

CONTINUING EDUCATION EXPERIENCES AND INTERESTS OF
HEALTH STAFF IN IFELOJU AND IBARAPA
LOCAL GOVERNMENT AREAS, OYO STATE

by

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DEDICATION

To the Blessed Virgin Mary for her loving
kindness and assistance; and to Adaku.

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ABSTRACT

Continuing education (CE) is an important component of staff development for health workers and ensures that quality services are delivered to consumers. This has been viewed by some authors as a way of eliminating "continuing ignorance," which is endemic among many rural health workers, who lack contact with outside resources and more highly trained professionals.

The Ibarapa District of Oyo State, Nigeria, is currently divided into Ifeloluju and Ibarapa Local Government Areas (LGAs). A variety of government (local, state and federal) and private health services and programmes are available in the area. This study is an exploratory descriptive survey that aimed at identifying previous continuing education experiences of health staff in the two LGAs as well as their interests in further learning. All available health workers (144) in nine private clinics, two state general hospitals, two local government health offices, eleven LGA clinics, and the University of Ibadan's Ibarapa Community Health Programme, were interviewed.

Four types of continuing education experiences were investigated, attendance at courses and workshops, learning from supervisors, staff meetings and personal learning through reading. An in-service course or workshop was attended by only 19% of health workers in the past five years. University and local

government staff had more opportunity for CE programmes. Persons working in the private sector were the least likely to have attended a course or workshop, as were staff who lacked a basic health qualification. Most (68%) had received a visit from their supervisor in the past six months, but in only 30% of these visits was anything done to update the health worker's knowledge and skill. Also 72% reported having attended a staff meeting in the past six months, but only 26% said that they learned new ideas at these sessions. Reading of professional texts, journals and references was reported by 58%. Staff without health qualification were least likely to have done any reading. All but 12 respondents expressed a clear desire to participate in in-service training programmes.

The desire for continuing education, especially in-service training opportunities, is not matched by actual experience of LGA health staff. More short courses could be organized at the local level by institutions such as the University of Ibadan, to stimulate staff interest in their work and upgrade their skills. Better advantage could also be taken of the learning potential of staff meetings and supervisory visits. Formation of a training committee comprising all the sectors should be charged with the responsibility of developing a yearly timetable for CE for all health staff in each LGA.

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CERTIFICATION

I certify that this work was carried out by Mr. Philip Chimee Onuoha in the Department of Preventive and Social Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria.



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CHAPTER ONE

INTRODUCTION

The adoption by the member states of the World Health Organization (WHO) in 1977 of "Health for All by the Year 2000 AD" (HFA 2000), as their main goal, and the recognition at Alma-Ata in 1978 of Primary Health Care (PHC) as the key to reaching this goal, marked a change in approach to health problems and health systems throughout the world.

High technology medicine seemed to be getting quite out of hand and leading health systems away from health promotion for the many towards expensive treatment for the few. The support for PHC means, among other things, manpower development, including the reorientation of existing workers and training new ones [WHO and UNICEF, 1978]. The PHC approach lays emphasis on the role of individuals, families, communities and traditional local health resources in promoting and creating better health. The community itself is thus transformed into a significant health manpower resource [Kieczkowski, Elling and Smith, 1984].

In order to promote, facilitate and ensure the necessary mobilization at the local level, various member states of WHO

embarked on a redefinition of the roles of existing health and health-related personnel, and the development of new types of personnel for the significant changes in skills and attitudes required for PHC [Klęczkowski, et al, 1984]. For example, in Zambia a major step in PHC policy implementation was, "Training of existing health workers for their new roles in primary health care" [Kasonde and Martin, 1983]. Not only do existing staff need training, but even the trainers themselves, that is the teachers of health workers, need updating in both the content and methods for effective primary care training [Shrestha, 1986].

As if anticipating the changes demanded by PHC, the Federal Ministry of Health (FMOH) in Nigeria, had in 1978 introduced a new breed of PHC workers to staff the basic health services. These were known as Community Health Aides, Community Health Assistants, Community Health Supervisors and Community Health Officers (CHO), listed in order of increasing sophistication of training and level of responsibility (FMOH, undated).

The programmes for these new breed of PHC workers were often a form of in-service training. The aides and assistants were often drawn from existing auxiliary staff such as ward maids and orderlies. The CHO cadre, were in most instances practicing nurses, medical assistants and public health superintendents, Supervisors achieved their posts through in-service training after

several years working as Community Health Assistants. Thus continuing education played an important role in establishing and maintaining this new PHC system.

Later in 1987, the names of assistant and aide cadres were changed to Community Health Extension Workers (CHEW) to give better reflection to their important community outreach role, which was intended to consume 80% of their time [Ransome-Kuti, undated]. By 1986, these new health workers were found to comprise 28% of the 130 government health staff in the former Ibarapa District of Oyo State, site of this study [Olumide, Brieger, Oyejide, Akinkugbe, Olayinka, Oladepo and Osinubi, 1986].

It is necessary to consider the duties assigned to and performed by these important primary health workers which

include -

... diagnosing and treating common conditions with simple measures, identifying pregnant women and ensuring that they deliver safely or identifying malnourished children and providing health education in the community. The community health extension workers mobilize the community for preventive actions such as building of latrines, wells and roads. Their role is to spread community health care into and within the community and in the most responsible manner. They are no aides to anybody but skilled health workers in

their own right with important functions to perform within the community health team. They are agents of change [Ransome-Kuti, undated]

These new cadres were able to perform a variety of promotive and curative skills relative independently because their training and job performance were based on guidelines or algorithms known as the "Standing Orders" [Ekunwe, 1984].

These new developments brought about by PHC exemplify the need for lifelong learning as noted by Wood [1983], to combat the problem he termed "continuing ignorance" among health workers. He observed that job performance requires a mixture of knowledge, skills and attitudes. In theory, health workers acquire all the knowledge, skills and attitudes they need during basic training, and then "qualify" and are expected to remember everything they learnt for their whole professional lives. In practice things are quite different.

To begin with, some of the items learned in basic training become irrelevant; they do not help the worker do his/her job. On the other hand, there are things the worker must know, but were never taught. Often these are procedures or solutions to practical problems that one faces in day-to-day work. At the same time the worker may have forgotten some of the still useful and relevant information acquired during basic training, especially if

there has been no opportunity to review that information and discuss it with others. Meanwhile, the job for which one was trained may have changed because circumstances have changed and new techniques have been developed. It becomes clear that basic training by itself is not enough, and if the health worker is to do his/her job effectively, the learning process must be lifelong [Wood, 1983].

This life long learning process has been termed "continuing education" (CE), and it is designed to prevent, cure and rehabilitate workers from the disease of "continuing ignorance." This disease has been discussed in epidemiological terms by Wood [1983] who looked at the population at risk, the location of affected individuals and the time of onset. With regard to those who are at risk, it has been discovered that there is no natural immunity to the condition as all health staff ranging from ward aids to professors of medicine are prone to the condition. The distribution of the at-risk population is all over the country, but is most especially found among the health staff who work in isolated health centres because they are visited fewer times, have fewer professional colleagues to interact with, have fewer materials to read and seldom have opportunities to attend meetings, seminars and courses.

In determining when continuing ignorance begins to attack

health workers, The African Medical and Research Foundation, AARF [1983], stated that medical know-how increases rapidly during basic training and reaches its peak at the time of qualification. When health workers start to work, they often begin to acquire additional practice skills at the same time that they start forgetting some of their theoretical knowledge. For a time the acquisition of skills may balance the forgetting of theory. This is the subclinical phase of continuing ignorance. As time passes however, and forgetting accelerates, signs and symptoms of deficient work performance begin to appear, and the syndrome of continuing ignorance becomes clinically apparent. At this point the individual health worker needs access, sometimes boosters of the remedy, that is CE activities, the aim of which is to reduce the incidence of the condition to a point that is no longer a threat to public health.

The problem of continuing ignorance is not best handled on a case-by-case basis. Health manpower policies are needed which promote training and motivation and ensure equitable distribution of human resources (WHO, 1989). Such a policy should also ensure the development of managerial, technical and scientific staff at a sufficient level of competence to carry out WHO goals at all levels of the health system. For example, "The National Health Policy and Strategy to Advance Health For All Nigerians" (WHO, 1988)

states -

Ministries of Health shall ensure that medical, nursing, public health and other schools of health sciences under their jurisdiction include in their education programmes the philosophy of primary health care, and the essentials of the managerial process for national health development, and to provide appropriate practical training in these areas.

This study is hinged on the Chinese proverb quoted by AMREP [1983] -

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

In any setting one will find health workers in each of these categories. Hopefully those who are found to be wise about the opportunities of CH can be identified and encouraged to lead the way for awakening those who are asleep to their potentials, to teach those who have not yet learned, and to control the effects of continuing ignorance displayed by those who are not aware of their own ignorance.

STATEMENT OF THE PROBLEM

During his twelve-week internship period, the researcher was in constant contact with the health staff of both Ifelofu and Ibarapa Local Government Areas (LGA) in Oyo State, Nigeria. He observed with dismay that some of the health staff who manned evening, night and weekend shifts in most of the PHC facilities had not received formal professional training. During inquiry about this problem he stumbled upon the fact that even many of the professional health personnel had not had any up-date course in their 15-20 years of service to the LGA.

Tobin, Wise and Hull (1979) posited that lifelong learning is absolutely necessary to continued competence. Also AMREP (1983) stated that rural communities are endemic areas for continuing ignorance. Having established the existence of some of the symptoms of continuing ignorance in the two LGAs, the researcher was motivated to conduct this study whose main aim was to document the extent, nature and equitable distribution of CE opportunities and experience among the entirety of health workers in all formal sectors within the district.

DESCRIPTION OF THE STUDY AREA

Ifelofu and Ibarapa LGAs (formerly known as Ibarapa District) in Oyo State, Nigeria cover an area of approximately 1,600 square kilometers and lie to the west of Ibadan, the state

capital. The district borders the rain forest belt to the south, but consists of rolling savannah with residual patches of forest growing near water courses. Most of the land lies between 400 and 600 feet above sea level, but rocky outcrops, rising to 1000 feet, occur here and there adding much to the natural beauty of the landscape [Ogunlesi, 1989]

With the exception of a few Fulani cattle herders, the inhabitants of the district consist almost entirely of Yoruba speaking people, who refer to themselves as "Ibarapa Meje," a term which refers to the seven major towns that make up the district. A projected population, based on the 1963 census, pegs the district at 237,260 inhabitants [Daly, Filani and Richards, 1981].

The district contains two state government hospitals, a total of eleven LGA maternity centres, nine LGA dispensaries, two environmental health offices (one per LGA) with at least one environmental health officer posted to each major town, and nine private hospitals/clinics. The hospital in Igbo-Ora, headquarters of Ifeloluju LGA, is managed jointly by the Oyo State Ministry of Health, The University of Ibadan, The University College Hospital and the Igbo-Ora Community. Thus four major sectors are involved in the delivery of formal medical and public health services in the district, the local governments, the State Ministry of Health,

the federal, represented by the University and the private.

Professionally trained health workers in the various government sectors numbered 130 in 1986 and included physicians, nurses, midwives, public health superintendents (or environmental health officers), pharmacy staff, laboratory technicians, health educators, medical records officers, community health extension workers and other technical staff [Oluide, et al, 1986].

In 1986 the then Ibadan LGA was chosen as one of the initial model PHC local governments for implementing the FMOH national health policy. This has resulted in a variety of in-service training activities both inside and beyond the district, especially for LGA staff, and primarily for those at middle and upper levels [Oluide, 1990].

ORGANIZATION OF THE TEXT

The preceding background information forms the introduction to the study. A more detailed review of literature concerning the concept of continuing education follows in Chapter Two. The third chapter describes the methodology of the study, which utilizes both survey research and case study approaches. The results of the study, which include both the demographic and professional characteristics of current health staff in the district, as well as a documentation of their recent CE experiences and future interests, are found in Chapter Four. Implications of the

findings are discussed in Chapter Five, with appropriate ~~recommendations~~ rounding up that chapter. The latter has been shared with the various health authorities in the two LGAs, in the hope that these may stimulate greater attention to the personnel development needs of district level health workers.

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CHAPTER TWO

REVIEW OF LITERATURE

The concept of continuing education (CE) is explored at the start of this chapter. The roles of CE in staff development and motivation are reviewed. The many forms CE might take are described. In-service training (IST), one of the most common forms, is reviewed in detail. The chapter concludes with a discussion on the special role CE plays in the transition of health systems from orthodox facility based services to primary health care (PHC).

THE CONCEPT OF CONTINUING EDUCATION

Continuing education has become a global concept that embraces a diversity of educational programmes and experiences geared to the adult who has broken bounds with full time or formal education [Akinpelu, 1991; Agunloyo, 1990]. CE involves a change in orientation in educational practice from learning that is tied to certain ages (i.e. children and youth) and places (i.e. schools) to an evolutionary approach to learning that occurs over time in a variety of settings [Akinpelu, 1991]. Thus CE is seen as a life long process [AMREP, 1987; Linton and Truelove, 1980;

Agunloye, 1990; Toffler, 1970; WHO, 1980].

