope that the program can later extend to other areas. The strength of this approach is its low input and potential of success initially. Here too the message gets more and more diluted and distorted when extending to other areas.

While many continuing education and training programs follow academic models, some forms of training are based on the community development approach such as Lepsa (learner-centred, problem-solving,action-oriented) which is used specially in East Africa. This approach is very appealing in that it revolves around the leaner, the problem and action to be taken.This modality of training will be used in the TOT training.

3. Methods of Training

The training process involves a number of methods the choice of which depend on persons who use them. Learner-centered, problem-solving and action oriented approach has now become the preferred approach.

Multiple methods of message propagation and development of skills are urged. The learning-by-doing approach is a method which is found to enhance the achievement of the desired skills and knowledge. The acquisition of substantive knowledge by the learner is facilitated with the help of the following:

a) provision of lecture by competent instructor who has the experience in dealing with the subject. The lectures should consider the knowledge,experience, competence and needs of the participants prior to the workshop.

b) The lectures must be simplified to attract the attention of the participant. The teaching should be participatory in nature to reflect maximum utilization of the parrticipant's knowledge and experience.

c) Teaching aids such as flip charts, videos and other pictorial presentations should be frequently employed to support the teaching-learning process.

d) Handouts or reference materials should accompany every lecture in order to ensure availability of reference material while participants go to their place of assignment.

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4. Factors to be considered during the selection of Teaching and Training Methods.

a) Learner related factors

- academic preparation of the participant
- experience of the participant
- age of the participant
- task to be accomplished by the participant
- the environment under which the individual functions
- knowledge of the individual's personal and social characteristics.
- the number of participants
- composition of the participants

b) Subject matter related factors

- the nature of the subject being treated in terms of its theoretical complexity and practical relevance.
- the availability of easily accessible reference books and materials.
- the familiarity of the subject matter to the participants.
- the degree to which available knowledge can be translated into practice at the community level.
- the scope of the subject matter.

c) Teaching Environment related factors

- the location and size of the classroom
- the facilities in the classroom which include electricity or proper lighting and ventilation, desks and chairs, overhead projector, blackboard, flip charts etc.
- the availability of facilities for field visits and practice.
- the presence of an enabling environment to conduct the training without interruption.

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5. Methods of Conducting Workshops

5.1 The preparatory phase

This phase anticipates clear statement on the objectives and outcomes of the workshop. The main objective of the TOT workshop is to prepare participants to give training to local health workers to facilitate the implementation of PHC at the operational level. The final outcome of the workshop is measured by the ability of the participants to successfully train the field workers in their own area of responsibility.

The participants should be identified and information provided on the objective of the workshop and the place and time for the

workshop in advance of the date of the workshop, allowing sufficient time for preparation and transport to the workshop site.

The instructors and discussion leaders should be identified and their consent should be confirmed before setting the date of the workshop. Materials for the workshop should be prepared in advance and should be ready for distribution during the workshop. All materials and funds should be available before the workshop.

5.2 The workshop subject matter

- Increasing participants scientific knowledge regarding PHC management

- Increasing awareness and sensitivity of participants in respect to the situation of PHC implementation globally and in Ethiopia.

- Improving Training abilities of participants by introducing participants to specific training skill

  . teaching methods

  * lecture
  * group discussion
  * reading assignment
  * taped messages
  * demonstration

  . Characteristics of an effective teacher

  * knowledgeable about the material to be given to the audience.
  * able to communicate, audible, clear voice and able to use good eye contact.
  * empathetic, patient, flexible, organized, punctual and trustworthy
  * objective, friendly and non-condemning.
  * deep personal commitment to the issue.

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ADULT LEARNING THEORY.

Adult learning theory recognises the following.

a. Adults have a wide experience and have learned much from life. Those facilitating adult learning should use methods which encourage them to share their own experiences and creates a situation where they can talk to one another. This means that participants and facilitators need to sit in a circle so they can see each other's faces. Speaking and listening is helped by the use of our eyes.

b. Adults are interested and learn quickly about those things which are relevant to their lives. So, to facilitate learning we should use an approach which identifies trainee's work related problems (training needs assessment) so these issues can be addressed during the workshops/training. Adults should also also have the opportunity to decide on training priorities, in the context of the overall topic and evaluate what they are doing in the group.

c. Adults have a sense of personal dignity. They must be treated with respect at all times and never feel humiliated or laughed at before others. This does not mean there is no fun in the lessons, but that the facilitator should be sensitive to other's needs and feelings. When we work with the community it is important not to laugh at those who don't know as much about something as we do. They will know something about things we don't know.

d. As adults grow older their memories may get weaker but their powers of observation and reasoning often grow stronger. So in our choice and use of teaching methods we should remember:

What I hear I forget.
What I see I remember.
What I do I know.
What I discover I use.

Tests have shown that
PEOPLE REMEMBER
20% OF WHAT THEY HEAR
40% OF WHAT THEY HEAR AND SEE
80% OF WHAT THEY DISCOVER FOR THEMSELVES
90% OF WHAT THEY PRACTICE.

So for effective learning methods which help people to learn through discovery and practice should be used.

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COMMUNICATION

1 Introduction.

There are many different ways of communicating messages to each other. We have radio, newspapers, books, etc. These are one-way communication. But the most common is communication between people. This should be two-way communication, and it is this type of communication which we want to look at in this lesson.

Listening is an essential part of communication and is a vitally important in the process of learning and counselling. Many times people do not listen very attentively to others unless they think they are experts.

This applies particularly to the relationship between professionals and the less well educated. For real communication to exist there must be a spirit of trust and appreciation of one another. This also means respecting and listening to each other.

Good communication is essential for our work with people and also during training courses. There are many ways in which we communicate. We can speak and listen but also our actions and behaviour can send messages to people.

2. Definition of Communication
Listening, speaking and actions as means of communication.
Communication consists of a sender and a receiver

MESSAGE

SENDER ——— RECEIVER

WAYS TO COMMUNICATE

words/spoken, written, sung
tone and volume of voice
actions/facial expressions
sounds/drums, trumpets, bells, whistle
colours
deeds
signals/codes
symbols
dreams
touch/vibrations
pictures/plays/games

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3. Causes of poor communication.

3.1 Misinterpretation is common. How we understand what someone says by word or deed depends upon the following factors:

EXPECTATIONS

All people have certain expectations of the speaker/hearer.
e.g. The teacher is the one who knows.
The counsellor should tell me what to do.
Some judge or label people:
e.g. The poor or disabled person is ignorant.

CULTURE

Many behaviours have different interpretations in different cultures.

LANGUAGE

Spoken, heard, written, body actions/expressions, colours
Even when people are speaking the same language there can be misinterpretation

STATUS

The person of high status is more likely to be listened to than the person of low status.

ATTITUDE TO THE SPEAKER/RECEIVER

It is difficult to have correct interpretation if there are relationship problems between the people speaking.

METHODS USED TO COMMUNICATE

If the wrong method is used at the wrong time.

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3.2 Labelling: Making a judgement about a person and always expecting that person to speak or behave in a particular way.
Jumping to conclusions.

3.3 Barriers created: by using the body (back turned) facial expression. By colours (red means danger/poison). By an emotional reaction.

3.4 Information is not received or remembered.
This may be because:

- the way of telling it was not interesting.
- the wrong person was given the message.
- there was no relationship.
- poor explanation.
- no clear theme.
- no preparation.
- attitude of the speaker.

3.5 Attitudes: pride, generation gap, disrespect, laughing, mocking, impolite, dictating, superiority complex, frustration. Lack of commitment.

3.6 Time: busy, speed of speech, looking at the watch.

3.7 The preoccupation of the speaker with other matters. Not paying attention or listening to what the person is saying.

3.8 Literacy levels: use of words/language.

3.9 In real terms we don't communicate because:

You don't listen to me.
You are selfish
You behave in a superior way.
You make me feel inferior.
I don't know you.
I don't trust you.
You don't respect me.
I don't respect you.
We have different cultures.
You use words I don't know.
You don't know my language.
My experience is different to yours.
You don't speak about things which interest me.
Your beliefs are different to mine.
You gossip about things I tell you.
We are not the same age group.
We don't talk with these things with men/women.
You don't have the same knowledge as me.
You don't understand my social situation.
You turn your back when you are with me.
You hide behind your desk.
You don't practice what you teach/preach.

4 Results of poor communication.

4.1 Relationship breakdown produces the unforgiving spirit, humiliation, misery, dissatisfaction, fighting, gossiping etc. Learning potential is greatly reduced in such an atmosphere.

4.2 Progress is hindered. If there is reduced learning the quality of the work will be reduced.

4.3 Break-up of team spirit. When co-operation is reduced it will be difficult to apply participatory learning methods which facilitate the learning process. Neither will we be able to find out people's real problems or views.

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1.4.2 P - Problem Posing

To help people to reflect meaningfully on their problems and find relevant and feasible solutions each lesson is built around one relevant and solvable problem. This problem is presented in the form of a `code'.

This `code' is a way of showing people the problem they have already expressed. A code never gives a solution. The code can be presented in the form of a role-play, story, picture, proverb etc.

After the presentation a series of questions are asked:

1. What did you see/hear.....?
   What was happening.....?
2. What was the problem.....?

1.4.3 S - Self-discovery

We then ask the following questions to promote analytical thinking and self-discovery

3. Why did it happen?
4. Does it happen in our situation?
5. What problems does it cause?

1.4.4 A - Action oriented

The last question focuses on actions which may be taken to solve the problem.

