International Development of Family Medicine in Palestine

Interim Course Evaluation Report

The Mothers and Fathers of Family Medicine, Palestine, November 2013

IDFMP: Interim Course Evaluation Report

Executive summary

Introduction and context

Family medicine is a crucial aspect of healthcare, providing horizontally integrated management of acute and chronic conditions, a gateway to specialist treatment and a platform for health promotion. But it remained relatively less developed in the Palestinian West Bank, where implementation faced significant obstacles due to isolation, occupation and conflict. The International Development of Family Medicine in Palestine (IDFMP) programme is a collaboration between academic general practitioners in England and Italy with the first family medicine postgraduate training programme in Palestine, led by Dr Samar Musmar, based at An Najah University in Nablus. The IDFMP has the following aims:

- To improve morale and self-esteem by providing solidarity, relieving isolation and inviting Palestinian doctors to show outsiders their successes
- To involve Palestinian doctors in the community of family physicians outside Palestine
- To share approaches and solutions to common problems in clinical and health policy- in a two-way process
- To improve health outcomes in the long term

The first phase of the programme was a one-week course delivered by the academic GPs to the 16 residents on the postgraduate course in Nablus. In later phases, the programme will be extended to include mentoring to family physicians in Palestine, wider international collaboration study tours in the UK and establishing links with the Palestinian Ministry of Health.

Financial support for this phase was provided by An-Najah National University, Medical Aid for Palestinians (MAP), the International Medical Education Trust 2000 (IMET) and the British Council, Palestine.

Course content

The content of the course was developed in collaboration with Samar Musmar and Suha Hamshari (one of the family medicine residents at An Najah). It covered:

- Clinical priorities (e.g. focus on a biopsychosocial perspective, comprehensive care and managing uncertainty)
- Health system issues (e.g. lack of specialist care, need for leadership)
- Educational priorities (e.g. change management, reflection on practices, the central role of the consultation in family medicine).
- Holistic care, community oriented practice and practitioner development were the three central themes of the course.

The methods of the course spanned didactic presentations by the faculty, interactive large group sessions, small group experiential learning and development of written (manifestos for Palestinian family medicine) and performance (role play) outputs.

Course evaluation

The evaluation was designed and conducted by the faculty to assess the strengths and weaknesses of the course so as to identify where improvements could be made in the future. It will be conducted in 2 phases: (i) immediate post-course evaluation of participants' perceptions of the course's methods, relevance, and impact on their motivation and of the perceived learning benefits; (ii) 6-month follow-up to evaluate to what degree participants have been able to transfer the learning benefits into their work practice and context. In this document we report the first phase evaluation. The key questions addressed by the evaluation of this first phase were:

- To what extent did participants demonstrate evidence of leadership transformation and empowerment?
- What were the immediate effects of the course on participants in terms of their perceived learning benefits?
- To what degree was the course relevant to the Palestinian FM context?
- What can be improved for the future?

Methods: post-course questionnaires (one designed by the faculty specifically for the course, one independently administered by the British Council), two focus groups with the participants, reflections on scenarios, manifestos, group discussions and role play. The findings from these data sources were then triangulated.

Findings

IDFMP questionnaire (18/19 respondents): large majority of the respondents were positive about the learning themes and learning methods. In general all components of the course were rated highly. The most highly rated was teaching methods and style. The least highly rated was relevance to work in Palestinian family medicine (although most respondents still rated this as good or excellent).

British Council questionnaire (19/19 respondents): 17 respondents either agreed or agreed strongly that the course had met their expectations and all 19 agreed or agreed strongly that they had gained new knowledge or skills.

Focus groups: Positive components of the course included the format, particularly the group work, role play, mind maps and videos. They had expected more discussion of clinical topics but embraced the work on organisation of family medicine. The session on intersectoral collaboration on the issue of domestic violence was considered inappropriate by many of the participants. The groups formulated recommendations around what they could do to further family medicine in Palestine (form a family medicine society, public awareness raising about family medicine, raising the academic status of family medicine, and running workshops on family medicine for the Ministry of Health) as well as recommendations for the Ministry of Health (increase family medicine capacity in primary care centres, give family physicians a leadership role in those centres).

Conclusions

Overall a key outcome of the course was a sense of empowerment of the participants and a reinforcement of their trajectory towards leadership in primary care services in Palestine. The course also identified specific problems in the current primary care services that implementation of family medicine would need to tackle,

including insufficient resources, limited role of current primary care generalists and poor patient understanding. The manifesto groups and the focus groups identified potential solutions to these problems, including effective allocation of resources by the Ministry of Health, public education, expanding the role and profile of family medicine and further development of family medicine training. The course participants will need ongoing support in order to meet these goals, from stakeholders in Palestine and the IDFMP faculty. The IDFMP aims to provide support through distance learning, mentorship, and additional educational opportunities abroad. There was some mismatch between the expectations of the course participants and its goals, and this would benefit from further exploration in phase two of the evaluation. In addition, the domestic violence session within the intersectoral theme was received badly and needs to be redeveloped, along with the preparatory material. The results of this report provide strong evidence that this course had a positive impact, and provides a good foundation upon which to base future courses and other initiatives.

Contents

Abbreviations & acronyms

FM – Family medicine
GP – General practitioner (United Kingdom equivalent of family doctor)
IDFMP – International Development Programme for Family Medicine in Palestine
MAP – Medical Aid for Palestinians
OSCE – Objective Structured Case Examination (a form of assessment used for health professionals)
RCGP – Royal College of General Practitioners, United Kingdom
SAPC – Society of Academic Primary Care, United Kingdom
WONCA - World Organisation of National Colleges and Academies of Family Medicine

Acknowledgements

This report was written by Jonathan Broad, a medical student at the University of Bristol, in March 2014, supervised by Professor Gene Feder and Dr Marlene Laeubli. Particular thanks are due to the IDFMP teaching faculty who provided ongoing editing and advice throughout the writing of the report. For information or queries, contact smusmar@najah.edu or gene.feder@bristol.ac.uk or paul.wallace@nihr.ac.uk

Introduction

The International Development Family Medicine Programme in Palestine West Bank (IDFMP) aims to support the development of family medicine (FM) in Palestine. A number of activities are being developed over the next few months, including training, academic exchanges and a leadership development programme. The first initiative took the form of a one-week course for residents of the Palestinian FM postgraduate education programme at An Najah University, Nablus. It was held in November 2013 with nineteen FM residents participating. The planned course evaluation is in two phases: immediately post-course and at six months. This document presents the findings from phase one; it considers the immediate perceived benefits of the course, and explores its achievements and limitations. The evaluation's aim is to inform future IDFMP programme development and decision-making. Phase two of the post-course evaluation will focus on the course's impact on the residents' practice and the application of the learning.

Context of family practice in Palestine and the IDFMP initiative

Family medicine is a crucial aspect of health care, providing horizontally integrated management of acute and chronic conditions, a platform for preventive health care and health promotion, and a managed gateway to specialist investigation and treatment. [1] [2]It has potential to play a major role in fulfilling the global priority of effective, equitable and accessible health care,[3] but its development and implementation in the Palestinian West Bank has faced significant obstacles due to isolation and the other consequences of military occupation and conflict. Family medicine has remained relatively under-developed, with most primary care currently provided by untrained general practitioners and specialists: internists, paediatricians and obstetrician-gynaecologists. The first postgraduate training programme for family medicine in the Palestinian West Bank was launched in 2010. Led by Dr Samar Musmar, a US-board certified family physician and dean for postgraduate medicine, the first cohort of physician residents is undergoing a comprehensive four-year training programme in family medicine. The training is funded by the Ministry of Health to develop family medicine specialists, aiming to culminate in a Palestinian Family Medicine Board exam, which is still in gestation. The first family medicine posts are shortly to be trialled with current FM residents set to take on pilot clinics as well as management responsibilities in the Hebron district.

Professor Gene Feder, an academic general practitioner (GP) with a commitment to the development of Palestinian health care, invited Dr Samar Musmar to give a seminar about her work and about family medicine in Palestine at the 2011 Society of Academic Primary Care (SAPC) annual scientific meeting. This was followed by a two week exploratory visit to the University of An Najah by Professor Paul Wallace. Meetings were held with Dr Musmar and many of the residents on the family medicine training programme, as well as visits to a number of primary care facilities in Nablus and Hebron. This visit led to a commitment to develop an international collaboration to support Dr Musmar's initiative. The embryonic project was subsequently

[1] Moira Stewart. Reflections on the doctor–patient relationship: from evidence and experience. British Journal of General Practice 2005; 55: 793–801.

[2] Jan de Maesener, Chris van Weel, David Egilman, Khaya Mfenyana, Arthur Kaufman, Nelson Sewankambo Strengthening primary care: addressing the disparity between vertical and horizontal investment Br J Gen Pract. 2008 January 1; 58(546): 3–4

[3] Barbara Starfield, Leiyu Shi, and James Macinko. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502).

presented to a wider audience of UK primary care academics at the interactive "dangerous ideas" session at the 2012 joint SAPC and RCGP annual conference in Glasgow, where Dr Musmar also gave a plenary lecture. The presentation was enthusiastically received and several academic GPs with a commitment to the development of family medicine internationally became actively involved in the further development of the initiative.

The IDFMP initiative, aims and objectives

It was agreed to formalize the collaboration with Dr Musmar and her colleagues at An-Najah University through the establishment of an international steering committee consisting of Dr Musmar and Dr Suha Hamshari (University of An Najah), Dr Anita Berlin and Prof Paul Wallace (University College London), Prof Gene Feder (University of Bristol) and Dr Harris Lygidakis (Vasco da Gama Group, WONCA Europe). The steering group met monthly via Skype telephone conferences and reached agreement early in 2013 on the establishment of an international development programme for family medicine in Palestine (IDFMP) with the following overall aims:

- To improve morale and self-esteem by providing solidarity, relieving isolation and inviting Palestinian doctors to show outsiders their successes
- To involve Palestinian doctors in the community of family physician outside Palestine
- To share approaches and solutions to common problems in clinical and health policy- in a two-way process
- To improve health outcomes in the long term

A framework to manage this programme is still being developed (see appendix one).

It was agreed that the programme would run over a period of several years and would seek to achieve its aims through a combination of international collaborative activities centring on teaching, mentoring and the provision of ongoing support to the family medicine residency training programme. The international course was agreed as the first phase of the programme, to be followed by a range of activities such as:

- Opportunities for experienced general practitioners and teachers from other countries to provide on-site and distance supervision and training to Palestinian family medicine residents,
- Opportunities for Palestinian family medicine residents to attend international conferences and participate in international exchange programmes
- Supporting a range of academic fellowships to enable selected Palestinian family physicians to develop their academic, clinical and educational skills in an international setting

We sought endorsement for the initiative from relevant UK professional organizations including the Society of Academic Primary Care and the Royal College of General Practitioners, as well as international bodies such as the World Organisation of National Colleges and Academies of Family Medicine (WONCA). Financial support for the programme was secured in the first place from An-Najah National University, and subsequently from Medical Aid for Palestinians (MAP), the International Medical Education Trust 2000 (IMET) and the British Council, Palestine.

The IDFMP course - design process, aims, content and methods

Course design - overall approach

The short residential course described in this report was the first step to achieving the overall aims for the IDPFMP project (see above). The steering group decided this course for current Palestinian residents would offer the greatest gain at the lowest risk. Other possible activities, such as extended mentoring in Palestine, wider international collaborations, study tours to the UK and establishing links with the Palestinian Ministry of Health were also discussed *during* the design process. In this way we could think more broadly about what ***might*** be needed to support overall development of FM in Palestine, while also becoming more focussed and clear about (a) priorities (b) practicalities for the short course. The course design followed a collaborative and iterative approach starting in early 2013 with monthly discussions and the collaborative development of the curriculum of the course. The members of the course design group (table 1) brought a wide range of interests and experience related to the development family practice.

IDFMP steering group & course faculty.