There is need to narrow the meaning of CE, because as Akinpelu [1991] has observed, CE is an amorphous phenomenon, which if taken in its ordinary sense, can be said to be as wide as any educational effort beyond and after initial schooling. If care is not taken in defining the concept, one might even say that secondary school education is a form of CE that follows initial primary schooling.

Several attempts at defining CE have been made, which reflect the inter-disciplinary application of continuing education. Thompson [1974], an educator, described CE as a process through which older and less qualified staff undergo updating that enables them to cope better with current duties and even take on new responsibilities. Another perspective from the field of business views CE as encompassing all systematically organized and planned efforts that are designed to improve the abilities of employees [Tobin, Yodorwice and Hull, 1979]. A labour viewpoint described CE as "workers' education" that enables the worker to participate actively in the labour movement, to improve personal and group competence, and to advance his social, economic and cultural interests [Anyanwu 1960].

In the medical field, Linton and Truolove [1980] define continuing education as the means by which the physician may

obtain the necessary information for the update and improvement of the health care of the community. This new information will help the physician develop new attitudes and patterns of behaviour.

Continuing education as defined by the African Medical and Research Foundation [AMREF 1983] is "that part of education that begins where basic training ends." Good basic training lays the foundation for further learning by providing the fundamental knowledge that the health worker needs to start his job. CE then builds on this foundation to improve the health worker's competence and enables him to adapt to changing health needs in the community and changing practices in the health care profession [Wood 1983].

The interaction between basic and continuing education is demonstrated by Thompson [1974]. Every improvement made in basic professional training curricula and methods renders unqualified those professionals already in service. Therefore even the best professional will need to retool, not once or twice, but constantly throughout his period of service.

Toffler [1970] who asserts that, "while it is not necessary for one to attend school for life, we find individuals who stop learning soon become stagnant." The purpose of adult learning is to improve one's competency in life. Toffler [1970] sees the adult learner as "running to stay behind," in an effort to update

his knowledge because the object of his quest is in a constant state of change. Lifelong learning is absolutely essential for continued maintenance of competency because, "We do not live in the same world into which we were born, and we will not die in the world in which we worked" (Mead 1958).

Mead (1958) pointed out that CE is an individual matter as well as a social phenomenon. The individual, through CE, must continually adapt to change or be doomed to be apart from the society (Stein 1971).

This process of adaptation and continued learning takes many forms (Agunloye 1990). It can be informal through recreational activities and hobbies or quite formal as in re-entry into second and third level certificate courses. In between are various forms of in-service training programmes and adult education courses. Unfortunately not every worker has access to these opportunities.

While there is a consensus that pre-service and in-service training should form a continuum, the mechanisms for achieving this are not often in place (Thompson 1974). The worker often must update himself. This is feasible to some extent in societies and communities where the professional is in constant contact with colleagues working along the frontiers of the discipline and is surrounded by advanced technological resources. For those who are based in rural communities, cut off by poor road and electronic

communication from forums of intellectual and professional exchange, the job of self-initiated CE is most difficult.

In sum, since the beginning of time there has always been something new to learn. Although there are preparatory programmes of differing quality and type, none ensures that practitioners will maintain competency throughout their careers. Continuing education is therefore a way for combatting obsolescence [Tobin et al, 1979].

A STAFF DEVELOPMENT PROCESS

Staff development is a process of improving the quality of an organization's human resources and is based on the fact that manpower is an organization's prime resource for achieving organizational goals [Stein, 1971]. Staff development, also known as manpower development, embraces all institutionalized and personal efforts or facilities available to workers to enhance their job capacity through improvement of competence, skills, awareness, attitudes and aptitudes [Anyanwu, 1960].

Tobin et al (1979) describe staff development as "both formal and informal learning activities that relate to the employer's role expectations that take place either within or outside the agency," and includes any effort to improve an employee's knowledge skills and attitudes. The American Nurses Association [Stein, 1971] indicates that staff development has

three component parts, 1) orientation, 2) in-service education and 3) continuing education. Another view gives staff development four component parts, 1) peer review, 2) practice audit, 3) re-examination and 4) continuing education (Tobin et al 1979).

The above descriptions and definitions reinforce the inclusion of CE as a major component of staff development [Oyesola, 1989; Anyanwu, 1960]. The role of CE in staff development meets the seemingly conflicting needs of employees to maximise the value of their labour and of employers to maximise productivity [Oyesola, 1989; Koontz, O'Donnell and Wehrlich, 1983]. CE enhances workers' earning power through better career opportunities, and strengthens the agency by producing more understanding and loyal employees [Osule, 1984].

MOTIVATION FOR CONTINUING EDUCATION

The desire for any kind of learning arises from a felt need. The perceived need for CE may arise from a desire for basic economic survival, but more commonly from a need to improve skills to maintain a present job, or qualify for a better job. At another level the employee may be motivated to continue learning as part of a need to continue growing as a person [Lynton and Pearce, 1978]. Thus the pursuit of continuing education is a natural component of the basic human needs for self-esteem and self-actualisation [Maslow, 1970; Adékanbi, 1991; Tobin et al,

1979].

Although adult learners have the natural motivation to identify their own learning needs and goals [Tobin et al, 1979], observations at rural health facilities often find that workers are under-employed, disinterested and unprepared to invest more than the minimum needed to get a job done [Amonoo-Lartson, Ebrahim, Lovel, and Ranken, 1984]. Payment of adequate salary and appropriate annual increments may not be enough to guarantee worker satisfaction [Pearson 1990]. Continuing education is needed to enable staff to aspire to their fullest potentials and increase efficiency and satisfaction [Pearson, 1990; Rush, 1983; Werner and Bover, 1983; WHO 1980].

FORMS OF CONTINUING EDUCATION

AMREF [1983] identified the following strategies for providing continuing education:

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

facilities.

Staff Meetings

Regular staff meetings are among the important tools of management [McMahon, Barton, and Plot, 1980] and may be held to discuss common problems, review progress and plan future work [AMREP, 1983]. Handled well, meetings can produce great benefits, but run badly, they can lead to frustration, acrimony and poor performance [AMREP, 1983]. Badly run meetings usually result when a team leader thinks little about them before hand. Thus Amonoo-Lartson, et al [1984] recommend using the five 'Ps' for conducting a good meeting -

- Planning is required to think through the purpose of the meeting, and knowing in advance what is expected to be achieved.
- Pre-notification aims at informing members well in advance about the time and agenda of the meeting.
- Preparation attends to proper sequencing and time allocation of agenda items.
- Processing is needed to deal with the structure and flow of discussion during the meeting so that members are kept to the point, old ground is not recovered, private side conversations are curbed, disagreements are reconciled and all members are encouraged to

participate.

- 1. Putting the meeting on record is the final process and thus summarizes important decisions reached and actions taken.

AMREP [1983] suggested that regular staff meetings can be held, perhaps weekly, to discuss a particular topic. For example the management aspects of diarrhoeal diseases can be discussed that involves all staff as follows: the environmental health officer could speak about sanitation problems that contribute to the incidence of disease, the clinical officer could explain the signs and symptoms of dehydration and indicate appropriate action, while the community nurse could explain the various components of oral rehydration therapy. With this approach, health workers can learn from each other during staff meetings.

Training Programmes

Many authors agree that courses and training programmes comprise an effective strategy in the continuing education of workers [AMREP, 1983; Walnwright, Taumocpsau, and Pollaki, 1986; Nadaspatra, Ramadasamurthy, Ramnath, and Mohanran, 1988; Rahim, Kaiser, Ghorashi, and Dower, 1988]. AMREP [1983] further stated the important decisions that should be made for a well organised and effective refresher programme, including who needs refresher courses, where to hold them, what teaching methods should be used,

what teaching materials will be needed, and who the teachers will be. In addition, evaluation of all refresher courses should take place before, during and after the work to describe, judge and improve on what has been done. More will be presented on this form of CE in a subsequent section.

Supervisory Visits

The potential for exchange of ideas during supervisory visits means that these "provide excellent opportunities for in-service training" (McMahon, et al, 1980). A regular schedule of supervision should be established, be it once a month, once in two months or quarterly (AMREP, 1983).

A supervisor is a representative of an organization's management with the delegated responsibility to mobilize human resources to accomplish the organization's task or goal (Ritchie, 1974). Therefore, supervisory visits often have administrative purposes, such as taking inventory, appraising performance against standards, checking progress in relation to goals, solving problems and resolving conflicts (McMahon, et al, 1980). These visits can also be educational, since the supervisor "is responsible for training and advising" his subordinates (Blau and Scott, 1963).

Examples of the educational use of supervisory visits are many. Case conferences can be planned during the visit (AMREP,

1983]. Supervisory check-lists are a recommended management tool [McMahon, et al, 1980], but these can also be used for educational purposes if items are explained to staff, and copies of the list are left behind for study (AMREP, 1983). AMREP [1983] also suggests that supervisory visits can be more educational if supervisors send in advance reading materials about new policies and techniques, for discussion when they arrive. Also, if the supervisors actually spend some time working alongside the health workers, they can learn through shared experiences. These educational opportunities will occur only if the supervisor plans each visit with a definite purpose and stays long enough to fulfill that purpose [McMahon, et al 1980].

Various styles of supervision have been described. McMahon, et al [1980] mention three, autocratic, anarchic and democratic, while Blau and Scott [1963] contrast the supervisory strategies of dominance versus leadership. An autocratic supervisor gives subordinates no choice and no influence in programme decisions. He simply says, "Do what I say." Initiative is denied, and workers are often made to feel humiliated and insecure. The anarchic supervisor leaves complete freedom of choice to the workers and lets them do what they like without much direction. The democratic supervisor takes a consultative role. He works together with staff to achieve objectives. There is an emphasis

on consensus when he says, "Let us agree on what we are to do."

The democratic supervisor helps people grow, take initiative and thereby become responsible workers.

Similar to the autocratic leader, is the supervisor who demonstrates dominance and seeks to extend his control over all workers, often beyond the authority vested in his position to command workers. He frequently resorts to formal sanctions and threats. In contrast the supervisor who practices leadership provides services and advice to his subordinates in such a way that they feel a natural obligation and respect for him. He facilitates their work by making sure that they have the supplies, resources and skills needed to get the job done. From the above, one can see that a democratic supervisor who displays leadership is the type of person most capable of using supervisory visits to their best educational advantage.

Self-Study

Self-study probably is and will remain one of the most important ways that people acquire information [AUREP, 1983]. In rural areas, however, getting books, periodicals and journals can be very difficult. Health workers in remote areas often do not even know what books are available, or where to get them, nor in many instances, cannot afford to buy them. One way that a district team can improve this situation is to establish a

centrally located district health library and organize a mechanism for circulating the books to health workers throughout the district [AMREF, 1983]. Weitzel [1988] warned that no developing country can afford a system that denies a whole segment of the health community (e.g. rural workers) access to the literature. He notes that even where library facilities are available, they are often ignored, but usually librarians are scarce and underutilized because they are based in institutions and limited in use to research personnel and post-graduate students.

IN-SERVICE TRAINING

In-service training (IST) as a form of CE is being reviewed separately because in scope, it takes more money, effort, time and other resources to organize and is perhaps the most quantifiable form of CE [American Society for Training and Development (ASTD), 1976]. Craig [1976], while tracing the history of training, indicated that once man invented tools, weapons, clothing, shelter and language the need for training became an essential ingredient in the march of civilization. What is significant is that man had the ability to pass on to others the knowledge and skills gained in mastering his circumstances. This was done by deliberate example, by signs and by words. Through these devices the development process called training was administered.

It is generally assumed that man began amassing knowledge at

the beginning of the stone age, and the date 1750 has been selected as signalling the close of man's first period of knowledge accumulation. Thereafter...

Technical and mechanical inquisitiveness took a tremendous spurt ... resulting in the doubling of human knowledge in only 150 years ... That in the next 50 years, by 1950, it doubled again. The single decade of the 50's witnessed the 'firing' of the technological rocket, and again our sum of knowledge doubled [Craig, 1976].

The negative side of these advances is the "fallout" of information that is no longer valid or pertinent. The rapidity of change has become a dramatic challenge to training [Craig, 1976].

This rapid change in the knowledge base of workers can be addressed through in-service training, which should be a continued learning process aimed at increasing an employee's skills, knowledge and attitudes in relation to specific aspects of the role expectation [Tobin, et al, 1979]. In-service training takes place under two conditions [Pearson, 1990]. First those who have the skills should be willing to teach, sharing their knowledge with those under their supervision, and secondly staff at all levels should have the opportunity for advancement that training provides.

While highlighting the rationale for training, Amoo-

Larson, et al [1984] emphasized that rural health services largely depend on auxiliary health personnel, and as such skills in health care should be widely distributed among those who provide rural services. Training must be built into the normal activity of these district health workers and not be seen solely as something that takes place in training schools or "added on" to the work routine if there is time.