6. What can we do about it? (The problem)

The answer should give what, when, who, where, how, evaluation criteria.

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2. The Practice of Transforming Education

2.1 How do we do it?

a Find out the main problems of the people so we can address a relevant problem.

To do this we MUST first study the community. We must find out the problems they feel are the most serious. We do this by listening to people in the community or people who will participate in our workshops. We listen to what they talk about when they meet with other people. Wherever people meet in groups to talk we should be listening to find out what are the things which concern them. We must find the things people have the STRONGEST FEELINGS ABOUT. The motivation of adults to learn and act is very closely linked to how strongly they feel about things. Listen for what people are WORRIED about; SAD about; ANGRY about; HAPPY about; FEARFUL about; HOPEFUL about.

b. Secondly, from this information we develop a `code'. A code is a way to pass a message.

2. The benefits of using a code

a. Codes bring back to people in an organised manner what you get from them in a disorganised manner. This requires immersion and involvement of the people in the process of problem identification.

b. Codes present to people, in a challenging way, their own problems.

c. The people themselves are helped to unveil their own reality. In the process of de-coding the coded reality the people will analyse their own situation. They will see themselves as the subjects of their reality and will see their problem in a new light. As subjects, they are the only ones who can effect change; they are the ones who matter in the process of bringing about change.

d. Codes are a tool of awareness raising (conscientisation). People can step back and look at their situation critically.

e. The preparation and presentation of codes requires team work.

3 The characteristics of a code.

In the coded message only the problem is given, NOT THE CAUSE OR A SOLUTION.

The `code' is developed from the preoccupation of the group or community. The code is a scene showing a concrete experience which is familiar to the participants. It should raise questions in the minds of the learners and stimulate them to think of different possibilities for a solution. The better the code the more the participants will learn for themselves and the less the facilitator will need to have to help them find an answer. This is important because research has shown that we only remember 20% of what we are told but 80% of what we discover for ourselves.

4 The AIM of the code is to stimulate discussion which leads to action.
It portrays the problem very clearly.
It enables all the participants to discuss the issue from the same perspective.
It makes the problem impersonal so it is easier to discuss.
It creates an interest in the problem.
It involves the participants in problem solving.
It stirs the emotions.

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2.5 The presentation of the code

The 'code' can be presented as a role play, through stories, posters, slides, songs etc. Much of the success of the learning depends upon whether:

a. the theme chosen really is the important preoccupations of the group or community and

b. the code really does raise questions about familiar situations in the learners own lives.

2.6 Code Development

How do we do it?

a. FIND GENERATIVE THEMES which can be used to stimulate discussion. For example, there are many different factors which cause a death. The generative theme is the one which people feel most strongly about. For example, a particular symptom which people can easily recognise, e.g. diarrhoea. With most problems there is not just one aspect or approach required, but many.

b. DECIDE which is the most important aspect to deal with. What DIRECTION WILL LEAD TO DISCUSSION AND ACTION.? Should the code deal with economic, political, environmental or other aspects of the problem? Do we need more than one code?

c. Choose ONE scene.

d. BRAINSTORM (get everyone's ideas)
how we can show the problem experienced by the people:
* THE SITUATION
* THE FEELINGS INVOLVED
* THE DIFFICULTIES
* THE PROBLEMS
* THE OBSTACLES
in a PICTURE, STORY or ROLE-PLAY.

e. CHECK that there is NO UNNECESSARY DETAIL to confuse the people and send them off the point. We should present the message so they see themselves in it.
A good code will:
- stimulates discussion.
- is simple, clear and short.
- ONLY deals with ONE topic.
- attracts interest and stirs emotion.
- enables total involvement.
- poses a problem relevant to the group but NEVER gives the SOLUTION.
- be realistic to the life situation of the people.
- be well planned and used at an appropriate time.

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2.7 De-coding.

After presenting the code or discussion starter the facilitator asks the group questions about the code to help them decode it. The facilitators' role is to /ask the right questions so that the participants can bring their own perspectives to the problem. Questions should be open-ended.

Five basic questions form the basis of the discussion.

a. Description of the problem or issue: What did/do you see happening? (in the picture, role play)
What is the main problem?

b. Why do you think it is happening? (Analysis of the cause)

c. Does it happen in our situation? (the answer should be yes if the code has been accurately based on the interests/concerns of the people).

d. What problems does it cause?
(Consequences for the future.)
What are the root causes of these problems?

e. What can we do about? (In the situation or to prevent it)

Discussing these questions helps the group or community to develop a critical awareness of their own situation and stimulates the search for solutions to their own problems. This is the basis of `conscientisation' and awareness raising.

2.8 The role of the facilitator is critical throughout the learning process. (S)he should be someone who:

- Is a guide.
- Ensures total involvement of participants.
- Knows the participants well.
- Is friendly, is observant and a good listener.
- Can encourage self-esteem in others.
- Plans well.
- Is able to summarise and synthesise information and use this frequently to remind participants of their progress.

3. Visual Aids required

role play
case studies
pictures
story telling
slides/films/videos
charts/graphs
flannel board

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A SUMMARY OF TEACHING TECHNIQUES

1. Transforming education or LePSA Awareness raising technique.

1.1 Those who describe the method using the name LePSA attach the following meaning to the the letters of the word:

Le- Learner centred.
P - Problem posing
S - Self-analysis/discovery
A - Action oriented.

1.2 Good for facilitating topics concerning:
Health and Development education.
Creating or raising awareness about sensitive and difficult issues and problems,
Promoting self directed change.
Analysis and solving of problems.
Developing or changing attitudes.
Building group solidarity.
Promoting group decision making.
Promoting group support systems.
Developing thinking and reasoning skills.
Contexturalised Bible study/teaching.

2. Games
Good for:
Ice-breaker: e.g. introductions.
Promoting participation.
Fun learning.
Exercise.
Refreshing tired minds.
Challenging, developing and
Changing and developing attitudes.
Developing human relations.
Evaluating knowledge.
Group formation/dynamics.
Creating equality.
Promoting co-operation.
Relationship building.
Doing serious things with fun.

3. Human relations exercise/ice breaking
Good for:
Building confidence.
Creating a conducive learning atmosphere.
Developing trust.
Building group solidarity.
Showing attitudes and behaviour.

4. Question and answer
Good for:
Difficult topics like AIDS.
Meeting participants expressed needs.

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5. Experiential learning
Good for:
Challenging and changing attitudes.
Helping us discover things about ourselves and others.
Promoting interest in the topic.

6. Questionnaire and individual tasks
Good for:
Finding out individual experience, knowledge, opinions.
Evaluation.

7. Interviewing 1-1
Good for:
Finding out information about other people.
Counselling.
Identifying personal problems.
Identifying conflict situations.
Discussing sensitive topics such as AIDS or family planning methods etc.

8. Demonstration
Good for:
Showing how to do something.
Helping people remember more.
Presenting a role-model.
Developing and showing attitudes.
Showing an appropriate approach/method.
Demonstrating a technical skill.
Teaching anything difficult to explain.
Visual aids required
Models. Pictures. Real objects

9. Visual aids which can be used during lessons.
Role-play. pictures, drama, video, models, real objects, slides, charts, graphs, flannel board
Good for:
Starting discussion (see LePSA method).
Reinforcing the message.
Showing the real situation.
Summarising a topic.
Showing and sharing others experience.
Compressing many ideas into a short space of time.
Showing things which people would probably never see in real life. e.g. through video.
Expressing a situation better.
Helping us identify with other people.
Moving us emotionally....motivates us to action.

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10. Audio aids
Tapes, songs, story telling, proverbs.
Good for:
Giving information.
Distance learning.
Self-evaluation.
Discussion starters.
Giving a message in a culturally accepted way.
Helping people to see their own situation portrayed through another situation.

11. Large Group discussion/ plenary session
Good for:
Expressing a variety of ideas.
Reporting back- others comment.
Expressing common aim or interest.

12. Small group discussion.
Good for:
Productive learning as it encourages more participation.
Analysing and solving a problem.
Encouraging concentration of participants.
Encouraging people to give their opinion.
Developing confidence in people.

13. Buzz groups (2/3 people discussing together)
Good for:
Getting people to participate.
Increases participant participation when the group is large and there is no time to go into smaller groups.
Generating ideas quickly.

14. Practice
How adults learn best.
Good for:
Developing skills, helps us master a task.
Evaluating performance.
Promoting effective and discovery learning.
Promoting co-operation.

15. Talk.
Good for:
Introducing/summarising a topic.
Question and answer.
Giving new information.
Explaining.
Sharing experiences.
Visuals which should be used with a talk. Pictures, Flip charts, Slides, Charts /graphs, Flannel graphs, overhead projector, hand-outs.

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THE TECHNIQUE OF PLANNING and FACILITATING A LESSON

A. Lesson Planning.

1. Definitions

Curriculum - An organised pattern of education which takes place over a longer period of time.

Course outline - The main themes of what will be included in a course

Timetable - What will be taught when and by whom during a course or workshop.

Lesson - One single topic which is part of a course.

2. Stages of lesson planning:

a. Definition of the topic.
b. Formulation of the lesson objectives.
c. Deciding on what you want to include...the necessary content, e.g. knowledge, attitudes, motivation, skills to be achieved.
d. Deciding on the methods to be used.
e. Selecting the teaching aids and materials required.
f. Decide how the lesson will be summarised and evaluated.