Bold = those involved in initial course design. Italics = joined faculty later. LY advised but did not travel to Palestine*

	Role/Training / Background	Experience / comment
Samar Musmar (SM)	Director of Family Practice Programme,	US trained and Board Certified Family Practitioner (FP) (the only fully trained FP in Palestine) & practising FP in Nablus
Suhar Hamshari (SH)	Palestinian FP Resident An Najah National University, Nablus. (Residents' representative and course participant.)	Trained in Al Quds Medical School, Palestine
Paul Wallace (PW)	Director of the *NIHR* Primary Care Research Network Professor Emeritus in Primary Care University College London, former London GP.	GP academic with extensive experience of international development of general practice (Italy, Poland, Albania, Lithuania). Founder member of the European

		Society of General Practice/Family Medicine.
Gene Feder (GF)	Professor of primary care, School of Social & Community Medicine, University of Bristol and GP, Bristol	Management of cardio metabolic conditions in family practice and the primary care response to domestic violence
Harris Lygidakis (HL)	General practitioner and member of World Organisation of National Colleges and Academies of Family Medicine	Experience in clinical governance and data collection and telemedicine.
Anita Berlin (AB)	Senior Lecturer in Primary Care, University College London, & GP in London	Curriculum design leadership in the UK and in primary care development in Spain, Brazil and Poland
Ann Louise Kinmonth (ALK)	*Emeritus Professor of General Practice, University of Cambridge* *Clinical Director of Studies and Fellow, St. Johns College Cambridge & GP Cambridge list*	*Undergraduate and postgraduate teacher of general practice and academic practice in UK with experience in Somalia, and Canada. Academic leadership and mentoring.*
David Jewell (DJ)	*General practitioner and researcher in Bristol, United Kingdom.*	*Former editor of British Journal of General Practice, with experience of critical appraisal of evidence and primary care publishing.*
Louise Younie (LY)*	*Senior Lecturer in General Practice, Barts & London School of Medicine*	*Doctorate in education, UK GP & recent experience in Palestine*

Consultation - the challenge of "relevance"

The group worked to ensure that design focussed on ***integrating*** the priorities of the residents, their course director (SM), and Palestinian primary care more broadly, with the experience and expertise that the overseas members could bring. The resulting course was therefore a collective endeavour – a co-production. To maximise relevance the aims were informed by SM's knowledge of the residents, their experience, the training they had received and the opportunities and constraints of working in Palestine. SM & SH consulted with the current residents regarding their priorities and expectations. In addition SM listed her own priorities (reflecting on her years training and working in US Family Practice). SM also completed a brief written summary of the FP residency programme including: aims and intended knowledge and skills outcomes; learning activities and clinical experience; and methods of assessment. AB studied documents including the residents' Log Book and the *Annual Report on The Health Status of Palestine (MoH 2012).* An initial list of priorities was agreed between AB and SM and shared with the group (box 1).

Box 1 Initial priorities identified

Clinical priorities

- Focus on holism (biopsychosocial) -
- comprehensive care - integrated approach (rather than understanding care by hospital specialty)
- managing uncertainty & messy realities
- increase patient understanding and involvement in own health (co-production of health)
- management of NCD should be by FPs - continuing care

Health system issues

- Lack of specialist care (e.g. only 1 endocrinologist in West Bank)
- Need change agents and leaders
- Role of the community/ engagement and inter-sectoral involvement with development

Educational Priorities

- This cohort are the **pioneers** (the *Mothers and Fathers* of FP in Palestine)
- Need for developing change management, advocacy and leadership skills
- Culture - expectation of didactic styles emphasising content rather that application; & assessments that focus on knowledge
- Potential for work-based and OSCE type assessment undeveloped
- Log book has potential to be developed into fuller portfolio
- Concepts of reflection, critical thinking and learning from significant events new
- Research plays significant role in training
- "The GP consultation" is not currently a focus of learning

AB then discussed these priorities at length with LY, a GP educator with recent experience in Palestine. LY advised on how to maximise relevance for the course participants and identified areas for which overseas faculty might need to increase their cultural and contextual awareness (box 2).

Box 2 Potential challenges for overseas faculty

Need for cultural sensitivity

- Dress codes, greetings & expectations
- Role and attitude to women -

Understanding patient culture:

- Importance of some religious norms
- Family more important than individual
- Children always children - whatever

Understanding clinical context

- Lack of resources
- Isolation
- Trends to middle-high income ill-health profile: obesity, DM, Smoking

Understanding Primary Care setting -

- Fragmented services, some vertical programmes, existing doctors untrained

age • Family expectations & honour may be as important as personal wellbeing (what is the impact of rules of marriage and inheritance?) • Conveying concepts of medically unexplained problems, somatisation and mental health in across cultures	• What nursing care/ social care available? Understanding educational culture & setting • Primary care provided general doctors with no specific preparation No training of trainers • No supervision in the community health centres (only in hospitals) and university

Defining aims & emerging themes

As a result of this consultative process a range of aims evolved. The expectations of course participants (the residents) were incorporated as a priority but did not delimit the final programme. Three themes emerged (Box 3).

Items in italics were NOT eventually included in the final programme (EVIDENCE denotes topic for which pre-course reading was provided.

Themes	**Learning objectives**	**Suggested core content**
1. **Holistic care:** **To increase understanding or** primary care and generalist practice (integrated & comprehensive care) *" preventing and relieving suffering"*	Participants can demonstrate understanding of primary care and generalist practice using an integrated and comprehensive approach.	1. Purpose of primary care & the role of the Family Practitioner (FP) - preventing and relieving suffering 2. Exceptional potential of each FP consultation - 3. Consultations skill - the **EVIDENCE** - what works & what patients want 4. Consultation skills - gathering info using approach 5. Consultation skills - the neglected 2nd half of the consultation-shared decision making & management planning 6. Real case-based learning - applying the biopsychosocial approach

2. **Community oriented practice**: To improve health promotion, disease prevention, public health, inter-sectoral work and community engagement	Participants have a sound understanding of how community oriented practice can improve health promotion, disease prevention and develop positive links with other relevant sectors.	1. *Population data - making a community diagnosis -* 2. Screening - the **EVIDENCE** 3. How to organizing a disease prevention programme (CVD, diabetes, obesity) 4. Working with other sectors (social, education, police etc.) - ?domestic violence, ?chronically ill child) 5. *Working with the community to reduce morbidity - enabling social networks & increasing health resilience* 6. Leadership & advocacy: step 1 creating a vision - (writing a ***Manifesto*** for Family Practice in Palestine) 7. Leadership & advocacy Step 2: sharing a vision (presenting your ***Manifesto***)
3. **Practitioner development**: To promote reflective practice, life-long learning, educational and leadership skills	Participants can demonstrate reflective practice and a commitment to life-long learning. Participants can demonstrate leadership skills including the ability to self assess and identify the strengths and needs of their colleagues.	1. Continuing professional development - the **EVIDENCE** 2. Significant events - learning from challenging cases & role models 3. Assessing practitioners' competence - the **EVIDENCE** 4. Giving and receiving Feedback - core skills 5. *How to build your own learning portfolio* 6. *Leading teaching, learning and assessment - the basics*

Selecting methods and content to match aims

Alongside agreeing the aims, the main themes and core content, we chose appropriate educational methods based on four considerations:

1. Sound educational principles
2. Faculty experience & know-how
3. Language and culture
4. Time and local resources

Given the very short time allocated to the course and challenges of ensuring relevance the design group were keen to introduce the residents to a wide range of topics and learning opportunities as well as ensuring they were stretched, had fun and had something tangible to take away (The Manifesto). The educational principles applied drew mainly from experiential and transformative approaches. These were used alongside knowledge

transfer strategies where they were more appropriate. Learning activities for each theme were developed by pairs or trios of faculty in accordance with their experience and expertise. Short didactic presentations and selected pre-course reading material covered:

- Generalist practice: What is the role of the family practitioner? Patient centred practice
- Community oriented care: screening; prevention - CVD & diabetes
- Principles of continuing professional development
- Effective assessment of clinical competence

Experiential and transformative approaches can be very challenging for participants, but potentially rewarding both in the short and longer term. We were especially fortunate to have enough faculty members to work with small groups. Tasks for faculty include creating a safe and warm environment, reducing teacher-learner hierarchy; openness and flexibility; acting as role models and maximising trust. While entirely consonant with our aims, the cultural and language dimensions added additional, sometimes unexpected, demands on these approaches to learning.

Transformative learning emphasises critical, creative and interdisciplinary thinking, and increasing collaboration, self-awareness and agency. Transformative approaches are linked to using education to address issues of social justice and are therefore relevant in the context of inequality (social and gender) and oppression. They are highly relevant where core goals are empowerment, teamwork and leadership development, but less concerned with behavioural competences. Three activities were employed to maximise the transformative potential for the residents:

- Participant presentations (multimedia): a "day in my life" including the description of a critical case
- Manifesto preparation: in small groups using, interactive "design thinking" techniques to identify and agree a real-world priority for change
- Intersectoral workshop - focussing on identifying and managing domestic violence

Experiential and active learning

Family practice in general and its core component - *the consultation* -require integrating a breadth of clinical knowledge with an understanding of human experience from multiple perspectives. Lifelong learning and teamwork depend on self-awareness and accepting feedback, and the intellectually and emotionally demanding aspects of practice require collaboration with patients and colleagues and reflection-on-action. Real and simulated experiences can be powerful triggers for developing these capacities especially if accompanied by discussion and feedback from peers. Three key activities were incorporated into the programme:

- Case based role play "Muna & Bashir": faculty and residents worked though a loosely scripted series of consultations in which they assumed the role of patient, relative or doctor - transcending the limitations of age and gender!
- Brainstorming: used to explore and solve problems i.e. - doctor& patient priorities for the consultation; ways to assess family practitioners etc.
- Group Presentation: the Manifesto

Planned and re-negotiated programme

The final timetable is included in appendix 7. Despite attempts at careful planning, given the challenges listed in Box 2, perhaps inevitably the course we delivered did not exactly match the timetable as envisaged and some activities were modified, restructured or simply dropped. Factors such as travelling, separation from family, exhaustion, and engagement in tasks (especially the Manifesto) led to democratically agreed alterations. The early morning meetings and the sessions on developing the OSCE were omitted.

A note on participant assessment

Given the brevity of the course, broad nature of the aims, and the focus on transformative dimensions such critical thinking, reflection, empowerment and self-esteem it was clear that any formal attempt to assess participant outcomes would be wholly inappropriate. Nonetheless it was hoped that the residents would become better able to self assess and identify their own strengths and those of their colleagues - valuable abilities in future leaders. As can be imagined, some of the intended outcomes of transformative learning such as increased self-esteem, negotiating or advocacy - essential to service development - but they do not lend themselves to direct evaluation or assessment using conventional tools, instead requiring longer term, critical evaluative methodologies.

The course evaluation

Overall evaluation approach and design

The IDFMP programme evaluation will be conducted in different stages as the programme develops. The short course evaluation reported here forms part of this wider IDFMP programme evaluation and was devised by and the teaching faculty in consultation with an independent evaluation specialist, Dr (PhD) Marlene Laeubli. This type of approach is compatible with the main purpose of the evaluation improving the design and delivery of future courses.

The overall evaluation concept is based on Donald Kirkpatrick's four-level evaluation model[4]. The assumption is that the actual or perceived benefit that results from training courses should be judged both immediately and by its actual use and utility in the work context. During the course, Kirkpatrick's model considers

[4] Kirkpatrick, Donald. *Evaluating Training Programs.: The Four Levels*. Berrett-Koehler Store, 1998.

participants' reactions and motivation (Level 1) and learning (Level 2). At a later stage, the evaluation focuses on practice in real life situations (Level 3) and results in terms of changes adopted (Level 4).

A preliminary version of the evaluation report was drafted by an undergraduate medical student, Jonathan Broad, and then edited by the UK faculty.

Short course evaluation

In line with Kirkpatrick's model, the short course evaluation has two phases. . Phase one evaluates the participants' immediate perceptions regarding the short course: its methods, relevance, impact on participants' motivation and perceived learning benefits. Phase two is planned to take place after six months to examine the longer term effects of the course, especially how, and to what degree participants have been able to transfer their learning benefits into their work practice and context. For the phase two evaluation, questionnaires and focus groups will be the main methods; these will be designed by the IDFMP faculty, again in consultation with Marlene Laeubli, and translated and delivered in Arabic by local evaluators.

The purpose of this report is to present results from the phase one evaluation: short term perceived benefits of the course. This is a formative evaluation so that modifications can be made and integrated into the next course and follow-up activities.

Key evaluation questions for phase one

The key questions addressed by the evaluation of this first phase were:

- To what extent did participants demonstrate evidence of leadership transformation and empowerment?
- What were the immediate effects of the course on participants in terms of their perceived learning benefits?
- To what degree was the course relevant to the Palestinian FM context?
- What can be improved for the future?