Training need both a present and future orientation [Larson, et al, 1984]. Staff need training to carry out their existing duties competently. They also need to learn how to achieve higher levels of competence in the future, either within their current work role, or by promotion or appointment to a job with greater responsibility. To achieve this there needs to be a training plan with every worker in mind. Several broad categories to plan for include -

- . New staff who need induction training to acquaint them with their responsibilities and local circumstances
- . Existing staff who are about to take up new responsibilities
- . Students, i.e. trainee health workers, attached to the district
- . Staff whose work is not up to standard
- . Current staff who could benefit from refresher courses

and updating

Training is neither a panacea for all organizational ills, nor a waste of time, but a balanced view is often hard to find among administrators who may have been enamoured by the potentials of training initially and have subsequently swung toward disillusionment [Lynton and Pareek, 1978]. This problem arises in part due to unrealistic expectations about what training can actually accomplish.

The issues that training can rightly address have as a common denominator a solution that "requires individuals to add to their apprehensive background specific, identifiable items of additional knowledge, skill or understanding [ASTD, 1976]. The particular benefits that can arise from training include increased productivity, improved quality of work, raised morale, development of new skills, knowledge, understanding and attitudes, correct use of new tools and processes, reduction of waste, accidents, turnover and absenteeism, implementation of new policies, work that meets standard performance levels, and finally continuity in leadership [ASTD, 1976]

The problems affecting training may also be compounded by the relatively higher cost of training compared to other CE strategies. These costs are not just monetary, but also arise because training ties up manpower, time, equipment and supplies

and disrupts production or service delivery [ASTD, 1976].

This problem manifests in a number of ways [Lynton and Pareek, 1978]. Managers may become reluctant to send the best qualified personnel for training. Inadequate use may be made of the staff on return from training. Yet training continues to be in fashion. No self-respecting country, no matter how poverty stricken, does without training. Lynton and Pareek [1978] estimated that India spent nearly US\$ 6 billion annually in the early 1970's on training. Slightly over half of the amount spent in the U.S.A.

The acceptability of training interventions can rise above the problems if it can be justified on the following grounds [ASTD, 1976]:

- When there is no better way to solve the operational problems confronting the organization.
- When other interventions have been considered and found less effective.
- When training is performance oriented.
- When new behaviour will be used on the job.
- When the job environment will permit the use of the new behaviours.
- When trainees can profit from the instruction.
- When trainees are in a state of readiness and each

sees a personal advantage in completing the programme.

Phases of Training

Three phases of the training process have been identified, namely pre-training, training and post-training (Lynton and Pareek, 1978). During pre-training the need for training is perceived and investigated. The employee, the supervisor, the management and even the clients may perceive a need for change in worker behaviour. Research is employed to answer such questions as what is going on in the environment and how it will affect the organization (ASTD, 1976).

Baseline data collection on training needs may begin with community diagnosis that outlines service priorities that in turn lay the foundation for job descriptions (Abbatt, 1980). Existing job descriptions and tasks should also be studied and compared to worker performance (Abbatt, 1980). The potential learners or trainees themselves should be actively involved in the data gathering and subsequent planning processes (Nicholls and Nicholls, 1978; Harrison and Hopkins, 1967). Based on the information obtained on training needs, the trainers clarify the precise objectives of the training programme, bearing in mind the use the organization expects to make of the participants afterwards (Lynton and Pareek, 1978).

Another pre-training activity is the selection of suitable

participants [Lynton and Pareek, 1978]. Suitability is partly a matter of convenience for both the individual and the organization, as well as an issue of appropriateness of the individual. Ideally popularity and reward for past performance should not be major considerations. The decision should be a joint matter between both the supervisor and the potential trainee.

Prior to embarking on training, the selected candidate should be motivated by the assurance that the organization regards the training as worthwhile and that steps are underway to utilize the trainee's new competence when he returns [Lynton and Pareek, 1978].

The training phase occurs when plans are transformed into reality [Oshiname, 1989]. A concrete lesson plan is needed which specifies objectives, content, methods, facilities, materials and evaluation criteria. Macdonald and Hearle [1984] suggest that each training session should include the following:

- Introduction/overview of tasks, skills and topics to be covered
- a probe into previous lessons
- elicitation of trainees' relevant experiences
- core elements of subject matter and relevant methods
- specification and organization of training activities

- discussion on issues arising from the session
- summary of the main points
- brief outline of the session to come

Training as an adult learning experience requires that trainees be encouraged to learn from each other. This happens when attention is paid to the learning atmosphere and effort is made to foster the development of a social system among the trainees. A favourable social climate ensures active participation by all in the learning process [Oshiname, 1989]. Other elements of this learning climate include appropriate rewards or reinforcement, efforts to make the trainees feel that they are cared for, and flexibility that allows for attention to individual needs [McMahon, et al, 1980; Abbatt, 1980].

The delivery of training content is enhanced in several ways. Training should proceed from simple skills, building to more complex ones. Judicious use must be made of relevant examples. Adherence to the time scheduled is essential [MacDonald and Hearle, 1984]. Repetition of salient points throughout the session should be combined with a review at the beginning of the next session aids retention [Oshiname, 1989].

The post-training phase begins when the formal IST ends. The participants go back to work and family. They should be prepared to anticipate the nature of encounters back home, because

people will hold certain expectations of the returned trainee. Also if the training has been of fairly long duration, the situation at home may have changed [Lynton and Pareek, 1978].

Ideally the organization and co-workers should help the trainee adjust back into the workplace and encourage him/her to apply the newly learned skills and knowledge. It may often be the case that the people left behind resent the trainee for the "holiday" he has taken, leaving them with the extra burden of work. Because of these potential problems, Lynton and Pareek [1978] recommend that the training institution maintain contact with the trainee, not only to facilitate re-entry, but to evaluate performance as feedback for future training.

PRACTICAL APPLICATIONS OF TRAINING IN PHC

CE of all health staff has been identified as the needed tool to reinforce knowledge, skills and attitudes of workers, as well as introduce new skills, methods and knowledge to these same staff. It therefore means that even the best trained and most skilled health worker needs to retool, not once or twice, but regularly in a continuing process throughout his/her period of service [Thompson, 1974]. Because of the importance of CE to PHC implementation as described in Chapter One, several examples of the application of this process in the PHC setting are presented. PHC requires not only training in new methods, but also

reorientation toward the cultural aspects of health care, if the goal of full community participation is to be achieved, as evidenced in a study from rural Columbia. Health workers there were found to have quite different and often conflicting beliefs from their clients. This affected service acceptance and compliance [MacDonald, 1986-7]. At the heart of the problem was the biomedical orientation received during basic training. Therefore training recommended to integrate medical and cultural issues as a way of strengthening primary care services.

In China large scale training of public health workers in the country side resulted in upgrading of 1.2 million staff to the level of assistant doctors as a means of improving the quality of health care in rural areas [Yinyu, 1989]. Even existing medical staff need in-service training, as was found in rural India where a survey of medical officers in charge of primary health centres were found deficient in basic skills, including nutrition [Mohapatra, et al, 1988]. In Sri Lanka, the morale of middle level dispensary workers was boosted following their involvement in developing training [Weerakoon and Jiffry, 1989].

PHC implementation relies heavily on recruitment, training and utilization of village health workers, but these community based volunteers can not be expected to work in isolation. They need adequate supervision and links with the health system

[Brieger, Ramakrishna, Akpovi and Adeniyi, 1987-8]. Unfortunately more attention is often paid to training the volunteers than their supervisors, as was the case in a community based health care project in rural Mexico [Shedlin, Wray and Correu, 1985-6]. The training of nurses or auxiliary nurses as supervisors at the sub-district level was sometimes haphazard, without adequate number of qualified trainers or clearly presented content. The trainees themselves complained that they felt inadequately prepared to pass on information and technical advice to the village health workers. In-service training during monthly meetings of supervisors was needed to solve the problem.

Rahim, et al [1988] followed up doctors trained on programmes in primary health care and hospital management in Sudan, and reported that 60-80% of the participants were using the newly learned management practices. They further noted that supervision helped to motivate the staff to continue with their new undertakings.

Training can boost the effective implementation of specific PHC programmes, as was done with immunization activities in Mozambique [Cutts, Kortbeek, Malalane, Penicelle and Gingell, 1988]. Annual seminars at the provincial level were held for district and community level staff. The topics changed each year according to the current phase of the immunization programme.

This phased approach to training was found to be particularly appropriate when new concepts and methods are being introduced.

Illiteracy is not a hinderance to continuing education. A participatory approach was used successfully to train illiterate midwives in Sudan on maternal and child health issues [El Tom, Mubarak, Wesley, Mathews and Lanro, 1984]. Improvements were facilitated by concentrating the training of a relatively small set of skills.

Continuing education capacity for district level health workers is being institutionalized in some Nigerian states [Centers for Disease Control, 1990]. Continuing Education Units in the Niger and Plateau State Ministries of Health have conducted baseline facility needs assessments and conducted basic training for local government health staff on child survival programme skills (diarrhoeal diseases control, immunization, malaria control). Follow-up supervision and evaluation have been used to reinforce learning and provide information for re-training.

CONCLUSION

The concept of continuing education has been reviewed and found to be defined as an important part of the staff development process and a source of motivation for health workers. CE was found to take many forms including the traditional notion of in-service training as well as self-study. The education and

training potentials of supervisory visits and staff meetings were explored. In particular, IST was found to be an important part of development throughout history. To be effective, IST needs proper planning through the preparatory, implementation and follow-up phases. Finally, CE was shown to have a positive effect on the implementation of primary health care in many countries by upgrading skills in, improving supervision and by increasing the cultural sensitivity of existing health staff.

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CHAPTER THREE

METHODOLOGY

Description of the design, scope and objectives of study begin this chapter. Dependent and independent variables are defined to give rise to hypotheses. The distribution of health workers in formal health services among both LGAs and the different practice sectors is presented as a basis for a full population study. Development and administration of the instrument, with pretesting in a nearby LGA is described. Procedures of data analysis and issues of validity and reliability conclude the chapter.

DESIGN AND SCOPE

This study is an exploratory descriptive survey that identified the previous continuing education (CE) experiences of the health staff in Ifelolu and Ibarapa Local Government Areas (LGA) as well as their interests in further learning. It can also be seen as a case study of the CE situation in the two localities which serve as model PHC LGAs in the Federal Primary Health Care Scheme [Oluwalde, 1990].

Continuing education is broad in scope. The researcher

however chose four basic forms of CE for study and documented the involvement of the health staff in these activities, namely -

- 1) Attendance at courses or in-service training programmes during the five years prior to interview,
- 2) Supervision by a senior colleague within the past one month,
- 3) Monthly attendance at staff meeting, and
- 4) Self-study involving reading of professional texts, journals and magazines in the past six months.

The choice of the respective periods of time for the various forms of CE was guided by review of literature, which emphasizes that CE should be a continuous, regular and routine part of district health team activity, organized throughout a health worker's career, and not just consisting of a few sporadic courses [AMREP, 1983].

The study focused on all health staff who practised in the two LGAs, be they in the private, local government, state government or university sector, all four of which deliver health services in the area. Not included were private chemists and patent medicine sellers and voluntary health workers, but only staff in the formal health services.

JUSTIFICATION FOR THE STUDY

Professional isolation has been identified as the major risk

factor for the development of 'continuing ignorance.' i.e. the gradual loss of knowledge and/or skill by workers who have not engaged themselves in refresher programmes to keep form with trends in their profession [AMREP, 1983]. The researcher believes that the health workers in the two LGAs are prone to this condition by virtue of their distance from major urban centres.

There is an inherent tendency for policy makers to neglect the rural communities and as such not involve as many health staff from such communities in CE programmes. Thus it is particularly important to study the CE experiences and opportunities of rural health workers such as those in Ifelolu and Ibarapa LGAs.

Also while it is not necessary for one to attend school for life, individuals who stop learning soon become stagnant, hence the purpose of adult learning is to survive today's work world by pursuing the ever changing quest to up-date professional knowledge [Tobin, et al, 1979]. This goal is achieved not only through the efforts of health policy makers and administrators, but also through the motivation and action of the individual health worker to improve him or herself. Therefore it is equally necessary to learn whether health workers attempt to keep themselves current and whether they are interested in CE.

Finally, the study provides a baseline upon which health policy makers can establish their future plans for effective

implementation of primary health care.

OBJECTIVES

The broad objective of the study was to determine the continuing education experiences and interests of formal health staff in Ifelolu and Ibarapa LGAs. The following specific objectives guided the research:

1. To identify the socio-demographic and professional characteristics of the health staff in the two LGAs.
2. To document the CE activities carried out by these staff,
3. To determine factors associated with participation in CE, including professional qualification, sector of practice and location or place of practice, and
4. To recommend appropriate CE activities and policies based on the findings.

STUDY VARIABLES AND HYPOTHESES

As noted above there are four major CE activities that are the focus of this study and therefore the dependent variables under investigation. In order to facilitate meaningful and measurable analysis, a time limit was placed on the various continuing education experiences. Since CE should be continuous throughout a health worker's career (AFREP 1983), one would expect that a health worker should have attended a refresher or in-service course within the past five years. Also monthly

supervisory visits are seen as the ideal, although exact schedules depend of local issues such as availability of transport and personnel [McMahon, et al, 1980]. Given the fairly good road network linking existing health facilities in Ifeioju and Ibarapa LGAs, plus the adequate staff strength, the ideal of a monthly supervisory visit could be expected. With regard to attendance at staff meetings, although AMREF [1983] noted that these should be regular, perhaps even weekly, a minimum of monthly attendance was deemed reasonable. While AMREF [1983] has also recommended that health workers visit district libraries at least once a quarter, the lack of such facility, except at the University's Ibarapa Programme campus in Igbo-Ora, pointed to the time frame of six months in requesting information about self-study.