3. How to select the topic.

Find out from the participants what problems or interests they have and base the lesson on one of these issues. The lesson must:

* be of interest or a problems to the participants.
* be relevant to the lives of the people.
* be of benefit to the learners.

It is better if this research can be done beforehand to give time to prepare the lesson plan properly.

4. The format of the lesson plan

The following headings provide a structure to the plan.

The lesson plans are divided into six sections.

Section one - Reasons for the lesson.
This section explains the need for the lesson in the process of the training. It may also indicate which lesson should come before and which should come after it as it tries to describe the context in which the lesson is set.

Section two - `Objectives'
This section lists the expected learning results of the lesson. It also lists other outcomes such as attitude modification under `Other things to be learned.'

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Section three - Time.
This section gives the time it is expected to take during the lesson. However, different groups vary in their speed of discussions and so this is only a guide.

Section four - Preparing the lesson. Background information.
This section gives the basic information required for the lesson. It may also refer the facilitator to other reference books.

Section five - Preparing teaching aids and the meeting place.
This section provides a check list of the things which the facilitator should prepare before the lesson, and space required for any activities.

Section six - Presenting the lesson. Activities
This section lists the different activities of the lesson in order of sequence. The facilitator follows this plan as they conduct the lesson.

B. Facilitating a lesson.

5. Steps in preparing the lesson (using a prepared lesson plan)

5.1 Pray for guidance.
5.2 Read through the whole lesson plan first.
5.3 Analyse whether you fully understand the topic. You may find it helpful to discuss the topic with a colleague.
5.4 Read any reference books you may have. Add relevant information which may not be in the lesson plan.
5.5 Write your own notes.
5.6 Make a note of all the materials and equipment you need.

6. Steps in organising the lesson.

6.1 Have all equipment available and working. Test it beforehand. Consider electrical needs.

6.2 Have all the teaching aids and materials ready :
* lesson plans
* hand-outs
* participants materials
* newsprint.

6.3 Prepare your room/s.
6.4 Communicate with other facilitators.
6.5 Communicate early with participants supervisors.
6.6 Follow-up the invitation to attend before the workshop.
6.7 Be mentally ready to adjust to the level of the learner, (e.g. dress, behaviour etc.).

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7.1.2 Presenting the lesson

The facilitator should generally follow the lesson plan. However, the following are some aspects of facilitating that need to be considered whilst presenting the lesson.

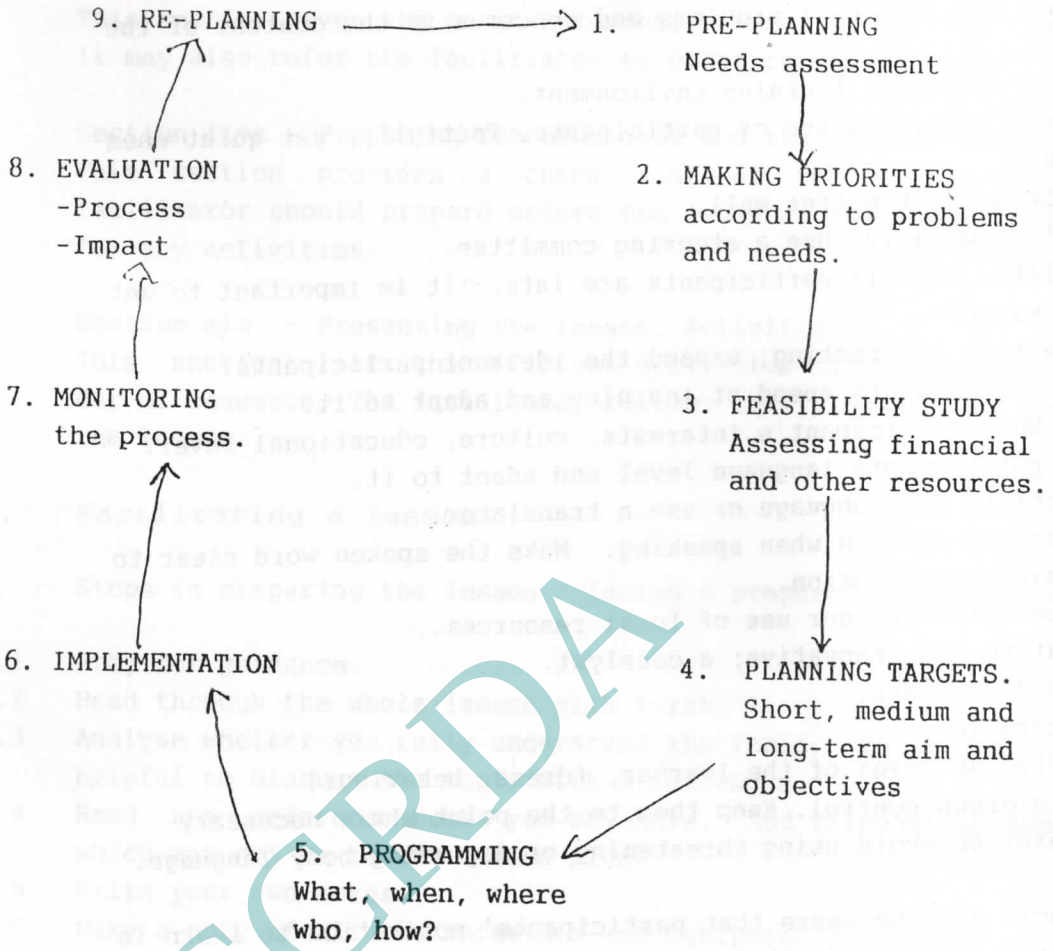
a. Appreciate and congratulate participants as often as deserved.
b. Consider participants' problems and concerns in the content of the lesson.
c. Create a conducive learning environment.
d. Encourage participation of participants. Tactfully, get quiet ones to talk.
e. Know the subject matter well.
f. Evaluate regularly. Use a steering committee.
g. Be on TIME. Even if participants are late, it is important to set a good example.
h. Make lessons interesting: expand the ideas of participants.
i. Assess participants speed of learning and adapt to it.
j. Get to know participant's interests, culture, educational level.
k. Assess participants language level and adapt to it.
l. Be fluent in the language or use a translator.
m. Be clear and audible when speaking. Make the spoken word clear to avoid misinterpretation.
n. Be resourceful in your use of local resources.
o. Be creative and innovative; a catalyst.
p. Be a good listener.
q. Be democratic.
r. Adjust to the level of the learner, (dress, behaviour)
s. Maintain group control. Keep them to the point where necessary
t. Be careful to avoid using threatening or degrading body language.

One should also be aware that participants' motivation to learn is strongly influenced by their relationship and attitude towards the facilitator. Here are some of the important qualities which will help participants to trust and respect the facilitator and promote commitment to the learning process:

a. Being confident.
b. Willing to learn from participants.
c. Being patient and approachable.
d. Accepting constructive criticism.
e. Treating others as equals. Is not discriminative.
f. Is fair and firm where necessary.
g. Shows respect for participants.
h. Is not defensive. Admits mistakes.
i. Shows sincerity and honesty. Admits when one doesn't know.
j. Shows a sense of humour.
k. Shows an interest in the work.
l. Doesn't make unrealistic promises.
m. Is friendly.
o. Is a good role-model.
p. Is flexible.
q. Is observant of participants needs.

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1 The Planning cycle



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2 Pre-planning

What do we think about before we plan.

a. Who is it for?
b. What is the aim? What should be the content ?
How do we find out what is needed?
c. Where can we hold it?
d. When should we hold it?
e. How many will attend?
f. What we need ?
g. What resources are available: financial, human, teaching materials, supply.

3 Planning Criteria

3.1 General

a. Who is it for? Target group.
b. What is the Aim of the workshop?
c. Content.
d. How can we involve the learners in the planning process.? How can we find out what they need to learn?

3.2 Deciding when to hold a workshop.

Considerations

a. How long will it take to prepare?
b. Will it coincide with another workshop?
c. Is the venue available?
d. Consider the rest of the organisations plans.
e. Season. (holidays)
f. Leave.
g. Availability of funds.
h. Time of the month. (participants home responsibilities)
i. Availability of resource persons.

3.3 Deciding how long a course should be.

Considerations:

a. Aim.
b. Content.
c. Participants commitments.
d. Ability of participants to concentrate.
e. Climate.
f. Resources: financial and human.

3.4 Deciding how many people to invite to attend.

Considerations.

a. Finances available. How many have been budgeted for.?
b. The level of learning aimed for. For effective learning with maximum participation about 20-25 participants is optimal.
c. Levels of participation required.
d. Number of facilitators.
e. The level of basic education. (The lower the level the more important it is to have 15-20 people)
f. The number of people required to attend.
g. The size of classroom.
h. Accommodation available.

3.5 Deciding upon a venue.

Considerations

a. Comfort: beds, washing facilities, food, water.
b. Quiet, well ventilated rooms help private study.
c. Cost and methods of transportation.
d. Accessibility to classrooms.
e. Distance which people have to travel.
f. Availability of electricity.

3.6 Budgeting. (Estimating the cost)

Considerations.

a. Transport and travelling of staff.
b. Subsistence (driver, participants, resource persons)
c. Food. Number of participants/resource persons/ days.
d. Accommodation/subsistence:
   - number of participants; resource persons; course duration.
e. Materials to purchase.
f. Unforeseen. 10% of the estimated cost.