Phase one evaluation methods

The principal methods for phase one evaluation were a post-course questionnaire and focus groups. In addition, evidence on participants' engagement and learning benefits was gathered through reflection on scenarios, manifestos, group discussions and role play.

Course process and manifestos

Data were collected throughout the course by the teaching faculty as follows: course attendance, range of materials and outputs from the group work during the course, and evidence on nature of engagement from photos. We interpreted engagement in the photograph by people's facial expressions and body language and the evaluators' perception of their meaning. We recognise that personal and cultural subjectivity in this process may limit the validity of this methodology.

As an output from the course, participants were invited to produce manifestos in small groups aimed at addressing a specific challenge in Palestinian primary care. The manifestos drew on their learning experiences throughout the week. The process applied the principles of Design Thinking a creative and collaborative approach to help groups identify and interpret challenges, then find and experiment with solutions[5]. This was intended to help course participants clarify the needs of primary care in Palestine and how to overcome these. Participants depicted contemporary primary care and its challenges through stories, mapped potential strategies, and gave presentations and role plays for a visionary future. These manifestos are included in appendix 3, and we have analysed their content thematically.

Post course

Participants were given a questionnaire by the British Council that is used across all affiliated projects (included in appendix 4). Anonymised questionnaires were administered in English in paper format to all course participants at the end of the final session, and they were emphasised to be independent of the course organisers. The questionnaire asked whether the course met the expectations of the participants, whether new knowledge was acquired, and how participants rated its quality. Participants returned questionnaires, which were collected and entered into Microsoft Excel by British council staff, who then provided aggregated data to the evaluators.

In addition to the British Council questionnaire, the IDFMP post-course evaluation questionnaire (included in appendix 3) was designed specifically for the course, measuring participants' perceptions of the methods, relevance and other aspects of the course, with free text space for participants to describe their pre-course expectations and perceived outcomes. At the end of the course, all 19 participants were asked to fill in the questionnaires using Lumos!, a web-based survey tool, and analysed using Microsoft Excel. The surveys were filled out using laptops with clusters of students being given a laptop each. Residents then took it in turns to complete the survey on line.

Mindful of the limitations of survey methods and knowing that it might well be difficult for participants to respond to the questionnaire's open-ended questions in English, two focus group sessions were developed and organised by the external evaluation consultant. Students on the An Najah Masters were then recruited and provided with face-to-face training and written guidelines by the external consultant in focus group technique so that they could then lead the focus groups in Arabic (see appendix 5 for the guidelines used for the focus groups). This gave participants the opportunity for free-flow, confidential discussions in their own language. The discussions were recorded and coded according to the main questions raised during the focus groups. The results were then analysed and a summary of the analysis in Arabic was fed back to the residents for comment. The final summary was then translated into English and sent to the course evaluators.

Triangulation

The findings from the different data were compared and then synthesised between data types. Where there was synthesis, this was compared and where there was discordance or questions for further analysis this was noted.

[5] IDEO (2014, February 2). The Toolkit for Design Thinking. *Design Thinking for Educators.* Retrieved February 2nd 2014, from http://designthinkingforeducators.com.

Results

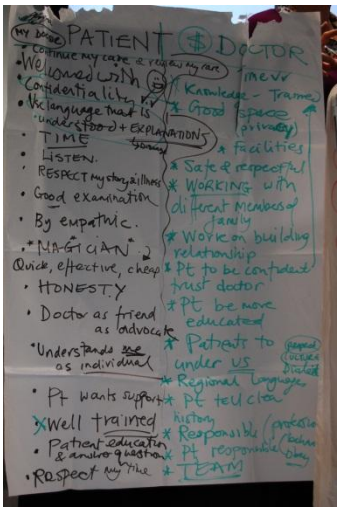
Course process and manifestos

Nineteen residents participated in the course, with sixteen men and three women, from a variety of year groups in the residency programme. In addition, six members of the IDFMP faculty provided facilitation for the sessions. Two participants left for two days due to constraints on their participation (see below). The location of the course (Nablus) poses a risk of settler violence towards Palestinians travelling to the city, especially after dark. To avert the potential threat, residential accommodation was provided for course participants. Two female doctors felt that it was inappropriate to stay in shared accommodation as they felt they had to spend time with their infant children and families, and therefore initially stated that they would be unable to complete the course. However, their decision to return for the last two days was perceived as a positive sign of their engagement and enthusiasm to attend. All of the sessions ran as planned, although participants were offered the option to invest more time in their manifesto preparation, and opted to do so; therefore the session on designing an Objective Structured Clinical Examination (OSCE) was cancelled on the last day.

As part of the course, participants were engaged in developing a series of materials, ranging from brainstorming to flip chart diagrams of the current context of family medicine in Palestine, to role plays depicting potential futures. A selection of these flip charts has been transcribed in appendix 6. The photos below demonstrate that participants engaged with the material and enjoyed the process, particularly surrounding the group work and scenarios. These fed into a wider process of smaller groups developing a family medicine manifesto for Palestine.

Participants were allocated into four groups based on a mix of gender, language ability and years in the residency programme. The participants named their groups: An Najah (Success), Layla (the daughter of one of the participants), Pathfinders and Jerusalem. All participants in the groups contributed towards producing a manifesto based on the process of Design Thinking, demonstrating acquired knowledge and applying the approaches that were developed in the course. The groups identified and discussed the context of family medicine in Palestine and the problems that they faced, and then tried to find solutions. They depicted solutions and their visions for the future of family medicine in different ways including role play and performances, with some overlapping themes emerging between groups. Concise written versions of each group's manifesto are included in appendix 2.

Course participants producing a radio show for patient education.



Effective brainstorming.

Others watch the show with enjoyment

A group discusses the manifesto

One of the groups working on its manifesto

Another group brainstorming for its manifesto

Post course questionnaires

All nineteen respondents returned the British Council questionnaire, and eighteen of the nineteen IDFMP faculty-designed questionnaires were returned, although some participants only filled in a minority of the questions. The results of the quantitative components are depicted in graphs below, with questions displayed according to percentage of most positive responses.

Quantitative analysis

Learning themes

The majority of participants responded positively about most learning themes, stating that the benefits were 'high' or 'very high'. Participants most positively rated the benefits of the 'Consultation and Doctor Patient Relationship' theme, with 15 respondents rating it 'very high' or 'high', followed by 'Understanding the role of the generalist practitioner and primary care'. The 'Inter-sectoral Work' was the only learning theme where more respondents perceived it as having an 'average' or 'low' benefit than gave positive responses, with an additional 5 respondents giving no response or stating 'not applicable'.

Learning methods

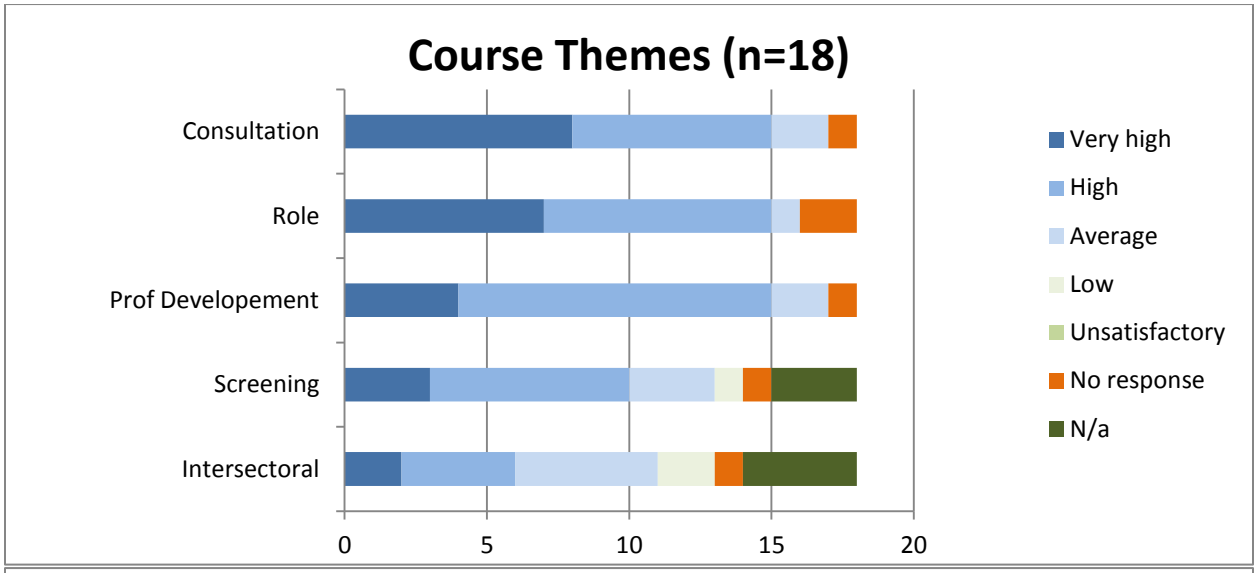
Participants responded very positively about all learning methods, except the session 'Designing an OSCE station', which did not take place due to time constraints. Participants most highly rated 'Discussion in small groups', with 17 rating it 'high' or 'very high', and the least highly rated of the sessions that took place was the manifesto presentation, with 12 participants rating it 'high or 'very high'.