Two categories of independent variables were studied, the personal demographic and professional characteristics of the health staff and the organizational environment. The former included sex, age and professional position and qualification of the individual respondent. The latter encompassed work sector (e.g. private or government) and location of practice (inside or beyond the LGA headquarters of Igbo-Ora and Bruwa towns).

From these variables, the following null hypotheses were formulated:

1. Sex of health worker is not related to undertaking of

CE activities.

2. Age of respondent is not associated with involvement in CE activities.
3. Qualification of the health worker is not related to participation in CE activities.
4. Position held by the respondent is not associated to his/her involvement in CE activities.
5. Sector of practice (LGA, state government, university or private) is not associated with participation of health workers in CE activities.
6. Place of practice of individual workers is not associated with CE opportunities and activities.

STUDY POPULATION

The study population consisted of all available health staff in the four sectors of practice, LGA, state government, university and private. They included doctors, staff nurses, public health nurses, midwives, dispensers and laboratory and other technicians. Others were medical records officers, environmental health officers (health inspectors), community health officers, community health extension workers and various auxiliary staff.

Based on information obtained from the officers in charge of the various facilities and services, the researcher documented a potential study population of 165 health staff in November, 1991.

A total population study was attempted. Table 1 shows the distribution of these health workers in the two LGAs according to sector.

DATA COLLECTION PROCEDURES

Instrument Design and Content

A questionnaire was used to obtain information from the health staff. It consisted of three sections. Section A contained questions on socio-demographic and professional variables as described above. Section B included questions about CE experiences, that is, the actual engagement in or involvement with the four major forms of CE studied. Section C comprised questions that determined respondents' interests in future CE activities, including whether they would like to participate in courses, what subjects they would like covered and reasons for these. Their opinions about the value of CE were also sought.

Protecting the Instrument

The questionnaire was drafted and first pretested among health workers at Oai-Adio in Ido LGA on 12th and 13th November, 1991. Oai-Adio is another rural community similar to those found in the study area and is located just east of Ibarapa LGA. Based on review of responses and the solicited opinions of those who answered the questions, some revisions were made in the instrument. A copy of the questionnaire is found in Appendix A.

TABLE 1

Distribution of Health Staff in Ifeloju and Ibarapa LGAsAccording to Sector of Employment

Sector	Local Government Area		Total (%)
	Ifeloju (%)	Ibarapa (%)	
LGA	32 (34.0)	23 (32.4)	55 (33.3)
State Ministry	29 (30.9)	11 (15.5)	40 (24.2)
University of Ibadan	20 (21.3)	18 (25.4)	38 (23.1)
Private	13 (13.8)	19 (26.7)	32 (19.4)
Total	94	71	165

Administration of the Structured Interview

The interviews were conducted between 24th November, 1991, and 11th January, 1992. First, permission was obtained from the respondents' supervisors, e.g. the LGA PHC Coordinators, heads of units, and directors of different clinics, who themselves were also interviewed (see Appendix B). Nearly all were interviewed at their duty posts, although a few were traced to their homes. In a few cases the interview was interrupted by demands of work, e.g. when a patient in the last stage of labour was rushed into a maternity centre, and delayed until a more convenient time. Effort was made to gain privacy for the interview and to put the respondent at ease. Several work sites had to be visited up to four times before the intended respondent was found and/or an interview was granted. There were no outright refusals, but two staff continued to defer the interview until it was clear that they would not participate.

The researcher conducted each interview himself. Each session began with an informal opening designed to relax the respondent. Confidentiality and anonymity were guaranteed. The interviews also closed on a friendly and thankful note. The researcher also made it clear to respondents that he himself was not in a position to promise in-service training, but that he would share the collective findings with the appropriate

authorities.

DATA ANALYSIS

Both manual and computer analysis were utilized. All questionnaire responses were hand coded by the researcher. The EPI INFO computer software programme, developed by the U.S. Centres for Disease Control, was used to generate frequency data, simple graphs and conduct statistical tests of association. Hypotheses were tested using both the chi-squared and ANOVA statistical tests. The 5% probability level was used for rejecting the null hypothesis.

RELIABILITY

To ensure that the data collected were reliable and valid, several steps were taken [Davitz and Davitz, 1977]. First the questionnaire was designed in simple English to facilitate easy understanding. The pretesting process, in a similar setting, was aimed at enhancing reliability of the final version. Inter-observer reliability problems were eliminated because the researcher administered all interviews personally.

VALIDITY

Concurrent validity was maintained by interviewing heads of units and services and reading available documentation about PHC activities in the two local governments [Oluide, 1990] to learn about the previous general in-service and continuing education

opportunities and activities available to staff. This could be compared to overall questionnaire responses to see if these were realistic.

Content and construct validity were ensured through review of relevant literature and review by persons experienced in in-service training and continuing education, such as the researcher's supervisor. Thus the chosen study variables and indicators, and the questions arising from them were seen to be valid representations of the study objectives.

LIMITATIONS

No study is without limitations. Although a total population study was intended, not all could be traced, particularly due to authorized leave and absences. As shown in the next chapter, the few who could not be contacted are not different from the main study group.

Another possible limitation may relate to the fact that four of several forms of CE were selected for study. Such CE approaches as mass media and correspondence courses were not included. On the other hand, those aspects studied were clearly within the control of the agencies and individuals concerned, and thus amenable to change depending on study findings. Although the researcher was generally able to ascertain the CE opportunities available to staff (see concurrent validity above), he could not

match each individual's response with actual participation because of guarantees of anonymity given to respondents.

Recall problems may have affected the validity of responses on in-service courses taken due to the five-year time span, but this could be overcome in part by checking the reported topic of courses attended and the recent priorities of PHC training held in the country. The final concern is external validity or generalizability. The two LGAs studied were both part of the initial Federal model PHC scheme. This may have had more influence on CE opportunities of LGA and University staff (who were partners on developing the models), but since the current Federal Health policy [FMOH, 1989] stressed major PHC responsibilities for all LGAs, the opportunities of Ifelaju and Ibarapa LGA health staff for CE may not have been much greater than that in other LGAs, and certainly one would not expect differences for state and private health sector workers.

CHAPTER FOUR

RESULTS

This chapter begins by reporting the socio-demographic and professional characteristics of the respondents. This is followed by presentation of respondents' continuing education experiences. Factors that may be associated with participation in continuing education are analyzed in this context. Finally respondents' interests in future CE activities are outlined.

CHARACTERISTICS OF RESPONDENTS

The researcher was able to locate and interview 144 (87.3%) of the expected 165 health staff working in the formal government and private health services within the two LGAs. Table 2 shows that 90.4% of 94 health workers in Ifelolu LGA were found, while 83.1% of the 71 workers in Ibarapa were interviewed.

Slightly over half of respondents were females (52.8%), and most were married (79.2%). Their ages ranged from 20 to 59 years, with a mean of 36.0 years. A large number practiced orthodox Christian religion such as Anglican, Baptist, Methodist and Presbyterian denominations (45.8%), while 25.0% attended the evangelical and syncretic Christian churches. The remaining 29.2%

TABLE 2

Proportion of Staff Interviewed in Each LGA

Number of Staff	Local Government Area		Total
	Ifelolu	Iharapa	
Expected	94	71	165
Interviewed	85	59	144
% Interviewed	90.4	83.1	87.3

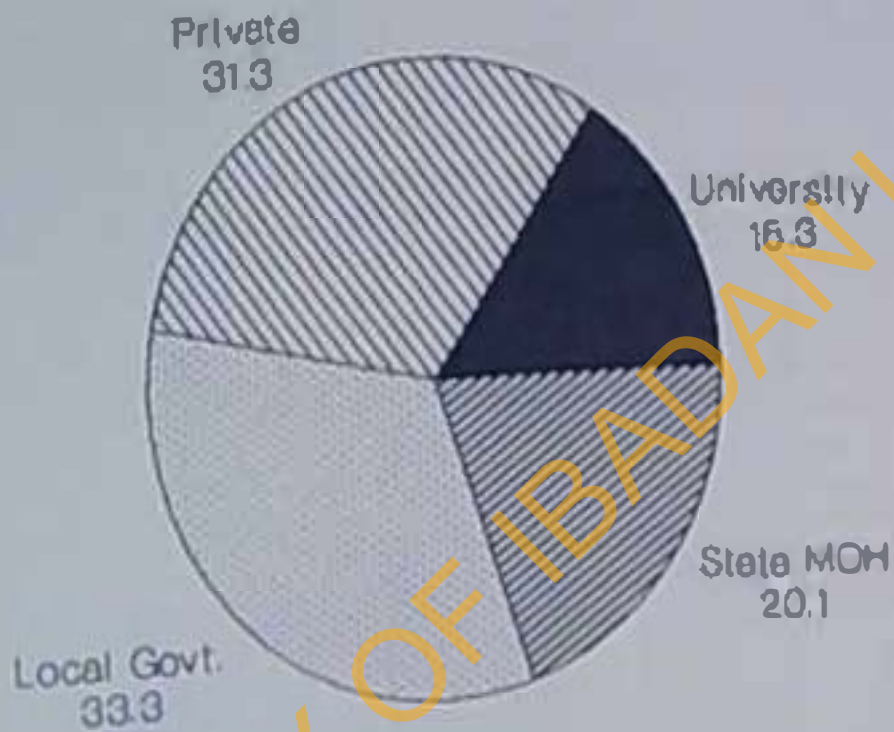
of staff were Muslims.

Figure 1 shows the distribution of the respondents among the four main sectors of health care practice. The largest group (33.3%) were found in the local government service, followed by 31.3% who worked in the private sector. State government employees accounted for 20.1%, while 15.3% worked for the University of Ibadan's Ibarapa Community Health Programme. Most (83.3%) were located in the two local government headquarters, Igbo-Ora and Eruwa.

Basic educational qualification varied within the study group. A slight majority (54.2%) had completed secondary school. Those trained at teacher training colleges accounted for 9.0%. Some had completed modern school or a few years of secondary school (18.8%). Only one respondent had no formal education, while 17.4% had completed primary school (see Figure 2).

Professional qualifications were quite varied, but 31.3% had none at all. The largest single category among those 99 with professional training were general nurses (34.3%). Other professional qualifications included environmental health (12.1%), medicine (10.1%), midwifery, pharmacy technicians and auxiliary nursing (at 8.1% each), and community health certificates (7.1%). The remainder underwent technical courses such as radiography, physiotherapy, laboratory technology and medical records as seen

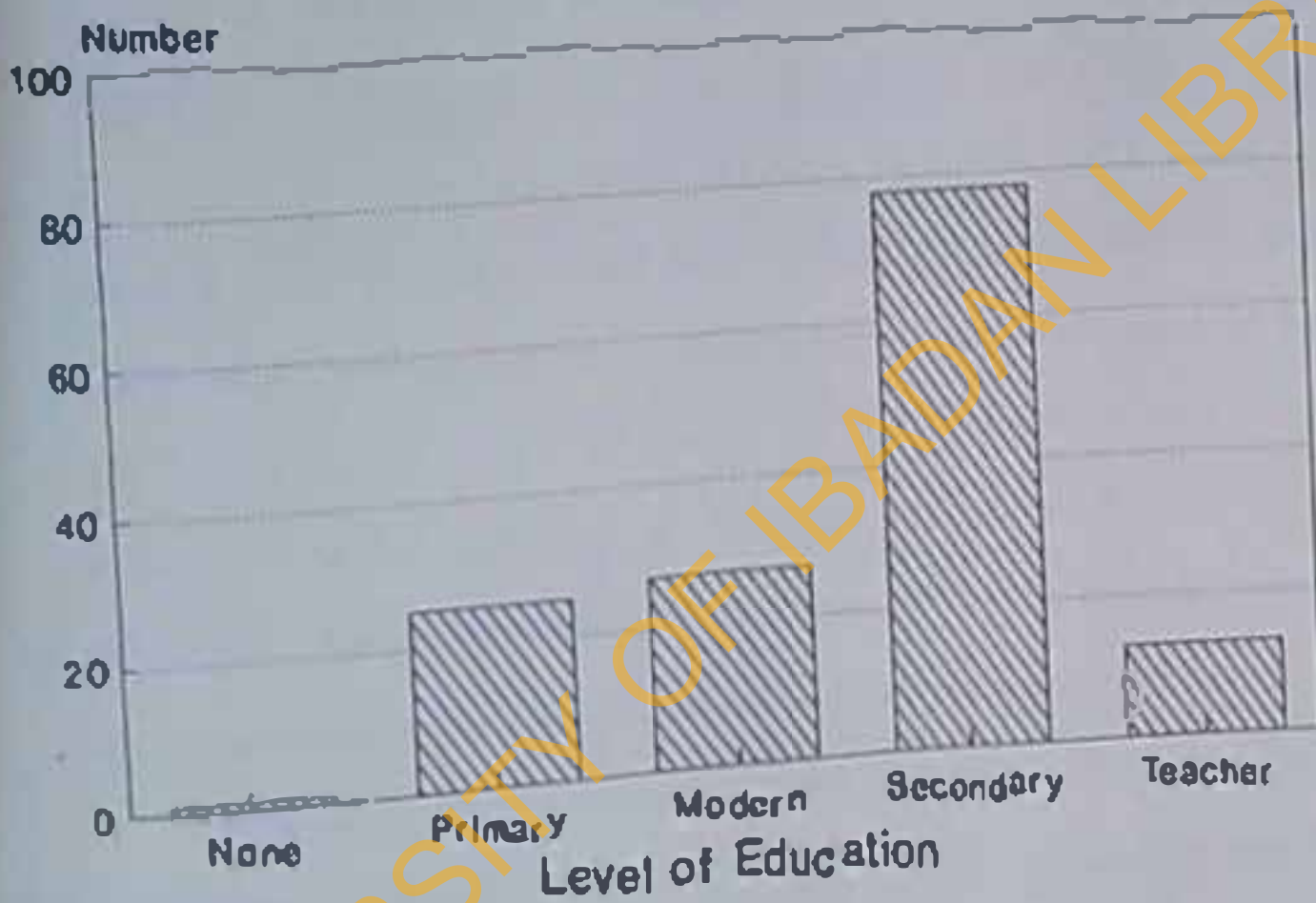
Health Staff by Sector



N = 144

FIGURE 1: DISTRIBUTION OF HEALTH STAFF BY SECTOR OF PRACTICE

Basic Educational Qualifications



N = 144

FIGURE 2: BASIC EDUCATIONAL QUALIFICATIONS OF HEALTH STAFF

in Table 3.