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4 Programming implementation

4.1 Identify training problems, needs, resources by consultation with relevant people. These could include, target group, supporter / supervisors, government / church officials, community/congregants.

4.2 Decision making (as indicated in section three) with the same group as were consulted for problem identification, needs, resources etc.
Decide upon:
* the target group.
* when to hold the workshop.
* where to hold the workshop.
* what to cover in the content.
* how you will organise everything.
* who will implement the decisions.

4.3 Budgeting (See 3.5)

4.4 Organising the implementation
a. Booking and checking the venue
b. Notify participants.
c. Contact resource persons
d. Collect equipment/supplies.
e. Prepare materials.
f. Prepare programme.
g. Arrange transport if necessary.

5 Implementation
Implement the plan as arranged in 4.1 - 4.4. and conduct the workshop.

6 Monitoring
It is helpful to have a steering committee comprising some of the participants and the facilitators to monitor the activities during the workshop. They can monitor :
a. if the workshop is meeting the set aim and objectives.
b. if the level is appropriate for the participants.
c. if the content is relevant to the needs of the people.
d. and advise on changes which may be needed.

7 Evaluation
There are many aspects of evaluation, It is advisable to have evaluation:
a. during the workshop
b. at the end of the workshop.
c. after six months to see how much of the knowledge participants have applied to their work situation and identify reasons for non-application.

This evaluation should be both objective and subjective to ensure that both fact and feelings are included.

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Primary Health Care
Foundations,Premises,Initial Conditions, Implementation Status,Strength, Weaknesses and Possible Future Trends

1. Introduction

Primary Health Care Strategy has been a term used consistently by health delivery systems of countries since the Alma-Ata declaration of 1978. Right from the start the term and the contents of PHC strategy became appealing to the then frustrated health professionals irrespective of the political and ideological orientation of countries. Ten Years after Alma-Ata situation analysis of PHC implementation revealed discouraging trends in spite of the commitments of countries to support PHC programs. Economic recessions, heightened political tensions, slow progress in food production, and weak health infrastructure and management capability were a few of the factors that were mentioned to explain the prevailing static situation in PHC implementation.

Many of the above mentioned problems are difficult to resolve in a short time with limited resources. However, improved management in health services has the potential of maximizing the benefits drawn from the available meagre resources. The way we organize and manage PHC programs determines our successes. The need for strengthening management of health services at all levels for proper implementation of PHC is now globally accepted. The thirty-ninth World Health Assembly (1986) passed a resolution urging member states " to pursue vigorously actions aimed at strengthening the management of their health systems based on PHC" and the WHO Regional committee for Africa, held in Bamako in 1987, reinforced the World Health Assembly urging member states to strengthen district health management. All the above statements point to the need for improved health management. The PHC Management Advancement theme of the TOT workshop is to help develop management strategies which help improve the achievements of primary health care programs.

The main goal of this topic is to briefly introduce the profile leading to PHC and catalogue management related problems in the implementation of PHC and through discussions identify the best management approaches which improve outcomes of PHC programs.

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2. Foundations of Primary Health Care

During the 1960s it became clear that the problem of achieving equitable health care delivery through out the world were growing rather than diminishing. Well intentioned development projects such as dams, other pockets of water increased the spread of schistosomiasis and industrialization provoked an immense and uncontrollable population drift to the cities of the third world, where growing peri-urban slums and unsanitary shanty towns encouraged the spread of communicable diseases. Forgotten millions of people in the remote areas while continuing to be born, lived too brief disease-beset lives and die often without ever having access to any of the benefits of modern medicine even in its rudimentary form. Preventable deaths due to poverty and ignorance remain high. Two obvious barriers impending progress in the health sector are shortage or lack of resources and lack of capability to appropriately manage health systems.

Alternative approaches to the delivery of health care were obviously needed and there were historical precedents for the upsurge of interest in developing strategies which benefit the majority of the population. The success registered by Cuba, USSR, China etc using locally trained health cadres to operate community based health services have inspired the development of health strategy replacing the defunct Basic Health Services era. The world community after carefully studying the global health situation and scrutinizing the existing strategy for health embarked upon the target of Health for All by the year 2000 using the Primary Health Care strategy. Primary Health Care as defined by the Alma-Ata conference in 1978 is " Care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every step of their development in the spirit of self-reliance and self determination.

The definition is very appealing and gives a feeling of satisfaction because it states all what needs to be said about a health delivery system. However, after in depth probing and in practice the concept was found to be difficult to operationalize. Many of the failure in implementation of primary health care can partly be related to ill and misunderstanding of PHC. Initially the cost of the strategy was under estimated and the concept was naively conceived. It meant that it is a cheap way of getting healthy population through the activities of community health agents and trained traditional birth attendants. The initial cost of PHC is very high beyond what developing countries can afford to invest.

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3. Premises for PHC

PHC can be viewed as having two distinct but related aspects.The first comprises a part of a philosophical development which is humanistically focused emphasizing the improvement of the well being of man which incorporates the physical, mental, and social environment. The second accentuates the technical definition of the term PHC which focuses on the specific activities and the location or point of contact with people.
PHC embodies the following activities or services: a) health education, b) food supply promotion and nutrition education, c) safe water supply and basic sanitation, d) maternal and child health care including family planning. e) immunization against the major infectious diseases, f) prevention and control of endemic diseases, g) treatment of common diseases and injuries and h) provision of essential drugs. It is required that the delivery mechanism for the provision of PHC services be designed to provide those services throughout the population i.e. in every community through out the country, and to be an important catalyst through which their activities can improve development at the community level. There are certain schools which advocate for selective primary health care approach in order to register noticeable success in a short time with interventions which are known to produce palpable results. Totally ignoring the comprehensive approach leads to failure in achieving sustained development of primary health care.

The philosophical perspective and the technical design of PHC discussed above are based on three underlying premises.

a) social justice as manifested by an equitable satisfaction of relative health needs is a necessary component of the technical design of the PHC delivery mechanism and the distribution of services which comprise PHC.

b) the process of socio-economic development and health improvement are inexorably interrelated.

c) by involving the local community in the:
   - design of the delivery system,
   - choice of input technologies, manifested for example in alternative manpower cadres providing each service,
   - operation and control of the PHC delivery mechanism, and
   - financing of services and related delivery system costs. Systems established will be used and sustained.

4. Initial Conditions facing PHC

All PHC programs operate in a particular political, social, economic, biological, demographic, cultural, administrative, and economical milieu. This milieu or context has considerable influence on : a) whether PHC is initially implemented, b) what

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PHC activities are emphasized in the implementation process and, c) whether the program is sustained or sustainable.

It is clear that inequities with respect to income and wealth distribution and the operation of ideas and individual freedoms alters progress toward social strategies of which PHC is one example. In countries which either have more constraint on individual freedoms, or where the distribution of the income and wealth is more unequal, the PHC concept which is implemented is different in terms of services offered, delivery mechanisms used and degree of community involvement the economic context of such programs also differ as a consequence.

It is important to recognize that while the achievements of improved health is an important social goal, it is not the only one which motivates individuals and societies. Other obvious objectives which men and nations seek to achieve include power, security and the satisfaction of other basic needs. Given that different societies seek to achieve a constantly changing set of objectives, the achievement of the objectives of Health for All by the year 2000. irrespective of means, including PHC, may significantly vary with the degree of continuing commitment placed on PHC and HFA over a period of time.

5. Implementation status of PHC

Comprehensive Statistics on the status of PHC implementation in Ethiopia is difficult to get. The only comprehensive PHC review document is the WHO-Ministry of Health PHC review study of 1985. Marked variations exist on the implementation of PHC in the country. Official statements indicate a high level of PHC implementation in the vicinity of ATTAt compared to other areas. Differences are vivid with in the components of PHC programs. While relatively much effort is exerted to implement vaccination programs little or no effort is shown to implement other PHC programs. The following statistical evidences although unrepresentative and inaccurate may help appreciate the status of PHC implementation.

5.1 Health education:

Almost all health institutions report health education activities. The public media i.e national radio, TV, Newspapers and the education media run extensive coverage on health topics with the emphasis on AIDS and vaccination. Attempts are made to translate some of the messages in regional and local languages. The major problems in health education are the limited variety and intensity of health topics covered, and too much emphasis is placed on imparting information which does not necessarily result in change of attitude and behaviour. Consistent efforts are needed to improve on methods that help bring about desirable practice. Translation of knowledge to practice is not an easy

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exercise and demands continuous sustained efforts by all those who shoulder the responsibility.

5.2 Water Supply and Sanitation:

Inadequate water supply and sanitation services pose serious threat to the majority of the population in Ethiopia. The proportion of the population, particularly in rural areas, covered by safe water is extremely low. According to current information from WSSA (1992), safe water supply for domestic and municipal use is provided to about 21.2% of the total population. Average per capita water consumption has been estimated to be 20 litres a day but in some areas only six litres or less a day per person are consumed. Furthermore, women have to walk long distances every day to fetch water for family consumption from unreliable water sources.

Through proper human excreta and refuse disposal and provision of bathing facilities, debilitating common diseases could be prevented, thereby, improving the health status and working capacity of the labor force. The poor sanitary toilet facilities is shown by the fact that 50% of the urban housing units do not have toilet facilities. 91% of the urban housing units have no bathing facilities of their own. Less than 10% of the rural residencies are estimated to own toilet facilities.