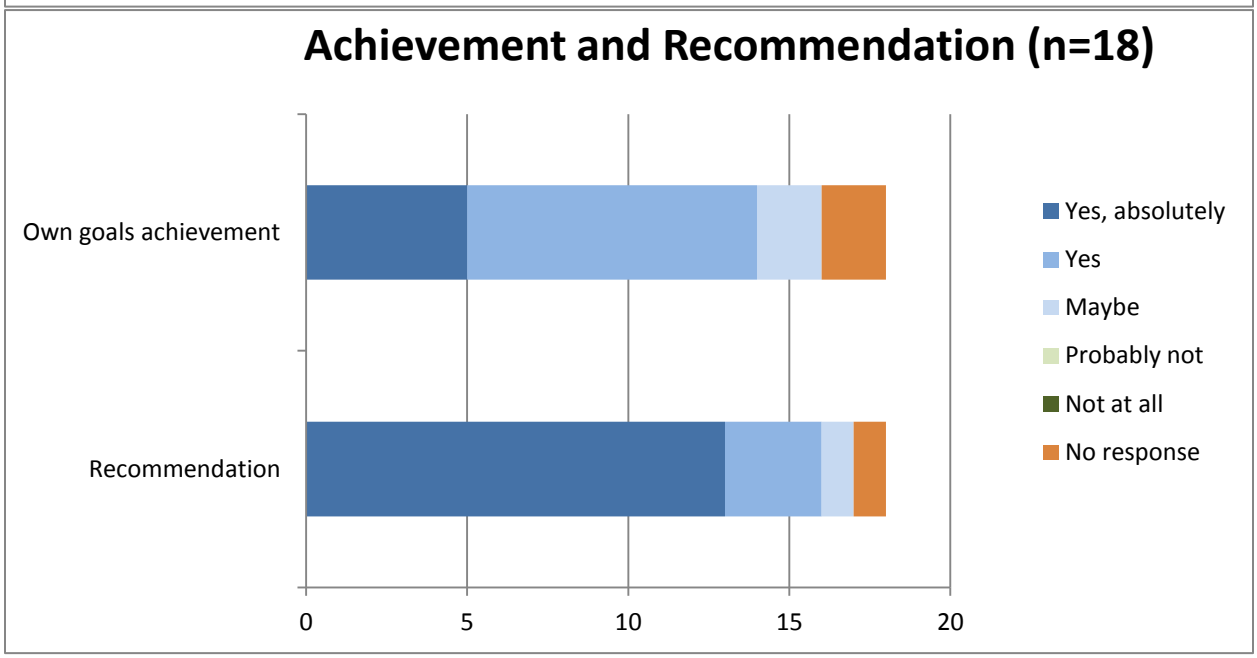
General impressions and achievements

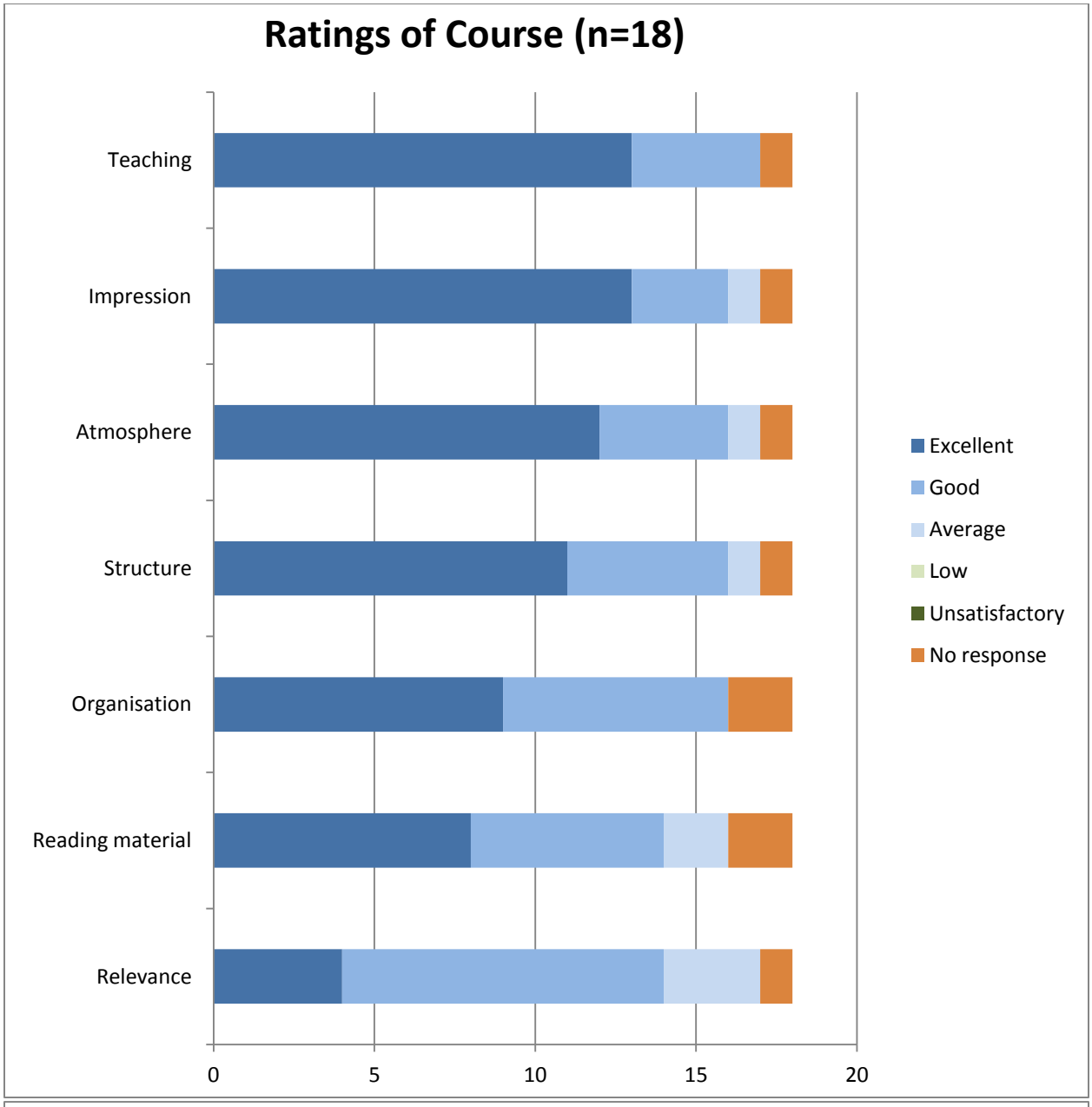
In general, participants rated all components of the course very highly. The highest rated component was the 'Teaching methods and style', where all respondents rated them as good or excellent. The least highly rated component was 'Relevance of the course to my work in Palestinian family medicine', where 14 out of 17 respondents rated it as 'good' or 'excellent'. When asked whether participants had achieved the goals that they had set themselves for the course, 14 respondents stated 'yes' or 'yes, absolutely'. In addition, when asked if participants would recommend the course to others 17 responded with 'yes' or 'yes, absolutely'.

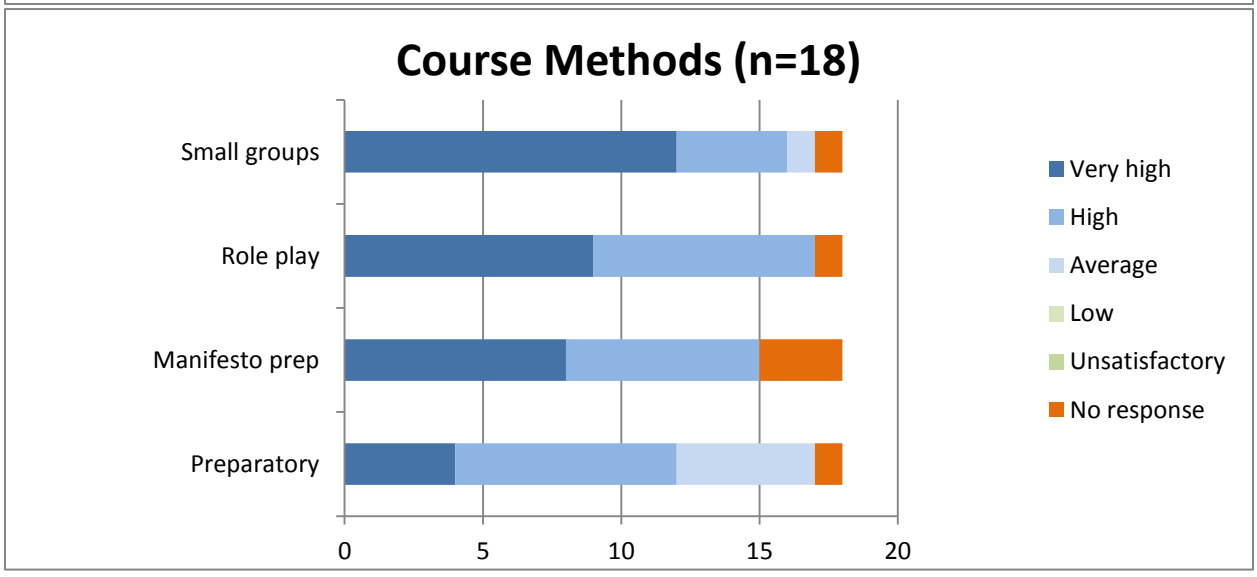
British council questionnaires

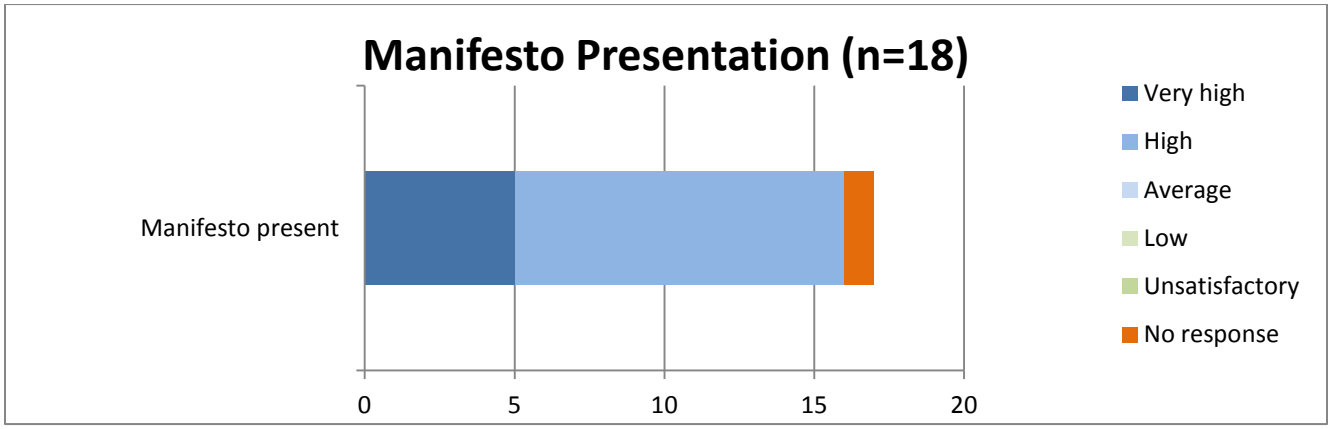
Seventeen participants either agreed or strongly agreed that the event met their expectations, with two neutral responses. All nineteen either agreed or strongly agreed that they had gained new knowledge or skills, and felt that that this was a high quality event.

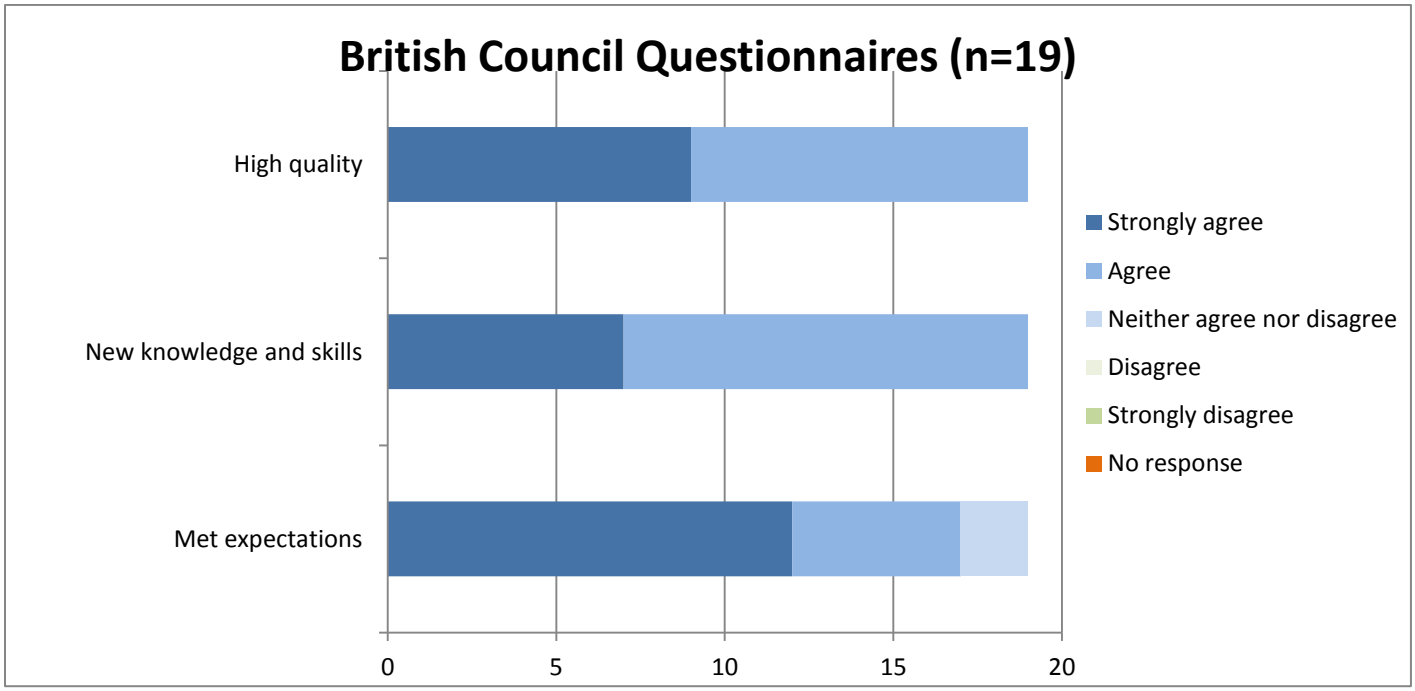

Course Themes (n=18)
Consultation
Role
Prof Developement
Screening
Intersectoral
0
5
10
15
20
Very high
High
Average
Low
Unsatisfactory
No response
N/a


Achievement and Recommendation (n=18)
Own goals achievement
Recommendation
0
5
10
15
20
Yes, absolutely
Yes
Maybe
Probably not
Not at all
No response


Ratings of Course (n=18)
Teaching
Impression
Atmosphere
Structure
Organisation
Reading material
Relevance
0
5
10
15
20
Excellent
Good
Average
Low
Unsatisfactory
No response


Course Methods (n=18)
Small groups
Role play
Manifesto prep
Preparatory
0
5
10
15
20
Very high
High
Average
Low
Unsatisfactory
No response





Free text analysis

Best aspects

Many participants stated the best aspect to be working together, small group work and problem solving. One participant said 'working together I really see the fathers and mothers of family [medicine]', one of the aims of the course, and another said they most enjoyed 'discussion and sharing our experiences', and 'working as a team under pressure'. Participants also positively mentioned the use of different educational methods such as role plays, manifestos and brainstorming, describing that these were mostly a new experience, with one student describing them as 'new style[s] of learning'. Many students also mentioned the positive experiences of working with other participants and the facilitating staff, mentioning 'lovely facilitators', or 'kindness of attendants'. In addition, one student mentioned the acquisition of new knowledge as their most positive aspect.