Those trained as auxiliary nurses worked exclusively in the private clinics and were trained on the job. The various community health certificate holders included Community Health Officers and the two former cadres of Community Health Aides and Assistants, now known as Community Health Extension Workers (CHEW).

Most of those with qualifications received their first diploma or certificate recently with 30.3% between 1982-86, and again 30.0% between 1987-91. Nine percent qualified over 25 years ago (see Figure 3). Out of these, 24.2% had received an additional qualification (e.g. Advanced Diploma in Health Education, Community Health Officers Certificate, general nursing for midwives and conversely, midwifery for nurses).

With regard to promotion or advancement, only 51.4% reported receiving a promotion since their appointment. These 74 workers had received on average 1.7 promotions, with two staff having been promoted up to four times.

CONTINUING EDUCATION EXPERIENCES

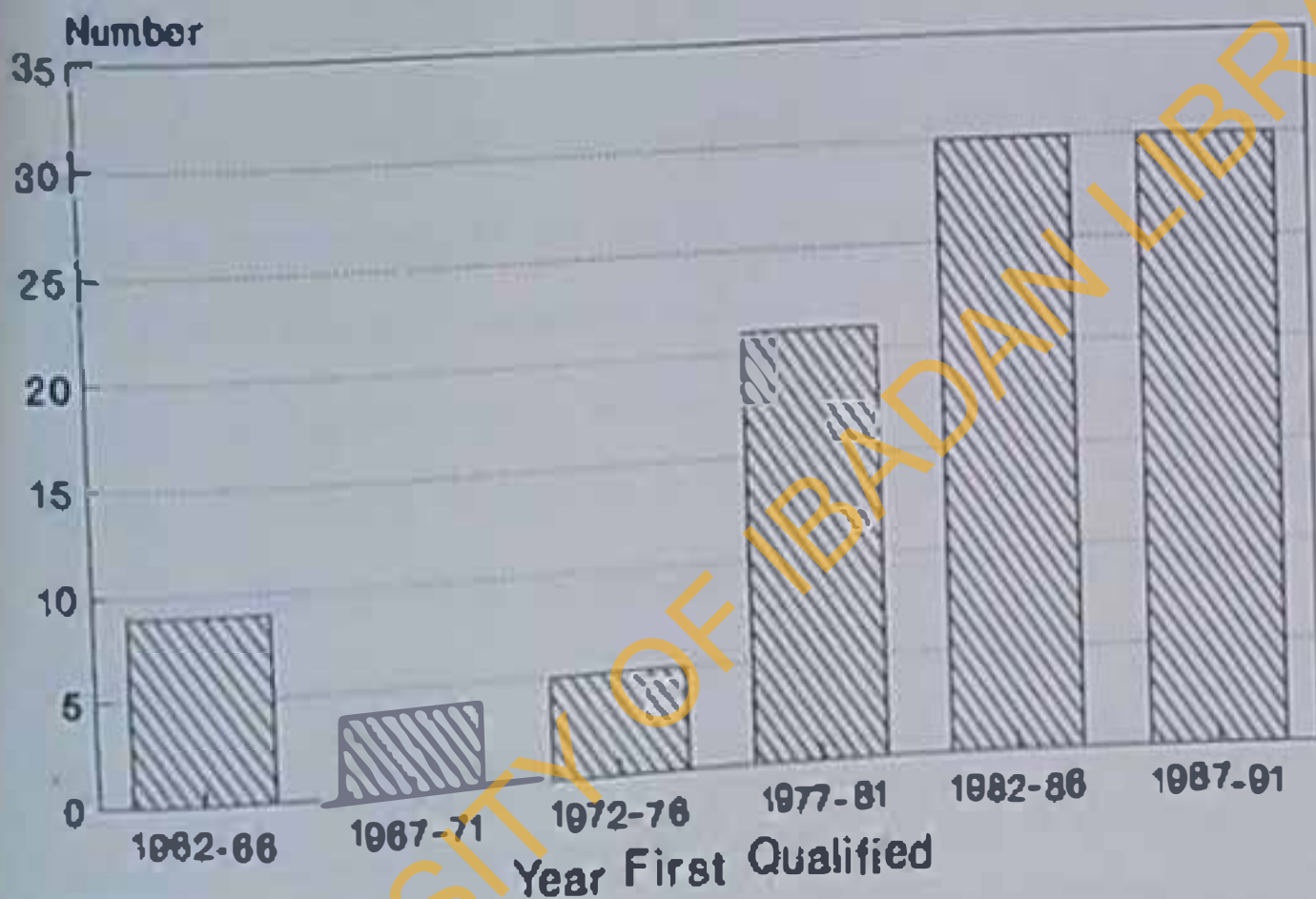
As noted in the previous chapter, this study examined four forms of CE, in-service training, supervision, staff meetings and self-study through reading of professional books. Level of participation in these activities is presented next.

TABLE 3

Professional Qualifications of Health Staff

Qualification	Frequency	Percent
Nursing	34	34.3
Environmental Health	12	12.1
Medicine	10	10.1
Midwifery	8	8.1
Pharmacy Technology	8	8.1
Auxiliary Nursing	8	8.1
Community Health Diplomas	7	7.1
Laboratory Technology	5	5.1
Medical Records	4	4.0
Radiography	2	2.0
Physiotherapy	1	1.0
TOTAL QUALIFIED	99	100.0

Date of Professional Qualification



N = 99

FIGURE 3: DATES OF FIRST PROFESSIONAL QUALIFICATION

In-service Training

Over one-third (38.9%) of workers had attended any course or workshop since they were employed, but more importantly, only 31.9% had attended a course in the past five years. In all, 76 in-service training (IST) courses had been attended by 46 respondents in the previous five years.

Most (72.3%) were short workshops and seminars related to specific topics such as the expanded programme on immunization, training trainers of volunteer village health workers, family planning and other primary health care issues. These were normally concluded in days or at most a few weeks. The other form of in-service training was professional courses. For example midwives underwent a general nursing training, nurses undertook the Community Health Officers course, and various workers attended advanced diploma programmes (for example in health education).

A good number of the IST opportunities (39.5%) took place within the local government. Ibadan, the state capital, was site for 32.9%, while others took place outside the state. Sponsorship was provided by the employer in most cases, that is either by the LGA (43.4%), the state (28.3%) or the University (23.7%). The Federal Ministry and donor agencies like UNICEF were responsible for 3.6%. A few people sponsored themselves (7.9%) or were sponsored by a professional body (2.3%). Only one person could

not remember who sponsored his attendance at an IST.

Reasons for attending the in-service courses were many. The largest individual response was "to learn more" (44.7%). Others attended out of general interest (14.5%), in order to specialize or gain higher qualifications (11.8%), or to improve themselves (6.6%). A fair number attended simply because they were selected (22.4%).

Most (92%) IST activities yielded no reported outcome for the participant. Four were reassigned to other duties as a result of their training, one was promoted, and one who had gone on self-study was employed. Five of the six who experienced a positive outcome from IST had attended professional courses. The one who had attended a short course in family planning, was redeployed to her hospital's family planning service.

Participation in any in-service course in the past five years was compared with independent variables as hypothesized. Table 4 shows a significant association ($p < 0.0008$) between sector of practice and participation in an IST programme. Half of the employees of the University of Ibadan had participated in IST as did 45.8% of local government staff. In contrast 27.6% of state ministry staff had attended an IST, and only 11.1% of workers in the private sector.

There was also an association ($p < 0.001$) between

TABLE 4

Attendance at In-service Training Compared with
Sector of Practice

Attendance at IST	Sector (%)				Total
	Private	LGA	State	University	
YES	11.1	45.8	27.6	50.0	31.9
NO	88.9	54.2	72.4	50.0	68.1
NUMBER	45	48	29	22	144

$\chi^2 = 16.80, \text{ d.f.} = 3, p < 0.0008$

participation in IST and qualification of the respondents. Only 13.3 % of 45 without professional qualification had opportunity to attend IST, compared to 40.4% of the 99 qualified workers (see Table 5).

Similarly, Table 6 shows a significant relationship ($p < 0.00001$) between attending a course and advancement. While 52.4% of 74 who had ever received a promotion also attended IST in the past five years, only 11.4% of the rest had participated in IST opportunities.

No association was found between sex of worker and IST opportunity. Males (32.4% of 68) and females (31.6% of 76) were equally likely to have attended IST ($\chi^2_{table} = 0.01$, d.f. = 1, $p > 0.94$). There was a significant age difference among those receiving IST (38.3 years average) and those without the opportunity (34.9 mean years) as shown in Table 7.

Supervision Experiences

Over two-thirds (68.1%) of respondents reported receiving a supervisory visit or session in the past six months, and each of those reporting having received an average of 5.7 visits or sessions. A closer look found that exactly one-third of the workers had been supervised in the past month.

The question relevant to this study is whether such sessions were educational in nature. Respondents were first asked an open

TABLE 5

Qualification of Health Worker Compared to
Attendance at IST

Attendance at IST	Professional Qualification		Total
	YES (%)	NO (%)	
YES	40 (40.4)	6 (13.3)	46 (31.9)
NO	59 (59.6)	39 (86.7)	98 (68.1)
TOTAL	99	45	144

$\chi^2_{\text{Yates}} = 9.22$, d.f. = 1, $p < 0.001$

TABLE 6

Promotion Since Employment Compared to
Participation in IST

Attendance at IST	Promotion		Total (%)
	YES (%)	NO (%)	
YES	38 (57.4)	8 (11.4)	46 (31.9)
NO	36 (48.6)	62 (88.6)	98 (68.1)
Total	74	70	144

$\chi^2_{(1)} = 24.57, df = 1, p < 0.0000009$

TABLE 7

Age of Health Workers Compared to
Attendance at IST

Attended IST	Number	Total of Ages	Mean Age	Variance	Std Dev
NO	98	3418	34.878	79.737	8.930
YES	46	1764	38.348	88.321	9.398
Difference			-3.470		

Variation	SS	df	MS	F statistic	p-value
Between	377.007	1	377.007	4.572	0.032100
Within	11718.965	142	82.458		
Total	12095.972	143			