5.3 Nutrition

Nutritional deficiency is a major problem affecting a large portion of the population particularly children under five years Malnutrition is one of the three major diseases killing children.Reports indicate W/A (<80%) of under fives 27-46% with marked variation between regions. The situation gets worst during drought periods.

5.4 Maternal and Child Health Care and Family Planning

The common practice of early marriage, harmful traditional practices during pregnancy, labor and delivery have long term traumatic and disabling effects on health of young girls and women. The limited net work of health care services are still inaccessible to them as shown by the fact that only 16% of the pregnant women make antenatal visits once during their pregnancy. The maternal mortality rate in Ethiopia is estimated to be between 600-1000/100,000 deliveries. Unwanted, short spaced and repeated pregnancies, lack of family planning services, malnutrition and anaemia contribute to the unacceptable maternal mortality and foetal wastage.

The situation of the Ethiopian child is not different from that of his mother. The various communicable diseases and malnutrition, particularly the six childhood diseases combined with diarrhoea are the main causes of morbidity, disability and mortality among children in the country. These are reflected in

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the high infant mortality rate (111/1000) and child mortality rate (159/1000).

Although some reports indicate high knowledge about family planning contraceptive prevalence rate is less than 5% with marked variation between urban and rural communities.

5.5 Immunization against the major infectious diseases

Following the declared eradication of smallpox in Ethiopia, Expanded Program on Immunization (EPI) was launched in 1980. The broad objective was to provide immunization services for all children under two years and all pregnant women by 1990. No quantitative targets were set except for the immunization coverage to be increased by 10%. each year as of 1980, the date the program commenced. The vaccination coverage occasionally goes up and down and in 1993 the vaccination coverage was as low as 12%. Variation in vaccination coverage are striking both by regions and health institutions. Attat Hospital in Gurage zone reports more than 90% vaccination coverage while others report much less (16-50%).

5.6 Prevention and control of endemic diseases

Cerebrospinal Meningitis, Relapsing Fever, Typhus, Typhoid, Malaria, Tuberculosis, STD are endemic in Ethiopia occasionally causing epidemics which result in enormous deaths and disability. Some have special programs such as Malaria and Tuberculosis control programs.

5.7 Treatment of common diseases and injuries

The health service coverage is officially estimated to be 46%. There is marked inequity in the distribution of health services and health personnel in Ethiopia. The majority of patients are treated at the health station and health center level. Preventive and curative services call for expansion of health care facilities, with adequate diagnostic laboratory services and essential drug supply. Due to lack of resources for preventive maintenance of buildings and equipment, and extremely limited recurrent budget allocation, the existing facilities cannot operate at the expected level. Treatment of common diseases and injuries is negatively affected by these situations.

5.8 Provision of essential drugs

Shortage of essential drugs is a common phenomenon in Ethiopia. At the same time, about 4000 drug items were in the market competing for the scarce foreign exchange allocation for drugs. Problems within the health service drug supply system include the following: limited resources for drugs, poor stock management and inappropriate demand forecasting, extremely limited logistics organization, and limited domestic production.

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6. Major Problems encountered in the implementation of primary health care

In the attempt to implement PHC in Ethiopia, a number of problems were encountered which include:

a. Absence of an infrastructure at the district (Awraja) level to implement PHC.

The absence of district health management organization hindered the appropriate implementation of PHC as PHC programmes could not be successfully planned, implemented and controlled from the central or regional levels.

b. Difficulty in achieving intersectoral collaboration

Better health status could be achieved not by health institutions alone but also through increasing efforts by other developmental agencies. However, much remains to be done to effectively create an environment conducive to intersectoral collaboration.

c. Inadequate health service coverage and maldistribution of available health services.

PHC requires the development of a network of health institutions with varying technical competence in order to institute proper referral and management control systems. Although encouraging trends are being observed, an increasing effort is highly needed to strengthen the infrastructure for proper PHC implementation.

d. Inadequate resource allocation

The required initial investment on PHC program is not as cheap as some people think. PHC program implementation requires proper resource allocation whose initial cost may be beyond the abilities of countries to fund PHC projects. Resources from international agencies and other income generating schemes may help alleviate some of the financial constraints facing developing countries. Resources are available from donor agencies, however, these resources are usually not used properly to help develop the infrastructure needed for implementation of PHC. Activities of Non-governmental organizations (NGOs) are not sufficiently coordinated to become reliable sources of funding for PHC. Nations should not be blinded to the fact that PHC programs are initially expensive, but in the long run they generate appreciable dividends.

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Health Managers must wisely spend the little money available to maximize benefits. There will always be a shortage of money for the health sector because governments in practice are not generous in appropriating sufficient funds for health because it is not an income generating institution. Secondly, the demands for better health service by the population are increasing. Health management is likely to operate under these circumstances for many years to come. Hence there is no alternative but to demand more output for a small input through continuous search of approaches that help maximize benefits.

e. *Absence of clear guidelines or directives to government institutions and mass organizations on how to implement PHC.*

Specific directives and guidelines are essential elements in the implementation of PHC program. PHC is a very wide concept subject to various interpretations. How do government institutions and mass organizations see their role in PHC? Unless this is clarified through clear directives and guidelines, the efforts given to PHC may be lower than expected or may be misdirected. Legal responsiveness and responsibility should be accorded to efforts in PHC. Many of the problems related to inaction in PHC may be trace to absence of guidelines and directives to institutions responsible for PHC implementation.

f. *Presence of culturally dictated harmful practices or unscientific beliefs and practices in Ethiopia.*

There are a number of known harmful health practices in Ethiopia. These practices are manifested in child bearing and rearing, food preparation, excreta and refuse disposal, etc. The types of practice pose an enormous problem to implement scientifically sound practices. Although attempts have been made to identify these practices, much remains to be known.

g. *Absence of sound legal rules to support Environmental Health Activities*

Improvement of environmental sanitation is an essential aspect of PHC and fundamental to any improvement in health status. The institution of proper environmental sanitation practices in a community requires, among other things, the support of appropriate legal proclamations and enforcement of them. The available legal public health rules are outdated, unrealistic for the objective realities of the country and lack enforcement. New public health proclamations should be enacted to enhance legal backing to PHC activities in health. It should not be taken to mean that force or coercion is the only means of achieving

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better community environmental health practices but it has been shown to produce innumerable advantages when combined with persuasion.

h. Weak community involvement in Health

One of the major emphasis of PHC is community involvement. The organization of communities by area, by gender, Age and profession appeared to respond to the organized community needs of PHC activities. At one point encouraging trends were observed, however, the community organization structure was used to fulfil other missions and the health sector almost disappeared from the agenda of community organization activities. At present community organizations are mostly non functional although some steps are being taken to rehabilitate or develop them. In areas where the local leadership is sympathetic to health activities, community participation is on the increase. It should be noted that achievements in PHC cannot be registered without full involvement of communities.

7. Health Policy of the Transitional Government of Ethiopia

The Health policy of the Transitional Government of September 1993 mentions many of the components of the PHC strategy.The Health Policy of the TGE gives emphasis to the following health activities:

a) the control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions,

b) the promotion of occupational health and safety,

c) the development of environmental health,

d) the rehabilitation of the health infrastructure and

e) the development of an appropriate health service management system.

The future achievement of the PHC program will depend on our ability to alleviate most of the problems mentioned above. Unless we provide viable solutions to the obvious problems of the past we can never be sure of the future.

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A Case study For PHC Management Advancement Workshop

Background for the Case Study

Boreda is a woreda located in Miteksa Zone of Dangur Region. The woreda is located in the southern part of Dangur Region with an average annual rainfall of 980 mms. Ten years ago severe drought hit the area because of short and scanty rain and the population became a victim of famine. An NGO called SABAT entered the area and helped the communities in reducing the effects of the drought by providing food and clothing to the estimated 100,000 population. The death rate due to famine was drastically reduced with the resumption of normal rainfall, and hence there was no drought. There is one health station located at the Woreda capital. There are two health assistants with a daily vaccination program mainly for people residing in the town where the health station is located. Other than medical services for ambulatory patients there are no PHC programs.

Two years after the drought episode, there was an unusual increase in the number of diarrhoeal cases and deaths, mostly occurring among children. SABAT was requested by the local government to study the situation and provide its recommendation to solve the problem.

Task 1: Discuss on how you want to proceed with the task. (30 minutes). Read guide 1 after the discussion.

Task 2: If suggestion given in guide 1 is acceptable to the group, proceed to discuss mechanisms for the implementation of Rapid Community Survey. (20 minutes). Read guide 2 after the discussion.

Task 3: Rapid Community Survey requires the development of questionnaire. Discuss the questionnaire contents in line with the assignment given.

During the discussion identify specific indicators which will help determine the scope of the problem and identify factors which may contribute to the occurrence of the problem. (30 minutes). Read Guide 3 after the discussion.

Task 4: Formulate questionnaire for questionnaire contents a,b,c, mentioned in Guide 3. (30 minutes). Compare your work with the sample questionnaire provided. Please work out the complete questionnaire either before the end of the workshop or after you have gone to your place of work.

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Task 5: Discuss your advise to the local government on the intervention measures to be taken. (20 minutes). Read Guide 5.

Guide 1.