Aspects for improvement or removal

Most participants noted that the course needed nothing more to improve it, and that nothing should be removed. However, some participants described the presentation given by the NGO Juzoor on domestic violence within the inter-sectoral theme as an unexpected feature, with some believing it was an

inappropriate part of the course. One participant said 'I think the Juzoor organisation are not in their place here', and another said there should be 'no more discussion about conflicting subject [like the] Juzoor presentation'. Others noted that the course could be improved by increasing the focus on clinical medicine or chronic diseases. Another participant noted the need for translated material. There were conflicting opinions about course length and density, with some participants suggesting ways to make it longer or to include more in each day, and others suggesting it should be shorter with fewer breaks.

Also of note was a technical misinterpretation with the question intended to ask about how to improve the course, whereas some participants appear to have perceived it as what improvements should the course cause in their practice. In response, participants noted that it should improve their understanding of the role and knowledge required for effective family medicine, and their relationships with patients. One participant said 'it should improve [our] understanding of family medicine's role… relationships between patients and doctors and …give [us] hope'.

Personal goals and reflections

Participants appeared to set themselves goals with some common themes, such as gaining new knowledge or experience, improving the quality of their work, sharing and working with others, and identifying problems, or a combination of these. One participant stated their goal was 'to improve my performance and have a complete picture about… how I can help my comrades to be…better'. As mentioned above, the majority of participants felt they had achieved these goals, and there appeared to be no relationship between goals expected and goals achieved.

On reflection, many participants felt that they had felt more empowered and confident in themselves or their role in positive change, with one participant saying 'I will be more believing in my ideas' and another saying 'increased self confidence' and another simply saying 'hope'. Others stated that they had learnt about working with others, including colleagues and patients. One participant said 'I liked discussions and sharing information with colleagues, I loved the way of learning… and I intend to adopt it', whilst another saying 'I am already having a good relationship but I will improve [my relationship with patients] more'. In addition, some participants felt that they had learnt particularly to improve their listening skills, with one participant saying they would 'be [a] good listener', another saying they would 'give patients time to say their complaints', and another saying they would 'be [a] good listener'.

Lastly, a large majority of the participants reflected that the experience had been a good one, and that they were grateful to the course organisers and other participants, and many stated that they would like it if there were another one to attend in future, for themselves and others.

Focus groups

The two focus groups were held at the end of the course in Arabic, and an English summary report was created by the facilitators. Two major issues were discussed: participants' reactions to the course in general

and to the learning benefits in particular, and their thoughts on the practical application of these learning benefits in the future.

Positive components

Generally, participants enjoyed the format of the course, particularly group work, role playing, mind maps and videos. One participant saying 'although the duration of the course was intense…we never felt bored… we were excited for the next… session all the time', and another said 'we felt that the brainstorming method was…very effective… to help us use our knowledge in a creative way'. In addition, participants felt positively about the staff, describing them as trustworthy and humble.

Participants had expected that there would be a greater focus on clinical topics, and did not expect discussion of the organisation of primary care, however recognised its importance, with one participant saying 'the problem is how to deliver patient services and flow', and another saying 'healthcare workers at primary healthcare clinics deliver services in a disorganised way, therefore having a trained family doctor in each clinic will help in …delivering better care'.

Participants also valued the lessons learnt through role play and group work, including decentralised decision making, ideas exchange, and teamwork. One participant said 'brainstorming and working in groups created excellent learning... that you cannot achieve in more than two months of hard work'.

Improvable components

All participants agreed that the only component that was negative was the Juzoor domestic violence session, with one participant noting that this was 'completely out of context'. Others noted the short duration of the course limiting the ability for participants to master the skills learnt.

Challenges for applying family medicine principles in the workplace

The participants recognised that they would face substantial obstacles in applying the principles learned in the course into their current work context. They supported the idea that FM practitioners should become the directors of primary care centres, but there was no agreement on how to secure the authority to do so. The existing structural organisation of primary care in Palestine and the lack of recognition of FM as a specialism by medical colleagues and the public were said to be the main reasons. Nevertheless, there was optimism that, step-by-step, change could come about. Needed actions that were suggested fell into two categories:

1. **What participants could do to improve family medicine**

Participants discussed establishing a family medicine society in Palestine, with members paying subscription, funds could then be raised to develop actions including targeting the public to spread awareness about the role and practice of family medicine. They could then hold monthly meetings with community leaders and selected community groups, where they could discuss the concept of family medicine and the community's expectations from family doctors. One participant stated 'they can fund a brochure', targeting the public for awareness about family medicine. Another said 'any idea starts like a small snowball, which becomes bigger with time... and our idea of family medicine needs time, team efforts and hard work to succeed in convincing others of the family medicine concept'.

But for substantial changes to current practice, they recognised the need to gain recognition and support for FM principles primarily from the Ministry of Health. Suggestions took the form of both indirect and direct actions. For example, improving the academic status of FM; one participant suggested empowering the university residency training programs in family medicine; others stressed the importance of teaching family medicine to the undergraduate medical students at the universities. As for direct actions, some participants stressed the importance of delivering a 1-2 day workshop directed at the Ministry of Health to discuss the importance of family medicine clinics in primary health care. Using learning methods similar to those used in this course would be helpful. One of the participants followed up by saying 'then, it is the Ministry of Health's responsibility to convey [a] clear message to all directories about the importance of family medicine implementation'.

2. **What the Ministry of Health could do to improve family medicine**

Hiring more doctors in the PC centres; there was a discussion about increasing the number of doctors in primary care and some of participants agreed that if multidisciplinary clinics for repeat prescribing and chronic diseases were implemented with the help of pharmacists and nurses, this would decrease the work load on doctors and give them extra time to apply the family medicine concepts properly.

Finally another participant added, 'the success will heavily depend on the efforts of the first group of family doctors and the future of family medicine will be decided upon the graduation of the first class'. 'Doctors' they said, 'should be more aware of their responsibilities and rights according to the law and [should] be given authority in applying family medicine concepts.'

Discussion

This evaluation combined qualitative and quantitative assessment of 19 participants' experiences on a one week course as part of the wider IDFMP initiative. As discussed, this evaluation focuses on the transformative leadership potential for participants, the perceived benefits and relevance of the course, and the scope for future improvement, with the intention to complement this with a second phase of evaluation to analyse its influence on practice.

Leadership and empowerment in primary care

Empowerment – a prominent finding is that participants described a feeling of empowerment from attending the course. Participants stated in the IDFMP questionnaire that their perceived benefits included empowerment and self-confidence, in line with the goals of the IDFMP initiative course to improve morale and self-esteem. Of note, one participant stated 'I will be more believing in my ideas'. In the focus group, participants described optimism that change could occur, and believed in their ability to create change. This is also evidenced by the commitment to producing the manifestos and the range of creative ideas that emerged from them.

Transformative leadership in primary care – participants also demonstrated leadership, particularly during the manifesto process, and enjoyed the creative identification of problems and solutions in primary care. This is in keeping with the transformative aim to develop reflective practitioners and leaders. In the survey the

manifestos were rated positively, consistent across the focus groups and in the photos, where participants seemed to be highly engaged with this component. In the focus groups participants recognised their potential role as future leaders in primary care in Palestine- and that 'the success …and future of family medicine…will heavily depend on [our] efforts'.

Although participants anticipated that there would be significant barriers to implementing solutions, they reflected on how they can overcome these barriers at a personal and systemic level. Participants described that this had not been part of their initial expectations for the course, and demonstration of their ability to co-produce their learning provides further evidence of developed leadership skills.

The course provided a strong foundation for the aims of practitioner development. Methods that provided inspiration such as the manifesto, which combined brainstorming, visioning and group work may be a particularly valuable component for future design.

Identification of problems in primary care

Certain themes emerged during the components of the course where the participants were exercising or developing their leadership skills, particularly during development of the group manifestos. Whilst not central to the aims of this report, these represent specific barriers and solutions that would need to be addressed to implement family medicine in Palestine and merit some discussion.

Insufficient resources to meet patient load - during the manifesto process, all groups mentioned the large patient load for each doctor, with some reporting seeing 150 patients per day in their clinics. A prominent consequence, clearly articulated by the participants was the short length of consultations, subsequent poor relationships with their patients, and limited capacity to provide anything beyond pharmaceutical care.

Lack of information systems - the Success manifesto group identified that there was insufficient record keeping or population health monitoring. Others mentioned a lack of information sharing between healthcare providers.

Poor patient understanding and expectation – the manifesto group, 'Layla', identified that there is not enough understanding of the role of family doctors, and that patients have unrealistic expectations of what they can do. Others mentioned that patients generally have a poor level of education about their health, and sometimes a lack of respect for family doctors. In discussion during the course, some doctors alluded that tensions sometimes arise with patients such that they perceive a threat of violence.

Limited role of primary care generalist doctors – two manifesto groups (Layla and Jerusalem) mentioned that the powers of primary care doctors are limited. Firstly, there is an overdependence on these doctors for repeat prescriptions, which may contribute inappropriately to the demand for consultations and patient load. Additionally, primary care doctors are moved repeatedly between clinics and have little autonomy in managing patients, as they receive instruction from specialists about exactly what treatment to give and if there are problems that arise, the patients must refer back to specialist care. Similarly, primary care doctors are unable to request investigations in hospitals. The current role of primary care doctors misses some of the key features of family medicine, notably the potential for continuity of care with a stable patient population.

Potential solutions identified

Effective allocation of resources by Ministry of Health – in the focus groups, participants cited the need for additional family medicine practitioners to meet patient load. Two manifesto groups identified the need to increase the number of doctors and clinics, which would allow doctors to have more time per patient (Pathfinders) (Jerusalem). In addition, one group suggested that basing doctors in a specific clinic would improve the doctor-patient relationship (Pathfinders). In the focus groups, participants cited the idea of the Ministry of Health creating specific clinics for repeat prescriptions and monitoring of chronic disease, combining nurses, pharmacists and doctors.

Patient and public education - three manifesto groups identified the need to improve patient education about their health, as well as the role of family medicine (Success, Pathfinders, and Jerusalem). This could be done, for example, by use of media to increase public understanding such as radio broadcast. Similarly, focus group participants suggested the use of brochures and other information sources to promote patient education.

Expanding the role and profile of family medicine - two manifesto groups mentioned the need to raise the awareness and understanding of the importance of family medicine, both with patients and colleagues in other healthcare centres and the Ministry of Health (Layla) (Jerusalem). In addition, these groups discussed the need to expand the powers of family doctors to provide more treatment, to be able to order investigations and to act as gatekeepers for healthcare in Palestine (Layla) (Jerusalem). Evaluation and dissemination of the work of family medicine in Palestine, especially to the Ministry of Health would further this goal (Jerusalem). This is further consolidated by responses in the focus groups, with one participant stating that 'doctors should be given authority in applying FM concepts'.

Focus on the consultation & the patient-doctor relationship - the manifesto groups highlighted different factors that could improve the consultation and doctor-patient relationships, in addition to the need for resources mentioned above. One group discussed the need for a patient relationship based on respect, kindness and education (Layla), while another identified the need for 'empathy driven change' (Success). Pathfinders discussed limiting the number of companions within a consultation room, and managing waiting lists better through a ticketing system.

Further development of FM training - in the focus groups participants mentioned that there should be further improvement of postgraduate training in FM and the inclusion of FM into undergraduate curricula. Two manifesto groups identified postgraduate professional development strategies to improve family medicine, including further personal education (Success), more continuing professional development/ courses; and improved residency programs and mentoring (Jerusalem). Success group added that opportunities for international medical exchanges would improve their knowledge.

Improved information systems- some manifesto groups mentioned the need for a computerised appointment system and referral systems (Success, Pathfinders), whereas Success group also stated the need for improved monitoring systems of patient health.