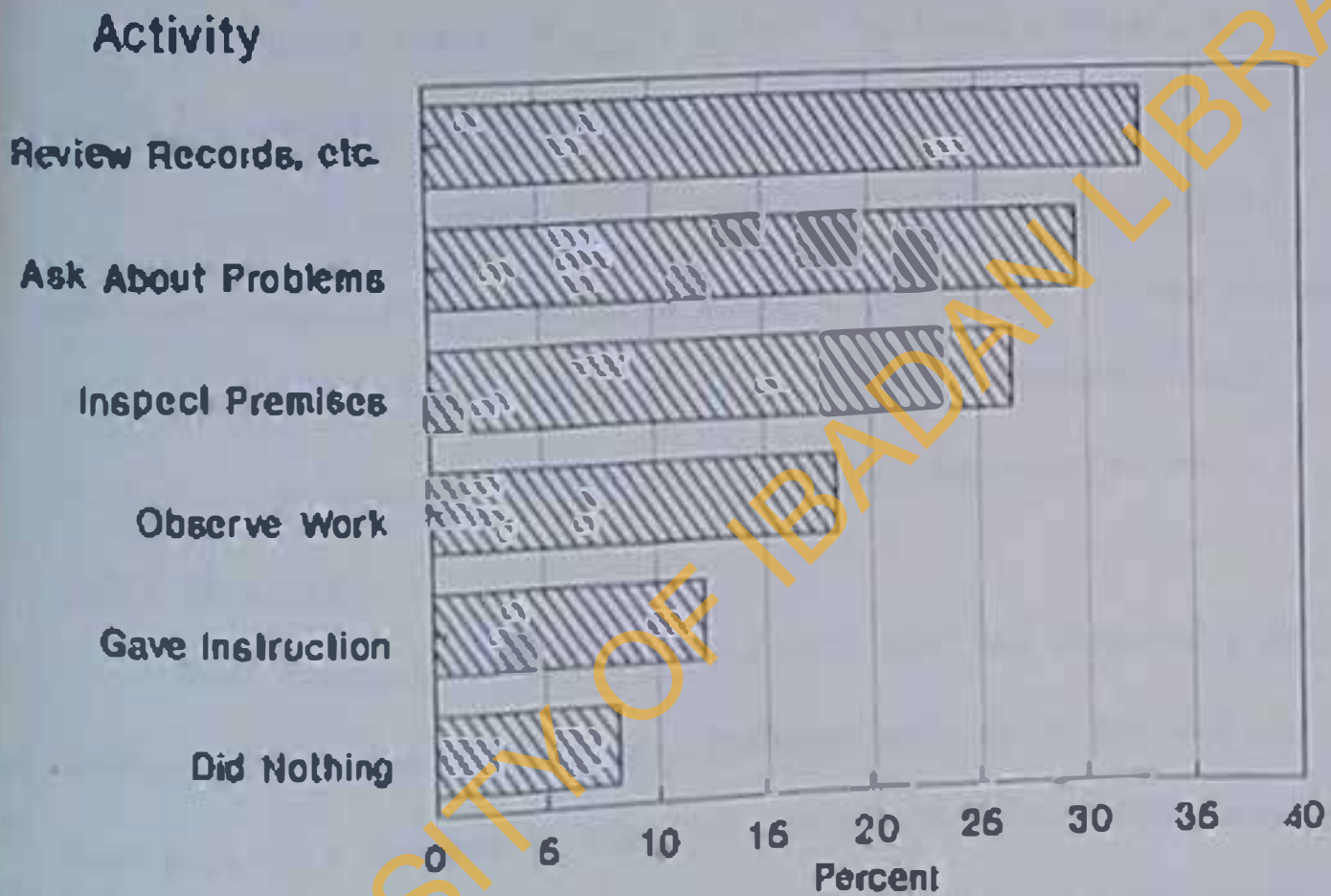
NOTE: F statistic is equivalent to Chi square) = 4.046
 Degrees of freedom = 1
 p value = 0.044787

ended question, what did the supervisors normally do when they visited? The most common activities reported by the 98 who had received supervisory visits in the past six months were inspection of records, equipment and supplies (32.6%) and asking whether workers had any problems (29.6%). Some mentioned that the supervisor simply conducted routine inspection of the premises (26.5%). Others (18.4%) said the supervisor observed their work. Supervisors were reported to have given specific instruction by 12.2%, for example explaining how to read haematocrit tests, while 8.2% noted that the supervisor did nothing at all or gave no answer (see Figure 4).

A more direct question was asked as to whether the supervisor did anything to update the worker's knowledge and skills. In response to this, 70.4% could not mention a specific effort on the part of their supervisor to update their skills. Of the 29 who commented, 21% said the supervisor advised or corrected them, 38% said he/she inspected their records, and 10% also mentioned routine inspection of the facility. Only 21% mentioned items of clear educational relevance, the teaching of a new skill and discussion of new developments and programmes.

Reports of monthly supervision were significantly associated with sector of practice ($p < 0.03$). Half of LGs staff had received supervision in the last month compared to 31.8% of state

Supervisors' Activities



N = 98

FIGURE 4: REPORTED ACTIVITIES CARRIED OUT BY SUPERVISORS

workers, 27.3% of University staff and 24.4% of those in the private clinics (see Table 8).

Location of practice was not associated with reported supervisory visits ($p > 0.24$). Visited were reported by 31% of the 120 working in the LGA headquarters, compared to 46% of the 24 working in other towns ($\chi^2_{Yates} = 1.41$). As noted earlier, no staff are working permanently in the remote hamlets.

Personal and professional characteristics of respondents were not compared with reported supervision because it was assumed that supervision is an issue of organizational management and should not be subject to individual worker characteristics.

Staff Meetings

Most respondents (72.2%) said that they had attended a staff meeting in the past six months, although only 54.9% claimed to have gone to a meeting in the past one month. Those (104) who had attended a meeting within six months stated various purposes for holding the gathering. Discussion of general progress at work was the most frequently mentioned item (73.1%). In some cases (12.5%) a specific activity (such as the immunization programme) topped the agenda. Staffing and management problems were reasons given by 7.7%, while 6.7% were not sure why the meeting was held.

When asked specifically what new idea or skill was passed on at the last staff meeting, most (67.3%) said "nothing new."

TABLE 8

Monthly Supervision Compared to Work Sector

Supervision Past Month	Private	Service Sector (%)		University	TOTAL
		LGA	State		
YES	24.4	50.0	31.8	27.3	33.3
NO	75.6	50.0	68.2	72.7	66.7
Total Number	15	48	29	22	144

$\chi^2 = 9.07$, d.f. = 3, $p < 0.03$

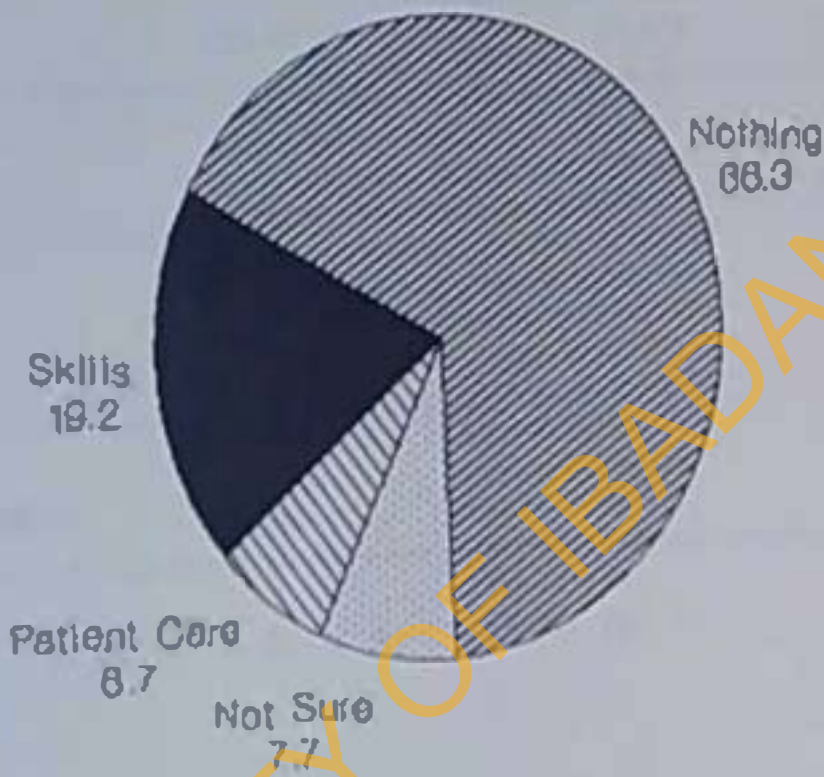
Nearly one-fifth (19.2%) could mention a specific skill learned including PHC house numbering, record keeping procedures, training of village health workers and improvisation with local materials. Another learning activity, discussing aspects of patient care, was listed by 6.7%. The remainder (6.8) could not remember or did not respond to the question (see Figure 5).

Workers in three sectors, private, LGA and University, reported nearly equal frequency of attendance at staff meetings (60%) compared to only 34.5% by state personnel (Table 9). This difference was not found to be statistically significant ($p > 0.10$). Neither was attendance associated with place of practice ($p > 0.23$), although only 41.7% of workers in the smaller towns reported attendance in the past six months, compared with 57.5% of those in the LG headquarters ($\chi^2_{total} = 1.44$).

Table 10 shows that although a higher proportion of men (61.8%) attended a staff meeting in the past month, compared with 48.7% of female staff, this difference was not significant ($p > 0.15$). Likewise, age is not seen to be associated with attendance ($p > 0.76$) in Table 11, with recent attenders averaging 36.2 years and non-attenders having a mean of 35.7 years.

In Table 12, the only factor found to be associated with attendance at meetings ($p < 0.02$), professional qualification, can be seen. Interestingly, those without qualification (71.1%) were

Items Learned at Staff Meeting



104 Attended Meeting In Past Six Months

FIGURE 5: ITEMS LEARNED AT RECENT STAFF MEETINGS

TABLE 9

Attendance at Staff Meeting in Past Six MonthsCompared to Sector of Practice

Attended Meeting	Private	Service Sector (%)			TOTAL
		LGA	State	University	
YES	60.0	60.4	34.5	59.1	54.9
NO	40.0	39.6	65.5	40.9	45.1
Total Number	45	48	29	22	144

$$\chi^2 = 6.10, \quad \text{d.f.} = 3, \quad p > 0.10$$

TABLE 10

Attendance at Staff Meeting in Past Six MonthsCompared to Sex of Health Worker

Attended Meeting	Sex		Total
	Male (%)	Female (%)	
YES	42 (61.8)	37 (48.7)	79
NO	26 (38.2)	39 (51.3)	65
TOTAL	68	76	144

$\chi^2_{\text{Yates}} = 1.98$, d.f. = 1, $p > 0.15$

TABLE 11

Attendance at Staff Meeting in Past Six Months
Compared to Age of Health Worker

Meeting Attended	Number	Total Ages	Mean Age	Variance	Std Dev
YES	79	2859	36.190	81.361	9.020
NO	65	2323	35.738	89.571	9.464
Difference			0.451		

Variation	SS	df	MS	F statistic	p-value
Between	7.266	1	7.266	0.085	0.767869
Within	12078.706	142	85.061		
Total	12085.972	143			

NOTE: Kruskal-Wallis H (equivalent to Chi square) = 0.231
 Degrees of freedom = 1
 p value = 0.631089

TABLE 12

Attendance at Staff Meeting in Past Six Months
Compared to Professional Qualification

Attendance at Meeting	<u>Professional Qualification</u>		Total
	YES (x)	NO (x)	
YES	47 (47.5)	32 (71.1)	79 (54.9)
NO	52 (52.5)	13 (28.9)	65 (45.1)
TOTAL	99	45	144

$$\chi^2_{\text{Yates}} = 6.06, \quad \text{d.f.} = 1, \quad p < 0.02$$

more likely to have attended a recent meeting than staff with professional qualifications (47.5%).

Self-Study Through Reading

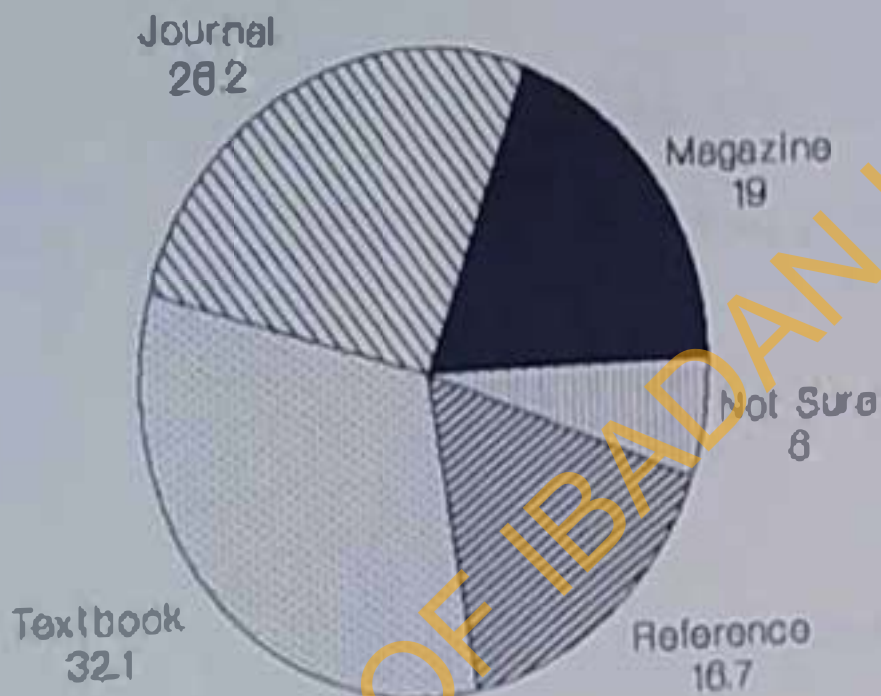
More than half (58.3%) of the health workers had practiced reading as self-study in the previous six months. Professional texts topped the list (32.1%) followed by professional journals (26.7%). Other items read included health articles in popular magazines (19.0%) and reference books (16.7%). A few of those who said they had been reading could not recall what they had read (6.0%), as seen in Figure 6.

Various reasons were given for reading. Many did it to keep abreast of recent trends (39.3%). Others read to gain more knowledge (26.2%). Some read to improve their practice (23.8%), while others saw reading as stimulating and interesting (8.3%). One worker each engaged in reading to prepare for examinations and as a reminder of what was learned previously.