* The first concern of the task is to confirm the alleged increase in the number of cases and deaths and find factors which may be incriminated for the alleged occurrence of morbidity and mortality.

* Decide on the source of information and types of instruments

* Rapid Community Survey is desirable to assess the situation. Local program managers often totally lack data upon which to assess of evaluate the health problems in the area. The " rapid survey" is a new tool for getting this kind of information quickly and inexpensively.

Guide 2

* Rapid Community Surveys are designed to help PHC managers collect population based information on health status, behaviour, and knowledge. The typical rapid survey can be carried out in two to three weeks from design to final report. It involves 200-300 household interviews, drawn from 30 clusters of seven to ten respondents. The interview schedule is short and the questions are framed in mostly "yes/no" terms to allow simple statistical analysis. Details on data collection and analysis are given in "Health Information" session of the workshop.

* The data collection technic may be record review, observation, rapid surveys, health worker interviews.The types of instruments are registers, survey questionnaires and case investigations. Since the health station records do not provide the required information for the assignment, survey questionnaires should be prepared. The questionnaire should be simple, straightforward and valid.

Guide 3

A survey is a study or investigation the purpose of which is to obtain more information to understand a problem or a condition. A questionnaire is one of the tools for collecting the desired information either through person to person interview or mailed questionnaire. In Ethiopia the former is the preferred and realistic approach because of high illiteracy rate and scanty postal services.

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The content of the questionnaire is governed by the nature of the problem being addressed. However, there are characteristics which are common to all questionnaire irrespective of the nature of the problem. These are

a) Every questionnaire must include identification information such as: address, age, sex, educational status, religion, race of the respondent.
b) Questions must be short and easily understood.
c) Only important questions should be asked.
d) Start the questionnaire with questions that are easy to answer and that deal with very familiar matters.
e) Put the questionnaire in a logical order.
f) Train the interviewers
g) Pretest the questionnaire on similar population.

The quality of information obtained during the survey depend heavily on three factors: a) proper sampling design, b) the design of the questionnaire, and c) the skills, training, and supervision of the interviewers.

To fulfil the information needs of the assignment the content of the questionnaire should include the following:

a) Identification of the respondent by various characteristics (refer above).
b) Age and sex distribution of the survey population
c) Diarrhoeal episode in the family during the last 2 weeks.
d) Deaths attributable to diarrhoea
e) Characteristics of those affected by age, sex, place and time.
f) Diet, water supply, excreta and refuse disposal, and personal hygiene practices of the affected population.
g) Measures taken to alleviate the problems of the victims.
h) Others including the observation of the environmental condition.

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Guide 4: Rapid Survey

PHC Managers need timely and useful information about the health status of their target populations so that they can do a better job of planning and monitoring PHC services. Local managers totally lack data upon which to assess or evaluate the health problems in their area. The "rapid survey" is a new tool to for getting useful information quickly and inexpensively. The typical rapid survey can be carried out in two to three weeks, from design to final report. It involves 200-300 household interviews, drawn from 30 clusters of seven to ten respondents each. The most obvious limitation is that the number of questions must be limited and managers cannot expect detailed findings or analysis. Rapid surveys are designed to assess levels of a problem in question and not to identify the determinants or causes.

Sample Rapid Survey questionnaire
Community assessment of primary health care

Identification

1. Study no._____ 2. Village no._____ 3. Cluster no.__

4. Interviewer no.___ 5. Respondent no.____ 6. Date of inter ----

7. Respondent age___ 8. Respondent sex____

9. How many people live in this household:_____(total)
Married women of reproductive age (15-49)_____(in household)
Current pregnant women: _____(" ")
Children less than 24 months of age _____(" ")
Children 2-5 years old _____(" ")

10. How many children do you have under two years of age?
___(number of children)
What are their names and how old are they?
Name_____ Age (months)_____ sex (m/f)__
Name_____ Age (months)_____ sex (m/f)__
Name_____ Age (months)_____ sex (m/f)__

11. How many live births have you had?___ (number)
12. How many of these are still alive?___(number)
13. How far away is the nearest health unit or health worker?
__(1) <5km/60 min walk __(2) >5km/60min.walk __
__(9) DK/NR

14-17 Which of the following health services are available there?
14. Maternal and child health __(1) yes __(0)No __(9)DK/NR
15. Family planning __(1) yes __(0)No __(9)DK/NR
16. Immunization __(1) yes __(0)No __(9)DK/NR
17. Medical care services __91) yes __(0)No __(9)DK/NR

18. Does any one in the household need to use prescription and non-prescription drugs? __(1) yes __(0)No __(9)DK/NR

19. If yes, are you able to get them easily?
__(1) yes __(0)No __(9)DK/NR

20. If no, why aren't you able to get them?
_____(1) Too far
_____(2) Too expensive
_____(3) Do'nt know where to get them
_____(4) other_____
_____(5) DK/NR

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21. What is the name of the local Community Health Worker(CHW)?
__(1) Knows(said name) __(0) Does/not know __(9)NR

22 Has the local Community Health Worker visited or contacted you during the last three months?
__(1)yes ___(0)No ___(9)DK/NR

Guide 5:

Guided by experience and literature review on diarrhoea it is not difficult to suggest intervention measures to prevent the occurrence of morbidity and mortality due to diarrhoea. Introduction of comprehensive PHC programs have a lot to contribute to the control of diarrhoeal diseases. The following PHC programs can help reduce the burden of diarrhoea in the community.

- Health Education on personal hygiene
- Breast feeding
- Growth Monitoring/ Nutrition education
- Immunization
- ARI
- Water and Sanitation
- ORT

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An Outline or Assessment And Determination of Information Needs

1. Introduction

This outline is meant to facilitate discussions on "Assessment and Determination of Information Needs". Hence the topic of information, will not be treated in detail. Information, including Health Information, in the outline is taken as "an input or resource which reduces uncertainties", so as managers could give better decisions. Data could also be considered as an input, but it is not as useful as information in reducing uncertainties. For instance, data on hospital beds, number of discharged hospital patients and length of stay of these inpatients can be considered as useful input for bed occupancy rate, turn over of hospital beds and average length of stay as information; the later being more analyzed data, while the former are simple statistical data concerning hospital facility and inpatients with their length of stay. Similarly, number of vaccinated children by type of vacination given is not the same as information concerning EPI coverage by type of Vaccine and defaulting rate (e.g. $\frac{DPT_1 - DPT_3}{DPT_1} \times 100$)

The difference between "data" and "information" is more important in decision makings where analyzed and interpreted data is required as an information for planning, monitoring and evaluation of programmes. Hence the more complete, reliable and timely information a decision maker has, the more s/he would be certain in decision making.

2. Assessment and Determination of Information Needs

In the assessment of information needs, it is necessary to identify:

- USERS
- PURPOSE and
- CHARACTERISTICS

of information required for decision making. Users of information could broadly be divided into three groups, depending on the decision levels they belong to. These are:

- Strategic Planning (Planners & Policy Makers)
- Management control (managers at middle level)
- Operational Control (technical Personnel) and

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The purpose and characteristics of the information required for the above levels of decision making do vary and as such the information needs are not the same at each level. To give an example at planning level the broad purposes of having information are to:

- undertake planning & formulate policy;
- measure the achievement of objectives & monitor performances;
- acquisition, use & distribution of resources
- initiate research & undertake training.

In general the characteristics of the information required at higher (strategic planning) level are:

- in summary form not detailed;
- future oriented (more of forecasting)
- relatively old since its sources are external and
- it is periodically used & not frequently.

On the other hand, at the other end of the organizational set up, i.e. at the operational level the purpose and characteristics of the information required for decision making would be as follows:

Purpose:

- to check the accomplishment of specific tasks;
- to control actions undertaken;
- to respond to daily faced problems and for other operational purposes.

The characteristics of the information required at this level would be:

Characteristics:

- more precise and detailed, not summary;
- not future oriented and less forecasting;
- current data, such as list of clients who had received service - on daily basis
- obtained from the same organization which intends to use the data collected;
- frequently used and not periodic one.

3. Discussion Points:

Lastly, discussion will be initiated using the following questions:

- what is information? What is data? What is their relationship & differences? give examples.
- How do you assess information needs?
- In relation to users, purposes and characteristics of

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information, identify different levels of health services and show practically how you would determine information needs for each level;

- Given the goal, objectives, targets and activities of a programme (p.g FP, EPI CDD) what would be the steps of identifying information needs for monitoring and evaluating the service.

ASSESSMENT OF COMMUNITY HEALTH NEEDS

One purpose of undertaking Rapid Assessment is to determine the community Health Needs. In this use, unlike the routine data collection method, the information is gathered from the community and not from health institutions. The main use of the data collected would be for planning, particularly for setting targets concerning health services and monitoring. Using the rapid assessment methods, the gap between what has been planned to fulfil the community health needs and what has been achieved (if health service was previously rendered) could easily be identified.

The users of this data are usually the district managers who intend to find out community health needs. The community consists of different target groups who will be listed viz a viz the health service needs here under.