Greater communication with other clinicians- lastly, two manifesto groups proposed the need for improved communication with other specialists (Pathfinders, Success).

Additional perceived benefits

In addition to the empowerment and the development of leadership skills, the course participants experienced a number of additional learning benefits.

Favourable reception – the results of the evaluation suggests that the course was, in general, received favourably by participants. In the British Council questionnaire, the large majority felt that the event had met their expectations, that they had learnt something, and that the course was of high quality. Participants reflected that they were grateful for the experience, would like to attend it again in future and would be likely to recommend this course to others. The British Council questionnaire, which was administered independently of the course organisers, adds further reliability to these results. The participants also stated in the focus groups that they been excited by the course throughout. In addition, two participants on the course returned despite having left earlier in the week for a number of reasons, which was perceived as a positive indication of their engagement.

Most aspects enjoyable – participants felt positively about most components of the course, especially the variety of learning methods utilised. In the focus groups, the participants stated that the group work, role playing and mind maps were excellent as a learning method. Similarly, participants rated all the learning methods highly in the survey, most highly rating small group work and role plays, which appeared to be a new experience for many of the participants. This is consolidated by participants' body language in the photos, which demonstrates a particular enthusiasm for these components.

Particular benefits – in the survey, participants highly rated particularly the learning themes of the 'Patient-doctor relationship and consultation skills', with some participants adding in the free text that they anticipated the course would improve their doctor-patient relationships. However, participants noted in the focus groups and free text that structural issues such as large patient load would continue to be a barrier to effective consultations.

Creation of a FM community – in the focus group, some participants described the unity of the course members, and the recognition of their role together in supporting the future of Palestinian primary care. In addition participants demonstrated in the photographs displayed here and elsewhere that they had a strong affinity for the group, in particular during the manifesto presentation and role plays. In the surveys the course participants discussed that they were grateful and felt close to their fellow course participants and facilitators, with one stating that they could 'really see' the notion of the first cohort forming a community of 'fathers and mothers' of FM in Palestine.

Expectations and relevance

The relevance of the course was a central consideration during the course design process.

Less positively rated - the post-course rating in this evaluation suggests there may be scope for further improvement of its relevance. The relevance was rated positively although relatively less so than other components, suggesting a need for further matching of the course goals to the participants' expectations. These include the topics mentioned in the survey free text such as a greater clinical focus including the management of chronic disease. In the focus groups, the participants stated that they expected a focus on clinical topics, and less on the organisation of primary care.

Further consultation on this issue with the course participants may be helpful to clarify whether and how to prioritise relevance in future, particularly drawing on the phase two of this evaluation in terms of participants' perceptions of relevance in retrospect, and how participants were able to implement their learning experiences in practice.

Transformation - contrastingly, participants underwent a change in their expectations of the course, which may represent transformation into their identity as leaders. Despite initial expectations of didactic clinical teaching, participants stated in the focus group that they recognised the importance of the focus on primary care organisation, and gained a strong preference for small group work and brainstorming. This may represent increased self awareness and leadership, aligned with the practitioner development learning objective.

Scope for improvement

Language barriers – language barriers clearly presented a challenge for some participants and this could be addressed by the provision of reading material in Arabic or simpler English, or ensuring a high proficiency of English in the participant recruitment, although this seems contrary to the inclusive aims of the course.

Preparatory material– reading material was less popular than other components. There may be issues with written language or, based on discussion with course organisers, the volume of content provided.

Domestic violence – the focus on domestic violence in the Inter-sectoral theme was the only aspect to be perceived negatively, and the presentation by the Juzoor NGO was deemed particularly inappropriate and conflicting. This is consistent between the quantitative data, the survey free text and focus group responses. It may be that the specifics of that presentation were inappropriate for the course or that the theme in general may have been perceived as outside of their remit. There is some tension between the theme of intersectoral work and the content of domestic violence, which appeared to be controversial and uncomfortable. This may relate to the difficulty of discussing such issues, and wider gender and social norms in Palestine that may differ to the UK. A different approach may be perceived as more useful, such as using an alternative format in the presentation, a different NGO or use of British-based case studies, for example. Further consultation would help clarify this issue.

Accommodation – there were problems with the accommodation being away from the homes of some of the participants, as two of the doctors felt that they would be unable to stay. This problem may be more likely to affect female participants and therefore consultation in advance of the next course may help to identify more appropriate options so that the course does not bias against the participation of women.

Methodological limitations of the evaluation

Limited scope – no attempt was undertaken to evaluate the IDFMP or An-Najah faculty members' perceptions of the course formally, although there were many informal discussions between IDFMP faculty members as to how they perceived the reactions of participants and where they felt improvements may be needed in future. This also means there was limited scope for triangulation between data. At this stage, the evaluation focused on participants' immediate perceptions about the course organization, learning methods and their learning

gains in terms of the relevance and transferability to their work context. No attempt was made to evaluate their knowledge and skills before and after the course.

Contamination and misunderstanding – there was clearly some contamination of responses in the post-course questionnaire. In four of the submitted questionnaires the free text boxes were identical or almost identical, whereas the item ratings differed, as did the time that the questionnaire was submitted. We interpreted that this was likely due to participants helping each other, noting that many lacked confidence in written English, rather than due to direct copying. Therefore, we decided to include the ratings but not duplicate the free text in the qualitative analysis. We perceived that this had likely reduced the depth of the results. Language barriers may have led to other misinterpretations, including the selection of 'not applicable'. For example, some participants rated the question on the benefits of the inter-sectoral theme as 'not applicable', when they appear to have meant that the benefits were 'low', judging by other responses in the free text.

Technical faults – there were other technical faults with the post-course questionnaire, which was not validated beforehand. For example, there were some questions missing N/A options, and particular confusion surrounding the wording of the question 'what should the course be improved?'.

Positive bias – there was a presence of acquiescence bias in the post-course questionnaires, where participants had a tendency towards responding positively. For example, the question about the OSCE session remained in the questionnaire, despite the session not taking place due to time constraints. The appropriate answer for this question would have been 'not applicable'; however, some respondents gave positive ratings. This may have been a misinterpretation, and suggests a bias towards positive responses, and that the relative number of positive responses may be more useful than the absolute number.

Need for validation – the questionnaire may benefit from further refinement and validation. There were some problems with wording and a bias towards positive responses. The questionnaire could be developed to further discriminate between the components of the course. For example, participants could be asked more about their own goals before and after or more questions could be balanced by negative framing of the questions.

Superficial focus group analysis – the analysis of focus group data was relatively superficial, perhaps due to the lack of probing and exploration of the questions and issues that arose during the discussions, or to the analysis procedure itself. The translation from Arabic into English may also have played a role.

The evaluation itself – this evaluation is a self-evaluation that was performed and supervised by members of the faculty itself, and is therefore open to positive bias. The results from the British Council questionnaire adds value in that it was independently administered and analysed; and the results complement the questionnaire tailored to the course.

Interim conclusions and recommendations

This phase one evaluation of the IDFMP short course aimed to answer the questions below:

- To what extent did participants demonstrate evidence of leadership transformation and empowerment?

- What were the immediate effects of the course on participants in terms of their perceived learning benefits?
- To what degree was the course relevant to the Palestinian FM context?
- What can be improved for the future?

Leadership and empowerment

- **Demonstration of empowerment and leadership** - course participants demonstrated that they felt more empowered with greater belief in their ideas about family medicine, and effectively brainstormed problems and solutions within Palestinian primary care. Participants also demonstrated leadership as they identified challenges and solutions in primary care, including the need for better resource management, expanded profile of family doctors, and further educational opportunities.
- **Ongoing support required** – this course will need to be followed up in order to meet its aims to support family medicine practitioners. The wider IDFMP initiative aims to support family medicine practitioners and health planners to develop those solutions further, through mentorship, additional educational opportunities and exchange.

Learning benefits

- **Positive perceived benefits** – the IDFMP course aimed to provide a space for the exchange of knowledge, and ongoing support for the establishment of family medicine in Palestine. The results of this report provide strong evidence that this course had a positive impact, providing participants with hope and empowerment. Therefore the course has met many of its aims and provides a good foundation upon which to base future courses and other initiatives.

- **Favoured components** – particularly positive elements included the patient-doctor relationship theme, as well as the use of creative methods such as brainstorming and the manifestos. Course delivery methods such as small group work, role plays and the manifesto were also well received.

Relevance

- **Scope for improved relevance** – the relevance of the course was rated less highly than other components. The reasons for this remain unclear, although there is some indication that they may be due to an expectation of a greater clinical focus and more management of chronic disease. Further assessment of the needs for the curriculum may help to improve the relevance, and additional consultation on the course goals could take place with primary care trainees or practitioners in Palestine. Alternatively, past course participants could be employed to help facilitate the design or delivery of the course.

Scope for improvement

- **Course factors**– areas for improvement included the domestic violence session within the inter-sectoral theme, which was received badly and needs to be redeveloped. In addition, the preparatory and reading material was highlighted as problematic, particularly given the language barriers. The content, format and volume of the reading material may therefore benefit from review.

- **Accommodation, gender equity and participation**– the constraints on the female doctors' participation in the context of accommodation for the course may require further consideration in future design in order to minimise the possibility of gender inequity and blindness.

Evaluation next steps

- **Evaluation tools improvement** – the quantitative tools used for evaluation would benefit from some changes, such as further clarifying some questions that posed challenges presented here, and measures to get a more balanced perspective of the course, such as using a mix of negative and positive framed questions. In addition, for the qualitative analysis, the evaluation of focus groups would be improved by deeper probing into issues as they emerged. This requires the support of focus group facilitators or the use of more experienced facilitators, which we hope to address in the phase two evaluation.

- **Further evaluation required** – the purpose of this report was to evaluate the short term effect, the successes and limitations of the course. This evaluation needs to be extended to examine the translation of what was learned on the course into the participant's working practice context and the wider context of the IDFMP initiative. This may take the form of a follow up questionnaire designed at six months by the faculty, adapted from the questionnaire presented here. In addition, an evaluation of the An Najah and IDFMP faculty's perception of the course may also be valuable, perhaps in a creative/artistic form as suggested by some faculty members. This may also be consolidated by in-depth qualitative discussion using the same facilitators or, if funding permits, using locally-based professional focus group evaluators in conjunction with Marlene Laeubli, an independent evaluation specialist who has already been consulted on the evaluation of the initiative. This self-evaluation of the course will be further consolidated by a wider, independent evaluation in the future of the IDFMP initiative as a whole.