The inability to read in the past six months ($n = 60$) was attributed to non-availability of books (56.7%), not knowing what to read (30%), and high cost of books (10.0%). A few (3.3%) said they did not have the time (Figure 7).

When the practice of self-study was compared with sex of health worker, a significant relationship was found ($p < 0.00002$). Nearly twice the proportion of male staff (77.9%) reported reading

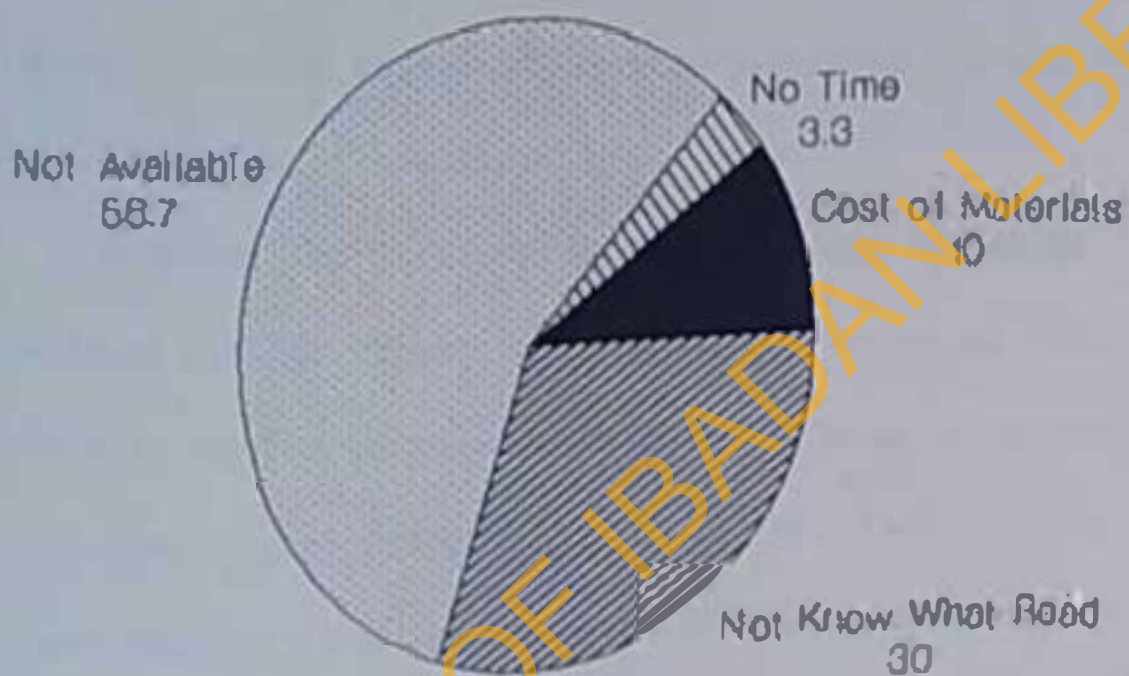
Reading Materials for Self-Study



N = 84

FIGURE 6: READING MATERIALS OF RESPONDENTS WHO PRACTICE SELF-STUDY

Reasons for No Self-Study



N-60

FIGURE 7: REASONS FOR NOT PRACTICING SELF-STUDY

In the past six months compared with female workers (40.8%) as shown in Table 13.

Table 14 also shows a significant association ($p < 0.000004$) between professional qualification and reading. Few workers with no qualification read (28.9%) when compared with their professionally trained counterparts (71.7%). No differences were found when comparing sector of service (Table 15), place of work (Table 16) and age of health worker (Table 17).

INTEREST AND OPINIONS ABOUT CONTINUING EDUCATION

Almost all (91.7%) of the respondents indicated that they would like to go for in-service training. The main reasons for negative answers were nearness to retirement, inability to understand English language and poverty. Some respondents mentioned more than one idea. More than half who desired further training expressed their wish to attend professional courses (64.4%) including general nursing, midwifery, community health nursing and environmental health. Specific topic short courses, mentioned by 18.9%, were immunization programmes, family planning, primary health care and others. Three respondents were willing to attend "any" course, while 29.5% had no course in mind at present.

The main, among multiple reasons for wanting to attend IST was "General interest" (49.2%), while others simply wanted to

TABLE 13

Practice of Self-Study Through Reading in Past MonthsCompared to Sex of Health Worker

Self-Study/ Reading	Sex		Total (%)
	Male (%)	Female (%)	
YES	53 (77.9)	31 (40.8)	84 (58.3)
NO	15 (22.1)	45 (59.2)	60 (41.7)
TOTAL	68	76	144

χ^2 Yates = 10.88, d.f. = 1, $p < 0.00002$

TABLE 14

Practice of Self-Study Through Reading in Past MonthsCompared to Professional Qualification

Self-Study/ Reading	Professional Qualification		Total
	YES (x)	NO (x)	
YES	71 (71.7)	13 (28.9)	84 (58.3)
NO	28 (28.3)	32 (71.1)	65 (41.7)
TOTAL	99	45	144

$\chi^2_{\text{ Yates}} = 21.62, \text{ d.f.} = 1, p < 0.000004$

"learn more" (13.6%). IST was thought to improve the practice of health care or make it more efficient by 20.5% of the respondents. Some (11.4%) thought that courses were the means for achieving the next level of their profession. In a similar vein, 9.1% wanted to undertake IST in order to "specialize," and 2.3% thought it would bring them additional certificates (see Figure 8).

Fewer of the 132 respondents who wanted training, wished for future IST to take place within the LGA (13.2%), while 40.9% specifically stated it should take place outside. Many (44.7%) did not care where IST would hold, while one person did not mention his preference.

Attempt was made to find out opinions on the possible benefits of CE. All but 7.6% could list at least one benefit. A total of 299 multiple responses were given (see Figure 9). Gain in knowledge was the most common benefit mentioned (65.3%). Many (38.9%) thought CE would make the worker more skillful and adaptable. Some thought CE would provide valuable experience (32.6%), or keep the employee up-to-date (27.8%). Others said CE would accord the worker more respect and recognition (17.4%) or enhance promotion prospects (16.7%). A few (9.0%) considered that one benefit was relief of frustration and boredom.

When asked directly, most health workers (93.8%) agreed that CE could enhance advancement, but their explanations of how this

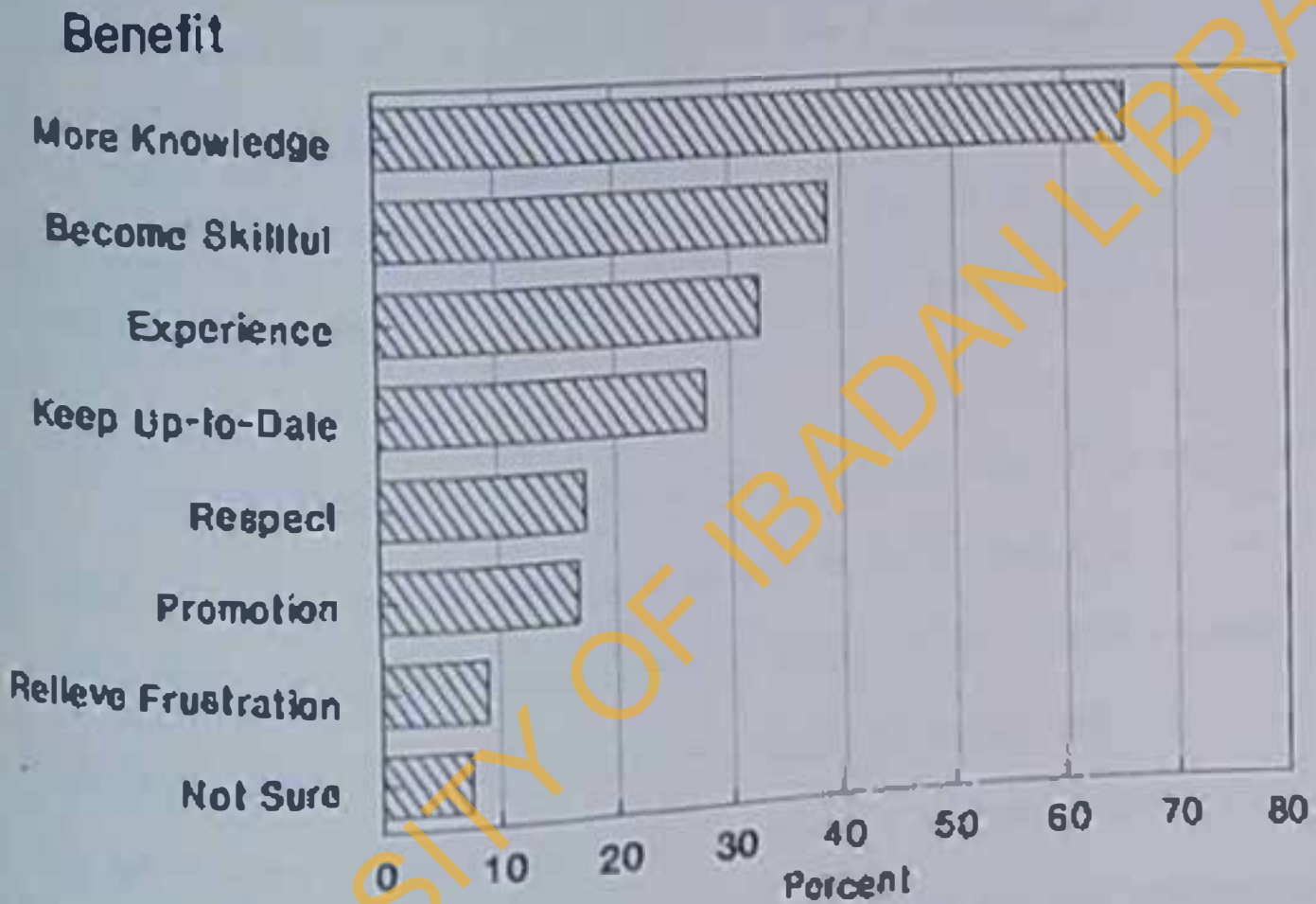
Reasons to Attend IST



H - 132

FIGURE 8: REASONS WHY HEALTH WORKERS WANT TO ATTEND IST

Perceived Benefits of CE



N = 144

FIGURE 9: PERCEIVED BENEFITS OF CONTINUING EDUCATION

worked varied, with some (12.6) of the 135 who initially said CE could help, not being able to supply a reason (see Figure 10). Knowledge itself was thought capable of enhancing chances for advancement (37.0%). CE was said to open up opportunities (28.1%), or give an employee the edge over others (15.6%). Some thought participation in CE enhanced the merit system of promotions (14.1%), while others thought it contributed directly to eligibility for upgrading (14.1%). A few (1.5%) stated that the prestige acquired through participation in CE would enhance promotion opportunities.

The health workers were asked how often they felt that in-service workshops and seminars should be held (Table 15). Half said these should be annual events, while 29.9% wanted workshops every six months. Other responses included every two years (6.9%), every three years (1.4%), and once in three months (2.8%). The remainder did not offer a suggestion. As for the recommended frequency of in-service courses, the largest number (45.1%) thought that these should take place yearly. Others thought the opportunity should be once in two years (25.7%), three years (13.9%) and five years (3.5%). A few suggested less than one year (1.4%), and the rest had no idea on frequency of training courses.

Reasons given for attending workshops and courses frequently included the need to keep abreast of current trends (23.6%), to

How CE Enhances Advancement

Means of Enhancement

Increased Knowledge

Better Opportunity

Edge Over Others

Enhance Merit

Expertise

Prestige

Not Sure



N = 135

FIGURE 10: MEANS BY WHICH CE CAN ENHANCE ADVANCEMENT

TABLE 15

Suggested Frequency for IST Workshops and Courses

Frequency	Type of In-service Training (%)	
	Workshops	Courses
Every 3 Month	2.8	0.7
Every 6 Months	29.9	0.7
Every Year	50.0	45.1
Every 2 Years	6.9	25.7
Every 3 Years	1.4	13.9
Every 5 Years	---	3.5
Not Certain	9.0	10.4
Total Number	144	144

avoid forgetting (19.4%), and to change with changing times (13.9%). Some thought that frequent workshops would relieve monotony (6.3%) or make workers more productive (2.8%). Those suggesting a longer duration between IST thought that such an arrangement would be more convenient (18.8%) and would allow enough time for the staff member to work and apply what was learned before participating in another IST (8.3%). The remaining respondents (6.9%) had no opinion on frequency of IST.

SUMMARY

Major findings of this study begin with the fact that nearly one-third of staff in the formal health services of the two local governments had no professional qualification. Most of these were working in the private sector, which itself accounted for almost one-third of respondents. Involvement in the four forms of CE varied from low to moderate. Less than two-fifths of workers had attended an IST in the past five years. Almost three-fifths had engaged in self-study by reading. Two-thirds reported receiving a supervisory visit in the past six months, and slightly less than three-fourths had attended a staff meeting in the same period.

These experiences were not evenly distributed among the staff. IST was more common among those in the LGA and University sectors, professionally qualified workers and older members of staff. Self-study was practiced more often by solo health workers

and those with professional qualifications. Supervision took place more often in the LGA health services. Staff meetings were attended more by workers without professional qualifications.