Target Group	Type of Health Service Needs
- Children under one year old	- Immunization Programme
- " " two " "	- " "
- " " three " "	- Growth Monitoring
- " " four " "	- Control of Diarrhoeal Diseases
- " " five " "	- Control of ARI
- " " six " "	- Control of Nutritional Problem
- Adolescents of 10-20 yrs.old	- Adolescent H. Program
- Women of 15-49 years old	- Family Planning
- Pregnant Women	- Antenatal Service
- All members of the Household	- Curative & supportive programme
- Households	- Environmental health (water supply & latrine)

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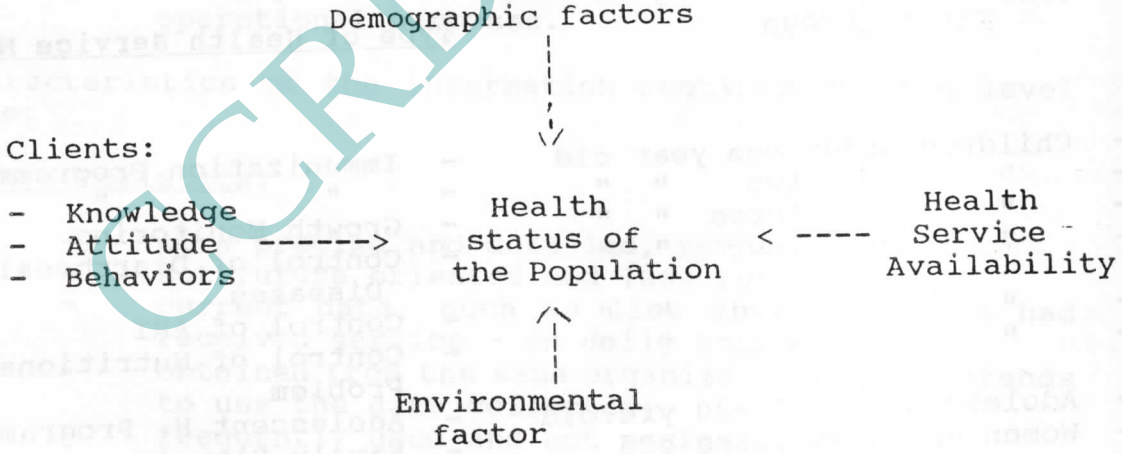
After determining the target groups and the community health service needs, it is important to specify the area where the assessment of community health needs would be undertaken. It could be, depending the level of representativeness required and availability of resources (including time, fund, manpower etc.), in one district or several districts where sample villages and households would be selected.

Other than coverage determination, which will be discussed in the next section, the rapid assessment of community health needs has the following specific objectives:

- to find out the size and distribution of the target group
- to identify specifically the target group which did not get the required health services; and
- to identify the level of knowledge, attitude and practice (behaviour) of mothers and others who need the service;

At this junction, it should be clear that almost always it is not possible, using the rapid assessment, to identify the cause of low performances.

To assess the community health needs taking the health status as the core of the matter the following conceptual framework would be used.



It is possible to undertake study on different types of targets, concerning the above factors and others. Nevertheless it is necessary to identify the target group for which data is to be completed concerning different types of topics. To facilitate such identification of target groups the following schematic presentation will be used:

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Topic to be Addressed	Data to be completed from
1. Health status of target groups	1. All members of the household
2. Demographic (age, sex etc.) factors	2. All members of the household
3. Antenatal care & safe delivery	3. Women who had pregnancy before a year
4. Family Planning	4. Married women 15-49 year
5. Breast Feeding	5. Women with children < 5 yrs
6. Diarrhoeal Diseases, ARI etc.	6. Women with children < 5 yrs
7. Immunization	7. Women with children 1-2 yrs
8. Growth Monitoring	8. Women with children < 5 yrs
9. STD & other communicable disease	9. Adults 15-49 yrs
10. Water Supply and Sanitation	10. At household level

During discussion the following points could be raised.

1. What are the target groups & type of Health Services addressed in undertaking assessment on community health needs? why do you do it? How (method) do you do it?

2. Prepare a framework to understand the relationship among different factors or variables to be included in the assessment

3. Finally list the topics to be addressed and the source of information.

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HEALTH SERVICE COVERAGE ASSESSMENT (FOR DISCUSSION)

A combination of an assessment of community health needs and performance assessment will give health service coverage assessment. Hence, under this topic the following questions will not be discussed since they were already dealt within the previous section. These are:

1. What for is the information needed? (for planning, monitoring and evaluation)
2. Who are the users of the information (planners & managers)
3. Which target population and PHC components does the user want to study (all the target groups & PHC programmes explained earlier e.g. children, women & adults)
4. What is the geographic scope & sample size for the assessment
5. What would be the study design & others to identify the type of data required some coverage indicators will be listed here under:

Type of Service	Coverage Indicators
- Antenatal Care	% of pregnant women receiving visits
- Delivery Assistance	% of delivcises assisted by health personnel
- Family Planning	% of women assisted by health personnel
- Growth monitoring/Nutrition	% of Children < 3 yrs who received growth monitoring service.
- Child Health	% of children < 5 yrs who had health examination
- ORT/CDD	% of children <5 yrs with diarrhoea who receives ORS

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- Immunization/children	% of children fully immunized
- Immunization/women	% of women 15-49 receiving T.T.
- Sanitation	% of household with latrines
- Water Supply	% of household who receive safe water
- Breast Feeding	% of women feeding up to 18 month
- Health Education	% of schools and other institutions receiving H/E programme

In general the objective of the rapid health service coverage assessment as to find out answers for the following questions in brief:

- what percentage of the target group are covered?
- what are the main reasons for some people for not being covered
- where do people go for services such as for treatment of disease

<u>Points for Discussion</u>

During the discussion, for each indicator the following questions will be addressed:

- Is the indicator valid (does it measure what is intended to measure?)
- Is it possible to get the information?
- What would be the alternative (other than rapid assessment) source of information.

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A FRAME WORK FOR THE GROUP EXERCISE ON INFORMATION COLLECTION FORMAT DEVELOPMENT AND INTERPRETATION OF DATA

You have a general information from health records that the EPI programme has very low (<25%) coverage. You want to study the reason for this low EPI coverage. You have decided that you will use Rapid Assessment Method using questionnaire. To do so, answer the following questions.

Questions

1. What would be the specific objectives of the study?
2. What questions would you list to help you in designing the questionnaire?
3. What are the target groups to be addressed?
4. Who would be the respondents?
5. What type of questionnaire (yes/no, multiple choices open ended, dates, numericals, ranges ... etc.) Would you design?
6. Design the questionnaire
7. Would the questionnaire be coded or uncoded?
8. What would be the Dependent & independent variables for the interpretation of data to be collected?
9. Construct Dummy tables to illustrate how you would analyze your data?
10. What makes the assessment a rapid one, from the questionnaire you designed?

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Health Management and Planning

1. Introduction

The level of Health a Nation enjoys is an outcome of interaction of cultural, social, economic and political environment that prevailed in the past and pursued at present. Although the above considerations are important in understanding the health of a country, it is equally influenced by the level of management prevailing in each country. Management influences all phases of our life and is increasingly becoming clear that societies could not exist without some form of management. Management is generally defined as a process of reaching organizational goals by working with and through people and other organizational resources. The role of management is to guide resources and efforts toward goal attainment. The individual, and resources are organized in a way that assures effective accomplishment of tasks which lead to organizational goal achievement.

2. Health Management

Health Management is simply management in the health sector. The principles of management remain the same and applicable to all sector including the management of health services. Health Planning is a management process through which the available resources for health are given direction for the achievement of the highest levels of health possible given the country's economic, social, and political circumstances.

3. Management Functions

In general, there are four management functions or activities that make up the management process. These are Planning, Organizing, implementing and Monitoring and Evaluating.

3.1 Planning

Planning involves choosing tasks that must be performed after careful analysis of the prevailing situation and resources available.The planning process also indicates how and when the tasks should be performed. Planning is future oriented and the past and the present trends should be assessed to forecast the future. It should, however, be noted that the changes which occur in the future are difficult to predict.

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Planning in PHC is governed by the general planning approaches used in the health sector. The planning process in PHC by necessity involves wide range of population groups and institutions which have a role in development activities of communities. Bottom-up planning needs to be institutionalized to ensure an expanded arena for community involvement in maintaining a high level of community participation which is an essential element in PHC strategy. The planning process should start by actively involving communities in the definition of the problem, setting priorities and consideration of alternatives for resolving the problem, identifying resources from within and outside the community which could be utilized for implementation of the agreed upon activities, monitoring and evaluation of activities pursued in the interest of the program of action. The results of the monitoring and evaluation would help indicate the future direction of activities.

Planning is therefore, a systematic development of action programs aimed at reaching agreed objectives by the process of analysing, evaluating, and selecting among the opportunities which are foreseen. In general the planning process involves six essential steps, namely:

Step 1: Stating Organizational Objectives.
Step 2: Listing Alternative ways of Reaching Objectives.
Step 3: Developing premises upon which each alternative is based.
Step 4: Choosing the best alternatives for reaching objectives.
Step 5: Developing plans to pursue chosen alternatives.
Step 6: Putting plan into action.

Planning can be either Strategic or Tactical. Strategic Planning is a long range planning that focuses on the organization as a whole. Long range is usually defined as a period of time extending about three to five years into the future. Tactical planning on the other hand is a short range planning that emphasizes current operations of various parts of the organization. Short range is defined as a period of time extending only about one year or less into the future.