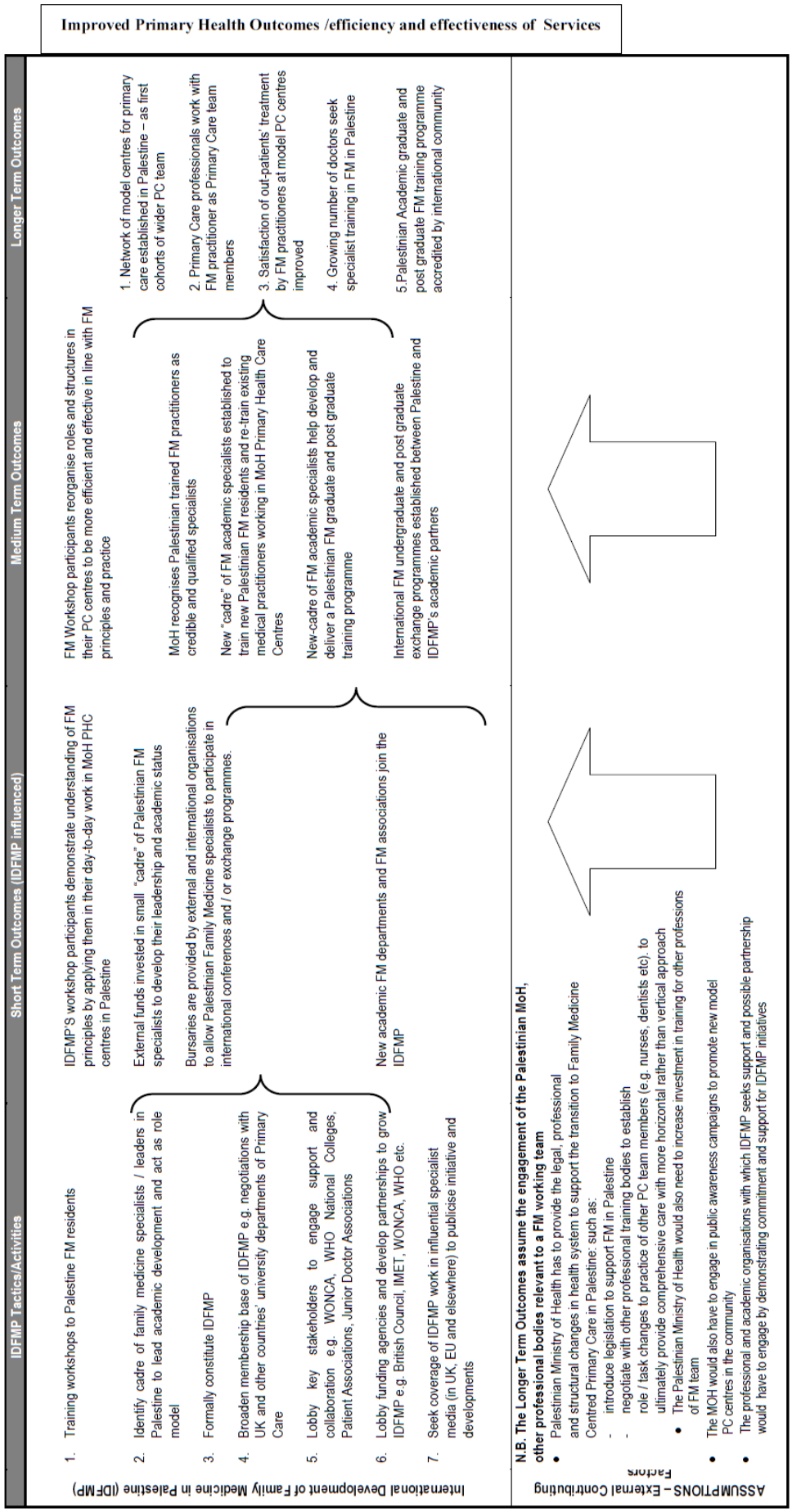
Summary

The results displayed here from various evaluative methodologies suggest that the participants demonstrated leadership skills, felt empowered and perceived a wide variety of benefits in the short term. The goal of transformative change in course participants has been demonstrated by effective identification of the problems faced by primary care in Palestine and strategies to overcome them. There was, however, some mismatch between the expectations of the participants and the course itself, which needs to be addressed in future development of the course and the IDFMP programme as a whole. Alternatively this may be an inevitable discord in the participants' move towards medical leadership that combine systemic as well as clinical challenges. This evaluation suggests that the IDFMP course forms a valuable contribution to the future of family medicine and population health in Palestine. Future opportunities for development may include mentorship, academic exchange, further educational opportunities and trainer-to-trainer development.

Appendices

1. IDFMP framework for change (intervention logic)
2. Manifestos for the mothers and fathers of family medicine in Palestine
3. IDFMP post course questionnaire (as seen by participants on Lumos!)
4. British Council post course questionnaire
5. Focus group guidelines for moderators
6. Contents of flip charts from brainstorming sessions

1. IDFMP framework for change (intervention logic)



2. Manifestos for the mothers and fathers of family medicine in Palestine

The results of the manifestos to date are summarised in the section below in the form of a manifesto for each group, and it is anticipated that this will be an evolutionary process with participants continually building on them.

Manifesto: Success group

Group members

Ahmed (optimist), Israa (sensitive), Naser (happy), Ali (thinker), Samer (friendly), Paul, (active - Tigger).

Background

We note that Primary care in Palestine faces a number of problems, including lack of doctors and other staff, medical equipment or enough clinics to manage a large number of patients. In addition there is a lack of medical records or health monitoring at a local or national level and patients do not understand their own health and the role of the family doctor.

Solutions

We believe in our ability to make a positive impact based on deep empathy and understanding people's needs and motivations. Firstly, we want to improve patient education, ensure that patients may see their own unique doctors at appointments and to instigate an appointment system and monitoring of clinics. Lastly, we want to develop better ways to find funders.

Goals

- To learn more about family practice
- To learn methods of patient education
- To find ways to build public understanding of family practice
- To develop opportunities for international experience for Palestinian family doctors

Manifesto: Layla group

Group members

Mohammed (quick), Haitham (happy), Khaled (quiet), Waleed (smart), Gene (committed)

Background

We identified the following problems in primary healthcare centres that we may be able to address. Firstly, the amount of time is short to see many patients. There is also limited understanding of family doctors by colleagues, patients and the ministry of health. Finally, the role of family doctor is limited whilst the expectation is unrealistic and inappropriate. In addition, there is a lack of clear policy over prescription, and a perceived competition with pharmacists who provide certain over the counter medicines, also leading to overprescription of drugs including antibiotics.

Solutions

The solutions we identified include more meetings and conferences with specialists and other medical centres, and to improve their understanding of the role of family medicine in the community. Also we believe that the role and rights of family doctors should be expanded to provide investigations, more treatment and to act as gatekeepers for healthcare. We believe in the need for a patient relationship based on mutual respect, kindness and being helpful, and for more patient education and time in consultations. Patient education of the role of the family doctor may take the form of posters, leaflets, TV and radio programmes.

Goals

- To improve public understanding and our own understanding of family practice
- To raise awareness about the role of family doctors
- To articulate the rights and duties of patients and doctors

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Manifesto: Pathfinders group

Group members

Ashraf (stubborn), Nawal (quiet), Mohammed Raba (The leader), Abed Al Gani (honest), Munjed (reflective), Harris (geek) and David (argumentative/ questioning).

Background

We discussed that there are too many patients for each clinic, meaning that doctors have a short consultation, a stressful environment and develop a poor relationship with their patients. This also leads to difficulties in maintaining confidentiality, lack of medical supplies and many referrals to specialists. This is made worse by poverty, many relatives accompanying visits and poor general health education. The primary care system must deliver universal care without having sufficient resources to do so.

Solutions

Our solutions were focussed around measures to improve communication systems and to streamline management and address resources. We proposed improving communication between primary healthcare and hospitals, and in addition implementing a computerised patient registration system that could incorporate referrals, monitoring of prescriptions, and patient feedback. Also, to streamline waiting lists, we proposed patients having long term prescription cards. In addition, we discussed giving out numbers to people in waiting rooms and limiting the number of companions to one. Finally we proposed keeping doctors attached to specific clinics, increasing the number of doctors per clinic and improving the insurance system.

Goals

- To improve our communication skills and time management.

Manifesto: Jerusalem group

Group members

Ismail (sad), Rami (adventurous), Suha (active), Hatem (hospitable), Adnan (wise man), Ann Louise (loyal)

Background

We discussed that some of the problems facing primary healthcare are the short length of consultations and high volume of patients, limited to prescription of pharmaceuticals, with family doctors needing to develop the scope of their responsibilities, and expand their skills.

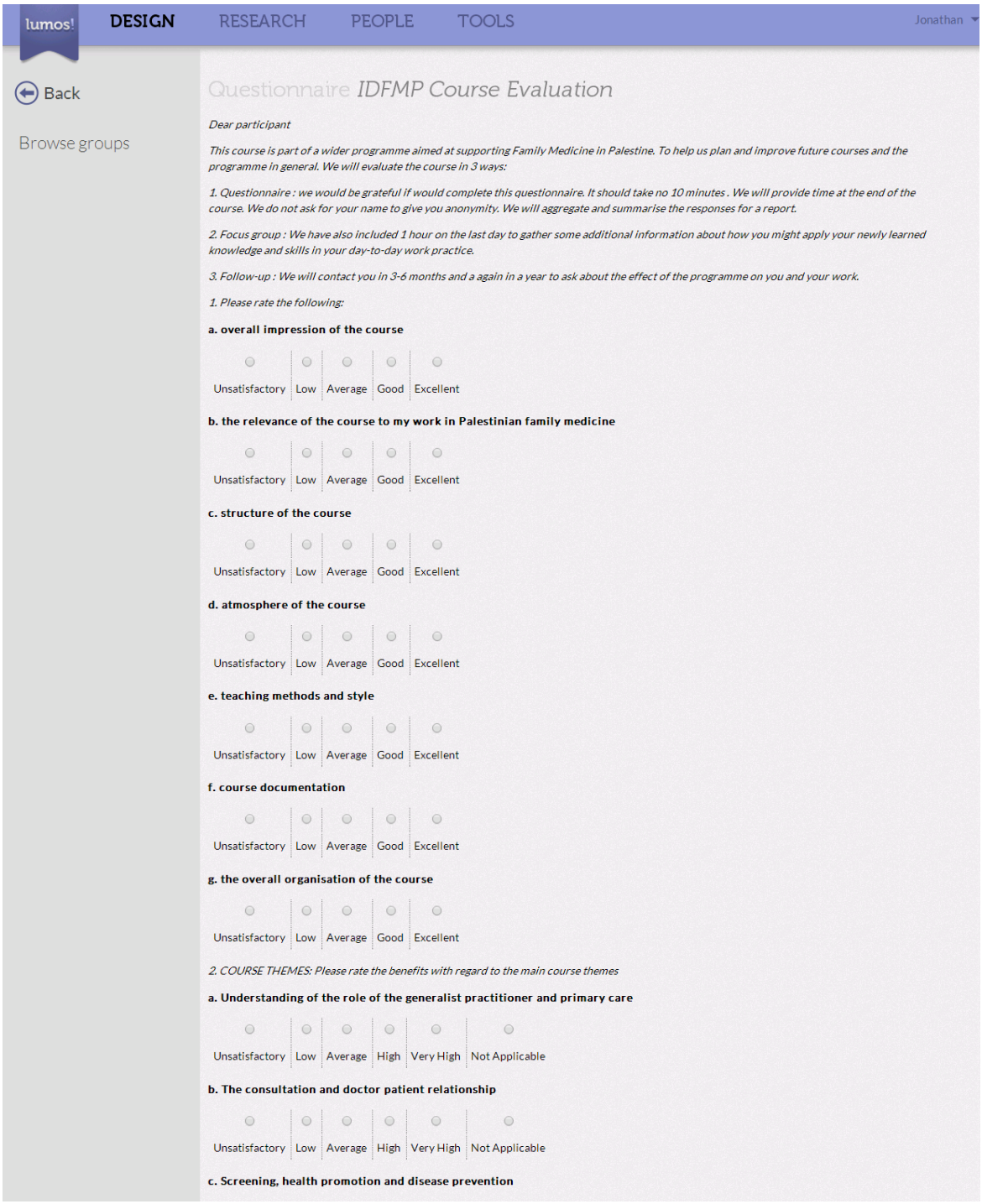
Solutions

We proposed decreasing patient load through increasing the number of primary healthcare centres, the use of nurses and pharmacists to provide some medicine, effective triage and having a specific day allocated to management of chronic illness. We also proposed increasing the availability of medicines, and disseminating a good culture of patient education. To improve the quality of family doctors, we suggest the attendance of international workshops and other continuing personal development opportunities, improving the training programs for residents, residents having regular meetings and evaluation with mentors and evaluation and generally improving teamwork. To expand the powers of family doctors, we stated the need to get the support of the Ministry of Health and greater awareness about the role of family medicine in the public. This could be achieved through evaluation and dissemination of our work. Lastly we proposed the use of media to provide public education about health and family medicine.

Goals

- To educate ourselves further about primary care
- To improve the management of the consultation

3. IDFMP post course questionnaire (as seen by participants on Lumos!)



lumos! DESIGN RESEARCH PEOPLE TOOLS Jonathan

Back

Browse groups

Questionnaire *IDFMP Course Evaluation*

Dear participant

This course is part of a wider programme aimed at supporting Family Medicine in Palestine. To help us plan and improve future courses and the programme in general. We will evaluate the course in 3 ways:

1. Questionnaire : we would be grateful if would complete this questionnaire. It should take no 10 minutes . We will provide time at the end of the course. We do not ask for your name to give you anonymity. We will aggregate and summarise the responses for a report.

2. Focus group : We have also included 1 hour on the last day to gather some additional information about how you might apply your newly learned knowledge and skills in your day-to-day work practice.

3. Follow-up : We will contact you in 3-6 months and a again in a year to ask about the effect of the programme on you and your work.