Nearly all staff desire CE and view it as beneficial to their professional development and advancement. The implications of these findings are discussed in the next chapter.

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CHAPTER FIVE

DISCUSSION

This study was aimed at documenting the experiences of individual health staff in two rural Local Government Areas in Nigeria, with four identified forms of continuing education, as well as at determining their desires for participation in future CE activities. The implications of results obtained are discussed in this chapter along with recommendations for more meaningful involvement for these health personnel in the CE process so as to enhance implementation of primary health care.

HEALTH WORKER CHARACTERISTICS

A variety of health care professionals are found in the two LGAs, and they vary greatly in personal and professional characteristics, especially in level and type of qualification. WHO [1981] estimates that in the least developed countries there is one physician for 17,000 people, in other developing countries an average of one to 2,700 people and in the developed countries, one for 520 people. With a projected population of around 230,000 for the two LGAs, the physician/population ratio is approximately 1 per 23,000. This implies a greater burden on the remaining

staff, a task they could more easily undertake, if the level of participation in CE activities within the area were higher.

Kleczkowski, et al [1984] had advocated that the least qualified staff capable of performing a function should be the ones assigned to that task, or conversely that highly sophisticated staff are not needed to perform basic services. One wonders how they would interpret the situation in the two LCAs where nearly one-third of staff have no basic health care qualification, and yet are responsible for handling essential services (e.g. ward maids taking deliveries).

It is unfortunate that such workers are also least likely to have had IST opportunities and take the least advantage of self-study. CE activities that could enhance their competencies. On the positive side, this level of worker is more likely to have attended recent staff meetings. Therefore it is incumbent on local health authorities to plan the educational components of such meetings, so that in future surveys a majority of workers will not report, as was the case here, that they learned no new ideas or skills at staff meeting. CE should be used, as Amoo Larson, et al [1984] suggest, to distribute health care skills widely among all those who work in rural areas.

It was encouraging to note in the current national climate that advocates "better life for rural women," that women appear to

have equal opportunity in securing employment in the health sector of the two LGAs. It is also fortunate to note that female health staff also have equal opportunity to participate in IST programmes. The area of CE where women fall behind is self-study. This can not be condoned, but may be explained by the fact that working women in Nigeria almost always carry the extra burden of housewife along with their formal job. This denies them leisure time to read.

Another important characteristic of health staff in the study area was that nearly one-third worked in the private sector, which itself accounted for 41% of the 22 functioning clinical facilities in the area. The unqualified health workers were disproportionately represented in this sector, and in addition staff in this sector were less likely to have attended IST or have received recent supervision. This is not a healthy situation when one considers the relatively sizable role private facilities play in provision of services in the area. Efforts to upgrade the CE activities in the private sector are needed and should be coordinated with those of the public sector services.

Age was another widely varying characteristic among the workers, ranging from 20 to 59 years. Those attending IST were on average older. Although some might say that younger workers are still fresh from basic training and retain more knowledge, it

[1983] has warned that continuing ignorance sets in right from the moment of graduation. Lynton and Pareek [1978] recommend that reward for past performance should not be a major reason for selecting staff for IST. In sum, all staff, regardless of age, are likely to need updating, and all should have equal opportunity for additional training.

Only slightly over half of the staff had ever had a promotion, although most had been on the job for over five years. Although very few who had attended IST programmes reported advancement as a direct result of attending a course, those who had experienced this CE opportunity were more likely to have been promoted. This finding was also in line with respondents' perceptions that one of the main benefits of CE is promotion and conforms with Pearson's [1990] view that training provides opportunities for advancement. Such opportunities boost the morale and productivity of workers [ASTD, 1976], and should be given greater consideration by local health authorities.

Although all CE activities covered in this study do occur in the two IGAs, their implementation appears to be haphazard, with many missed opportunities.

Not only are supervisory visits relatively infrequent (only one-third had been visited in the preceding month), but when they do occur, little of educational value is reported to occur. The

few visits that took place appear to be little more than courtesy calls. This is unfortunate, because as noted in Chapter One, the currently functioning health facilities, for the most part, are quite accessible by road.

Not only does supervision provide the opportunity for learning [McMahon, et al 1980], but training should be a major function of the supervisor [Blau and Scott, 1963]. Like any other CE activity, education during supervision should be a planned process. Regular schedules of supervision are needed that allow enough time for interaction and learning [McMahon, et al, 1980]. This process should be adopted in Ifeoluju and Ibarapa LGAs.

Staff meetings are important management as well as educational tools [Amonoo-Lartson, et al, 1984]. Although most authors recommend regular staff meetings, AMREP [1983] goes as far as to recommend weekly meetings. This could certainly be possible at the facility level. LGAs may not be able to gather all their workers on a weekly basis, but if the proposed PHC districts within each LGA were functioning, weekly meetings might also be possible within these smaller geographical zones.

Unfortunately only about half the workers reported attending a staff meeting in the previous month, and even then, the agenda rarely included CE. Meetings are a relatively inexpensive way to deliver CE because they offer the possibility of sharing, that is

the opportunity for workers to learn from each other [AMREP, 1983]. As noted above, staff meetings are an important missed opportunity for CE for those staff without professional qualification. They could greatly benefit from the knowledge and experiences of their trained colleagues.

Self-study is probably one of the best and more easily adaptable forms of CE for the rural environment [AMREP, 1983], but this too has been found to be another major missed opportunity in the two LGAs. The reasons for not practicing this form of learning are cogent. Books and journals are costly and not easily available, but local resources do exist.

There is a library within the district belonging to the University of Ibadan's Ibarapa Programme. While only University students and staff can borrow the books and journals, others could theoretically sit in the library and read. Recently the hour of operation have been extended to 8:00 p.m. Effort could be made to increase awareness of this facility among local health workers and encourage them to take advantage of this resource.

It is reasonable considering the lack of professional training that some workers said they do not know what to read. Here is where other forms of CE could be tied together. Supervisors could recommend reading materials and help circulate them. Items read during self-study could later be discussed at

staff meetings to enhance understanding and application.

RECOMMENDATIONS

It is fortunate to note, even with existing low levels of CE, that there is an overwhelming desire by health workers in these rural LGAs for CE opportunities. They have expressed the need for IST both on specific work-related PHC topics as well as for advanced professional courses that would enhance competence and promotion. They are realistic in their expectations that shorter courses should occur approximately yearly, while longer programmes should be scheduled at wider intervals. Having listened to these health workers concerns and desires and analyzed their past opportunities, the researcher offers several recommendations for improving CE in the study area.

1. Training Committee

A Training Committee is needed in each LGA. It could be chaired by the Supervisory Councillor for Health or the PHC Coordinator. The different cadres of workers as well as the different service sectors should be represented. The committee should identify training needs and draw up an annual schedule for CE activities within the locality as well as coordinate participation in CE activities offered by various state, federal and donor agencies. The training

committee could also oversee the library established within the LGA PHC Department. The Local Government Authority should also finance all CE activities carried out within LGA.

2. Libraries

Universally authorities should encourage health staff in Ifeoluju and Ibarapa LGAs to utilize the Ibarapa Programme Library in Igbo-Ora. In addition LGA PHC Departments and State and private clinics could begin to build their own libraries by requesting the numerous free publications available to developing country readers such as "Africa Health" and "Dialogues on Diarrhoea." Funds should also be made available to purchase basic texts and reference books for the LGA PHC Departments, the various clinics. A librarian should be assigned from among existing staff and receive supervision from the LGA Training Committee as noted below.

3. Supervision

Each sector and authority should draw up a supervision plan. This plan should take account of the training or learning needs identified by the LGA Training Committee. Supervisors should make specific effort to reinforce or supplement knowledge and skills learned during IST.

4. Promotions

Since this study has found a link between participation in IST and advancement, it is necessary that local health authorities make participation in training available equally to all workers regardless of age, sex and professional qualification.

5. Qualifications

Since the proportion of workers without professional qualification is high, as is their level of responsibility in delivering health care, specific plans should be made by each LDA and clinic to organize locally short IST programmes relevant to the duties of each group of these workers. In addition, where eligible, such workers should be given the opportunity to undertake longer IST courses such as that for Community Health Extension Workers.

CONCLUSIONS

It has been variously defined and explained in this study to encompass different forms of up-date and refresher programmes for health workers. It has been recommended as the cure and prevention for 'continuing ignorance,' which affects all health workers, but is more endemic in the rural areas. It is more endemic in the rural areas, and hence

health workers in these locations are at risk of continuing ignorance. Hence this study investigated the experiences and interests of those local health workers in CE activities.

The major finding was that participation in the four CE activities under study, in-service training, self-study, supervisory visits and staff meetings, was only in the low to moderate range. Few staff had undertaken IST in the past five years, and only about half had practiced reading as self-study in the past six months. Staff meetings and supervisory visits were infrequent and educational opportunities during those activities were usually missed.

The two LGAs were found to have a fairly large number (one-third of the total) of workers without formal health training. These same workers generally had less opportunities to participate in CE activities although their need may likely have been greater.

Furthermore, the study identified an overwhelming desire by all health workers for more CE opportunities. They perceived the value of CE in terms of professional advancement, and this was worked out in the association even between participation in IST and job promotions.

It is hoped that the results of this study will stimulate action by all health authorities, private and public, in the two LGAs to take prompt and thorough action to redress the

inadequacies of continuing education programming and in the process better equip their staff to meet the challenges of primary health care.

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APPENDIX A
QUESTIONNAIRE

CONTINUING EDUCATION NEEDS AND INTERESTS
OF IBARAPA HEALTH STAFF

Dear Respondent,

This questionnaire is aimed at finding out the continuing education needs and interests of all health staff. Please answer the questions as honestly as possible. Your responses shall be used for statistical analysis only and shall be treated with confidence.

SECTION A: DEMOGRAPHIC CHARACTERISTICS

1. SEX Male Female
2. AGE in years _____
3. Marital Status _____
4. Religion (please specify denomination) _____
5. Basic Qualification
 - () Primary School Leaving Certificate
 - () N.A.S.C.
 - () Teacher Training College
 - () Others (specify) _____

6. Professional qualification and year/date of qualification

Qualification

Date

_____	_____
_____	_____
_____	_____

7. Sector of Practice

- Employed by a Private Practitioner
- Employed by a Local Government Authority
- Employed by State Government
- Others (specify) _____

8. Place/Location of practice where hospital/office is situated. _____

9. Position first held after finishing from professional training school. _____

10. Position currently held. _____

11. Date/Year of last promotion. _____

SECTION B: HISTORY OF CONTINUING EDUCATION

12. Have you had in-service training course/programme/workshop since leaving professional training school?

- Yes No Not Certain

13. If 'yes,' complete the table on page 6.

14. If 'no,' why not? _____

15. Is there a schedule for supervisory visits from local government office/State Ministry of Health?

Yes No Not Certain

16. Did your supervisor visit you in the past six months?

Yes No Not Certain

17. If yes ...

a. How many times? _____

b. When was the last visit? _____

c. What does he/she normally do when he/she comes? _____

d. Does your supervisor do anything to keep your technical skills up-to-date?

Yes No Not Certain

e. If 'yes,' what did he/she do on the last visit? _____

18. Do you have a regular staff meeting?

Yes No Not Certain

19. If 'yes,' ...

a. When did you last attend? _____

b. What was the purpose/reason for that meeting? _____

c. What specific new ideas or skills were passed on to you when you last attended a staff meeting? _____

20. Have you read any book, journal or magazine to improve your technical skills for your job in the past six months?

Yes No Not Certain

21. If 'yes,' ...

a. What did you read? _____

b. Why did you read this/these? _____

c. If 'no,' to Question 20, why not? _____

SECTION C: ATTITUDES, INTERESTS AND DESIRES ABOUT CONTINUING EDUCATION

22. Would you like to go for more in-service training, workshops, programmes?

Yes No Not Certain

23. If 'yes,' what subjects would you like covered in the in-service programme, and why?

Subject

Why?

24. Where would you prefer the programme to hold?

Within the Local Government Area

Away from the Local Government Area

Both

25. If 'no,' to Question 22, why not? _____

26. Do you like the job you are currently doing?

Yes No Not Certain

27. If 'yes,' why? _____

If 'no,' why not? _____

28. What are the benefits of continuing education?

_____	_____	_____
_____	_____	_____
_____	_____	_____

29. Do you think continuing education can enhance your promotion or advancement?

Yes No Not Certain

Explain your answer _____

30. How often should a health worker receive continuing education courses? _____

31. Why do you choose the period above? _____

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CHART TO RECORD IN-SERVICE TRAINING PROGRAMMES ATTENDED

	#1	#2	#3	#4
Year/Date				
Topic				
Duration				
Who Organized				
Where Held				
Who Sponsored you				
Why Did you Attend				
Outcome or Result of Attending				

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APPENDIX B

Primary Health Care Department
Ifelolu Local Government Area
Igbo-Ora, Oyo State

3 December 1991

Dear Health Staff,

Compliments of the season to you all.

Please, the bearer is a professional colleague who is in this LGA for research. Kindly cooperate with him fully to make his programme a success.

Thank you.

A. Osinwole
(signed)
Co-ordinator
Primary Health Care
Ifelolu Local Government
Igbo-Ora