3.2 Organization

Organizing is a process of establishing a formal structure of authority through which work is arranged, defined and coordinated for the attainment of predetermined goal and objectives. An organization is a body of interdependent parts which together form a whole so that control and direction of various activities can be achieved for the attainment of specified goals. How we organize ourselves determines our success of achieving the objectives of PHC. PHC involves the efforts of various individuals and organizations and requires an elaborate organizational structure which commands the efforts of individuals and organizations toward the attainment of common objectives.

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3.3 Implementation

Once the task is planned and the organization structure is drawn, concrete measures must be taken to put the plan into action. This is known as implementation of the plan. The implementation process may take the form of various subsequent tasks, which should be performed by carrying them out in a planned and orderly manner. The essential materials and human resources are provided to execute the activities as planned in order to attain the predetermined level of achievement. In PHC the implementation process calls for the input of various individuals, groups, and organizations, the sum total of which should lead to the achievement of better health status of communities.

3.4 Monitoring and Evaluation

This is the tool that management uses to insure that what is planned actually takes place and the desired effect is achieved. This should not be taken as a merely an end process in the planning cycle. Details of monitoring and evaluation is given during the subsequent sessions of the workshop.

Decision Making

One of the main functions of a manager is to make decisions. Every one every day makes a decision without probably thinking that he/she is involved in a decision making process. When making even an elementary decision, one consciously or unconsciously discriminates between various alternative measures that could be taken to resolve a problem. A decision is a choice made between two or more alternatives. It dose not matter which alternative is chosen but a choice is made. Decisions could be made by an individual or a group. Although group decisions are time consuming, decisions by a group are very likely to consider wider options and come to a decision of common agreement which has a greater chance of being implemented.

Supervision

Another important function of a manager is to help professionals or others involved in health work attain competence and better work performance. This can best be achieved through improved supervisory support. Supervision can be described as an activity to oversee the work of others by authorized person. The main purpose of supervision is to improve the competence of the individual by creating learning environments which induce the individual to learn and perform better.

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4. Planning and Implementation of PHC at the Community Level

While it is expected that the range of circumstances in different countries will necessitate some variation in implementing primary health care, differences in the interpretation suggest a need for better understanding of what we mean by PHC in the light of experiences so far. Concern to equity and justice are basic to our understanding of PHC. PHC is mainly about ensuring access to the resources and services available to satisfy the health needs of individuals and communities by reducing gaps between those who have access to health care and those who do not; gaps between high and low infant mortality rates in different groups; gaps between those with safe water and adequate food supply and those who lack these essentials for good health. It is about an equitable and just distribution of available health and social resources, and the need to reallocate existing resources in such a way as to preferentially meet the health needs of those whose needs are greatest.

PHC demands that people themselves become key actors in improving health. Health involves much more than simply delivering health services to a group of people, as was often said in the past. The health system based on primary health care must therefore assume major new responsibilities for empowering individuals and communities for more responsible involvement in action for their own health development. Basic prequisites for PHC implementation are Community involvement, intersectoral collaboration and utilization of appropriate technology. The planning and implementation of PHC at community level requires the active involvement of communities and development organizations during the planning and execution process.

In Ethiopia there was attempt to involve communities in the development of PHC at the community level but these attempts were superficial and short lived. The organized communities were not sufficiently utilized for health promotion. In areas where some temporary success were registered, the activities were not only limited in scope (training of CHAs and TBAs in the absence of basic infrastructure and capability to maintain their services) but also lacked the capacity to maintain continuity.

The Planning and implementation of PHC at the community level should be able to address effectively to these short comings in order to register the desired level of PHC implementation.

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Monitoring and Evaluation

1. Background

Monitoring refers to the assessment of the of the process leading to the achievement of the desired outcomes. Successful accomplishment of the activities of the process is expected to lead to the attainment of the planned objectives.

Evaluation is defined as the process of determining the extent to which predetermined objectives and predetermined levels of operation are attained. It is not an end process in the planning cycle. Evaluation should be performed during all stages of program planning and program implementation. It is the feed back mechanism that constantly provides the necessary information for appraising any phase of implementation, allowing or permitting adjustments and improvements to be made as needed.

The problem in evaluation is not how to evaluate but what to evaluate. In assessing the value or worth of a health program, there are two broad classes of questions that can be asked: the first relates to effectiveness which is oriented toward assessing the extent to which work was accomplished compared to what was intended: the second question involves efficiency which is directed to the consideration of economic costs. Concern with efficiency may also lead one to study possibilities for rearranging a program, or personnel, or materials in an effort to reduce costs without reducing effectiveness.

2. The process of Monitoring and Evaluation

Monitoring and evaluation involves periodic collection and analysis of selected indicators which will enable managers to determine whether the key activities are carried out as planned and have expected effects on the target population. The value of monitoring and evaluation is to identify problems; take corrective measures; measure achievements of targets and assess trends in health status. Some indicators include the following:

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A- For PHC services

a) Input indicators:

Availability of personnel, supplies, equipment and funds.

b) Output indicators:

- utilization of services
- quality of care
- contacts, visits to health institutions
- access to services

c) Effects:

- coverage
- knowledge and skills

B- For PHC management

a) Input indicators:

Availability of trained personnel, supplies, information, and guidelines.

b) Output indicators:

- services or activities completed
- frequency of management activities
- quality of management activities

c) Effects:

- PHC services available, accessible
- staff performance
- worker knowledge, skills, and behaviour
- community satisfaction with services
- quality of PHC services

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3. Steps in Monitoring and Evaluation

a) Planning for Monitoring and Evaluation

i) specify objectives
ii) decide on scope
iii) select the indicators and standards
iv) choose information sources (routine records, logistics records, treatment registers, patient records, activity reports, population based records) and develop data collection procedures (record review, observation, rapid surveys, health worker interviews etc.).

b) Implementation

i) collection of data
ii) tabulation and analysis of the data
iii) presentation and reporting of the findings (review users and their needs, adapt report to users needs, use graph and tables,highlight major findings, recommendations for action)
iv) taking appropriate action based on the findings (if problems have ben identified: identify causes, describe obvious causes, collect data to find unknown cause(s), plan and implement solutions).

c) Assessment

Decide whether to continue monitoring

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Assessing the Quality of Service

1. Introduction

Quality assessment is different from an ordinary evaluation of program performance. Evaluation often focuses on resources (supplies, equipment, personnel) or inputs , and service delivery outputs such as number of children vaccinated and number of people treated. Quality health care (defined by Roemer and Anguilar, WHO-1988) is defined as " Proper performance (according to standard) of interventions that are known to be safe, that are affordable to society in question and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition."

Service quality assessment is the process of determining whether PHC services are provided according to established norms for quality care. By using explicit process criteria, in the form of observation checklist, the service quality assessment tools and methods can help managers determine whether specified procedures are being carried out, how well they are being carried out, and which tasks need improvement.

Service quality assessment can be used to monitor and strengthen the quality of care in PHC programs. The quality can be assessed using checklists. The service quality checklists are designed to record the observation of the service delivery encounters between providers and clients. The checklists are made up largely of lists of tasks that providers are expected to carry out in various programs.

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2. Service quality assessment procedures

Service quality assessment process followed by managers and supervisors consists of seven steps, namely;

Step 1: Specify the scope and objectives

The usual objective of quality assessment is to identify strength and weaknesses in the service delivery and to make subsequent corrections in order to improve the overall service quality.

Step 2: Select the unit of observation and data collection techniques.

Quality can be assessed by following clients through the system, by observing health workers provide services to different clients, and by observing a specific procedure several times.

Step 3: Select and adapt the appropriate service quality checklist(s).

There are several checklists that could be used. The responsible person may select the long or the short version of the appropriate service quality checklist. See sample checklist given below.

Step 4: Develop the sampling procedures and select sample (optional).

This step is only necessary if the objective is to conduct a study or evaluation of quality in an administrative area, such as a district or zone. The purpose of sampling is to make an objective assessment of a large group without having to assess every member of that group.

Step 5: Carry out the assessment.

This step involves actual implementation of the quality assessmt process as planned.

Step 6: Compile and analyze the data.

The information collected during a service quality assessment may be tabulated using a simple matrix. If multiple observation checklists are used, the tabulation can be done on the checklist, eliminating the need to transfer the information to the tally sheet.

Step 7: Report findings, provide feedback data, and take corrective actions.

Quality assessment is the first step in quality improvement. It should be followed by steps designed to maintain the quality of those tasks that are done well while identifying and implementing ways to improve the quality of those tasks that are not done well.

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3. Sample of Rapid Quality Assessment Checklist for "Community Assessment of Primary health Care (overall)"

I. Identification

1. Health facility_____
2. Observer/supervisor_____
3. Date_____

II. Did the service provider :

4. Register all children <5 on the family health card? __yes __no
5. Register all women over 16 on the family health card? __yes __no
6. Vaccinate or arrange for vaccination of children who need to be immunized? ___yes ___no
   (If there are malnourished children in the house)
7. Check to be sure that nutritional counselling, food supplementation, and/or medical attention are being received? ___yes ___no (If any children have diarrhoea)
8. Recommended ORT and help the mother to prepare and administer it? ___yes ___no (For each pregnant woman)
9. Ask if she is receiving prenatal care and arrange prenatal visit if necessary? ___yes ___no (For all households)
10. Refer interested women or couples for family planning services? ___yes ___no
11. Discuss water,hygiene, and sanitation? ___yes ___no
12. Establish good rapport with the mother? ___yes ___no

N.B. This is just one example. You can develop several checklists for all PHC programs and activities.

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