1. Please rate the following:

a. overall impression of the course

Unsatisfactory | Low | Average | Good | Excellent

b. the relevance of the course to my work in Palestinian family medicine

Unsatisfactory | Low | Average | Good | Excellent

c. structure of the course

Unsatisfactory | Low | Average | Good | Excellent

d. atmosphere of the course

Unsatisfactory | Low | Average | Good | Excellent

e. teaching methods and style

Unsatisfactory | Low | Average | Good | Excellent

f. course documentation

Unsatisfactory | Low | Average | Good | Excellent

g. the overall organisation of the course

Unsatisfactory | Low | Average | Good | Excellent

2. COURSE THEMES: Please rate the benefits with regard to the main course themes

a. Understanding of the role of the generalist practitioner and primary care

Unsatisfactory | Low | Average | High | Very High | Not Applicable

b. The consultation and doctor patient relationship

Unsatisfactory | Low | Average | High | Very High | Not Applicable

c. Screening, health promotion and disease prevention

Unsatisfactory | Low | Average | High | Very High | Not Applicable

d. Inter-sectoral work (example domestic violence)

Unsatisfactory | Low | Average | High | Very High | Not Applicable

e. My professional development and the assessment of family practitioner capabilities

Unsatisfactory | Low | Average | High | Very High | Not Applicable

3. Please rare the teaching methods and course activities

a. Preparatory reading materials

Unsatisfactory | Low | Average | High | Very High

b. Discussion in small groups

Unsatisfactory | Low | Average | High | Very High

c. Role play – consultations skills

Unsatisfactory | Low | Average | High | Very High

d. Preparing the Manifesto

Unsatisfactory | Low | Average | High | Very High

e. Presenting the manifesto

Unsatisfactory | Low | Average | High | Very High | Not Applicable

f. Designing an OSCE station

Unsatisfactory | Low | Average | High | Very High | Not Applicable

4. What was the BEST aspect of the course for you?

5. What should the course be improved?

6.What should be removed or omitted?

7. What was the most unexpected or novel part of the course?

8. Would you recommend this course to your work colleagues and other family practitioners?

Not at all | Probably not | Maybe | Yes | Yes, absolutely

9. Your own goals : please list the goals you set on the first day

Indicate whether you have achieved these goals:

Not at all	Probably not	Maybe	Yes	Yes, absolutely
○	○	○	○	○

Affirmation: What positive things did you learn about yourself during this course:

Ideas for change: What ONE thing will you change in your practice or yourself as a result of this course:

COMMENTS: Please write a brief note about your thoughts and reflections about this course ... Imagine you are writing a postcard to a good friend:

Thank you!

4. British Council post course questionnaire

1. This event met my expectations

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

2. I have acquired new knowledge/ or skills through this event/activity

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

3. Overall this was a high quality event

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

4. How likely are you to recommend the British Council to a colleague or a friend?

0 1 2 3 4 5 6 7 8 9 10

5. Focus group guidelines for moderators

International Development of Family Medicine in Palestine Programme

Post Course Evaluation

MODERATOR NOTES and PROPOSED GUIDELINES FOR FOCUS GROUP DISCUSSION

On Sunday, November 17th at the beginning of the course:

It would be helpful if the UK Course Facilitators (or Marlène) could inform residents that there will be a course evaluation. It will take place on Thursday 21st November at lunchtime and will consist of a written, anonymised questionnaire and their participation in focus group discussions, which is being organised by the course evaluation team. All information provided by the residents will be treated in complete confidence.

The post-course evaluation is important for three reasons:

1) to obtain immediate feedback on the course content, structure and delivery to help improve future courses
2) to help understand how relevant and / or readily the knowledge and skills gained through the course can be applied to their work situation
3) to help guide the IDFMP planners in developing other activities aimed at establishing family medicine in Palestine

On Thursday 21 November – Post-course Questionnaire – to be completed individually by each course participant and handed to evaluation team member (15 minutes maximum)

Focus Group Discussion (FGD) –
Background information:

- There should be no more than 10 participants per focus group. Since there are 19 participant residents, there will need to be 2 Focus Groups
- Focus Group language should be Arabic
- There should be 2 persons leading each of the 2 Focus Groups – 1 moderator and 1 observer / note taker /recorder
- MPH students will be asked to lead the 2 FGDs. Dr Zaher will be recruiting students and, during the week, Marlène will hold a workshop to help prepare them for the task.
- The sessions should be recorded, but not necessarily transcribed afterwards. Rather, a summary of the main points, insightful and/or unexpected comments, agreements and disagreements etc. can be written up as soon as possible after the FGD and after frequently listening and "coding" from the recordings to ensure that all key information has been included in the summary.
- It is absolutely essential that the identity of any person taking part in the FGD cannot be recognised in the summary. Direct quotes should be used as much as possible to illustrate a point, but not if it would identify the source of information.
- It would be best if participants could be seated in a circle rather than at desks or in a lecture hall. The idea is to make people feel at ease and not restrained by a formal setting. Room should be well ventilated, well lit and not cramped. The essential objective is to make people feel comfortable so that they can be easily engaged in discussion.

The main aim is for participants to share their thoughts and ideas about the course and, through group discussion, to generate more information than would possibly happen in a 1-1 interview.

See next page for guidelines on questions to be asked to stimulate discussion and draw out information for IDFMP planners

Focus Group Guide / Script

At the beginning of the Focus Groups – introduction (5 minutes)
The FCD moderator and note taker should introduce themselves and explain the purpose and use of the exercise as follows:

- to help understand how relevant the knowledge and skills they gained through the course is to their work context and how readily can they be applied
- that the information gained through the discussion will be used by the IDFMP project planners to further develop the course and other similar activities
- that participants can be assured of total confidentiality of information - that all information gained through the discussion will be written up in summary form and in such a way that the identity of any particular person will not be recognisable

The following should be used as Guidelines, not to be read as a questionnaire – prompting questions should be used throughout to be clear what is meant – for example "can you give me an example, how would that be, why is that so, who, how, etc." Also, at the end of each phase, try to summarise by saying, "so, in short, what I have understood is xxxxxxxx", is that correct?" Then move on to next phase:

1st phase - Warm up to put people at ease (10 minutes)

- So, what are your general reactions to the course?
- What aspects did you enjoy the most? (People will generally include aspects they didn't enjoy too, but if not, you can ask them)

2nd phase – Focussing on new learning (20 mins)

- What new skills or knowledge do you feel you gained from the course?
- What aspects were **particularly relevant to your current work** situation?
- Is there any **aspect that you feel was LESS relevant to your current** work situation?
- Is there anything that you learned through the course that you feel would be **more difficult to apply in your current** work situation?

3rd phase – Focussing on challenges in applying new knowledge / skills – prompt to understand possible challenges in work context, personal abilities, work colleagues, resources etc. and how they might be able to turn these challenges into new opportunities for improvement (20 mins)

- What challenges do you foresee in applying the knowledge and skills learned through the course?
- **What would help** overcome these challenges?
- What **could you do to overcome** these challenges?

- With your new skills / knowledge, **what changes in the way you practice family medicine now would you expect of yourselves in 6 months time?**

4th Phase – Wrap up – thank everyone, tell them what will happen next – (5 mins)

Moderator should repeat the main aim; that is that IDFMP planners will use the information to help develop the course and other family medicine initiatives but that their confidentiality is absolutely assured.

Suggest that they may have copy of the Discussion summary to review before its being given to the IDFMP planners.

Tell them that it is likely that we shall be back in contact with them in 6 months time to find out how they have been able to use their new skills and knowledge at work

6. Contents of flip charts from brainstorming sessions

Difficult stuff - things that we find challenging in the consultation

All the issues that lead to a feeling of being overwhelmed, and shows a need to prioritise and negotiate with patients

· Dr-patient conflict
· Breaking bad news
· Sexual matters
· Referral to psychiatrists
· Cancer
· Diabetes
· Disabled children
· Death, especially sudden death.
· Unexpected pelvic mass
· Cultural conflict
· Suicide
· Violence, against women, children (& sometimes men)
· Neurological illness
· Hopeless prognosis

2. Our course for generalist doctors (what IDFMP participants would include in a training programme)

· Evidence of appropriate consultation skills
· Understand evidence based medicine
· Working in a team
· Skills for lifelong learning (CPD)
· Understand principles of rational prescribing
· How to listen to patients & improve Dr. /patient relationship
· With trust & security
· Show respect and treat patients as equal
· Understand place in the system of health care, and how to work with family
Medicine specialists
· Show leadership
· Making changes in the system
· Advocacy
· Understand community health
· How family medicine functions within the community
· Where the patient exists in the community
· IT skills
· Record keeping
· Data collection
· Informatics
· Demonstrate the importance of continuity
· Medical ethics
· Practise ethically & legally
· How to share patient information with others
· Apply rules of family medicine to improve practice
· Understand the importance of prevention and health education.

3. Why should we assess doctors?

For all
· Improve health
· Improve care overall
· Improve relationships between all sectors

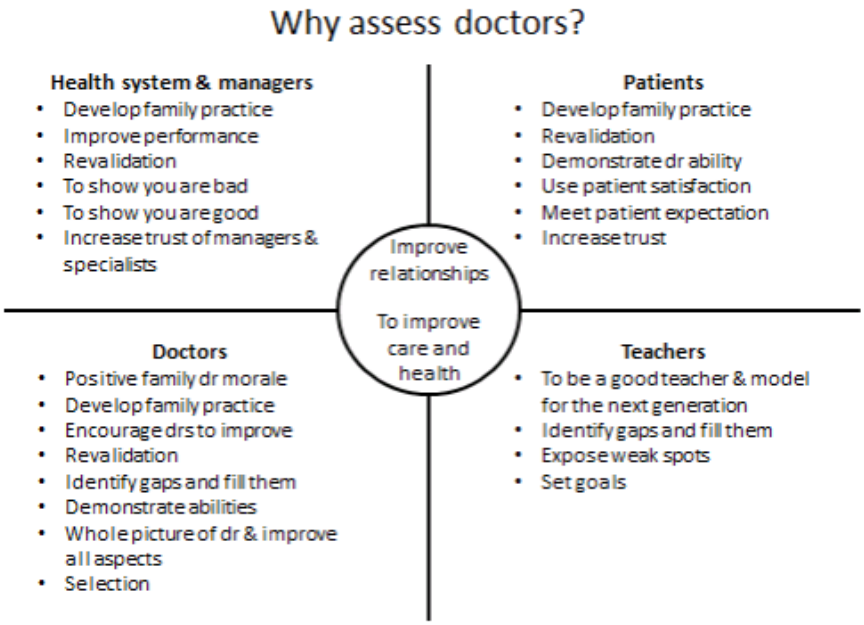
For health system managers
· Develop family medicine
· Improve performance
· For revalidation
· To show if Drs are good or bad
· Improve trust of managers and specialist doctors

For patients
· Develop family medicine
· Revalidation
· Demonstrate doctors' ability
· Improve (use?) patient satisfaction
· Meet patient expectations
· Increase trust in family medicine specialists.

For doctors
· Develop family medicine
· Positive feedback – improve doctors' morale
· Encourage doctors to improve performance
· Revalidation
· Identify gaps and fill them
· Demonstrate abilities
· Whole picture of doctors
· Improve all aspects
· Identify weak spots
· Selection

For teachers
· Identify gaps & fill them.
· To be a good teacher & model for the next generation
· Identify weak spots
· Expose gaps
· Set goals

Arranged as a diagram it comes out like this:



What is a good test (assessment)? *Remember the fundamental problem that validity is often inversely relate to reliability*
Test should measure what we want to test – validity
Testing should be comprehensive
Reflect 'real' performance – use simulation
Focus on what happens in the clinic & consultation
Examine doctors' reasoning and decision making
Health outcomes? Audit
Robust/standardised/reliable & repeatable
Knowledge is the foundation – what the house is built on
? Essays
? MCQ
True/false answers
Short/clear
? Random??? Not reliable
Viva/interview
Case based
MCQ to test performance - ?give MCQ to patients
Supervisors' reports

4. What to assess

Performance
Clinical method
Decision making
Clinical outcomes
Behaviour, relationships & communication with colleagues &
Patients
Knowledge
The map
Cost effective
Evidence based
Skill
Physical examination
Procedures
Teaching: patients & other health professionals
Character
Attitude
Professional
Self-confidence
Probity – not corrupt & can be trusted

Punctuality

Rules Skills for Small group learning

5. Feedback in role play
· First ask the 'doctor' how the consultation went
· (to test his or her degree of insight)
· What I want from feedback
· What I did well
· How to improve, making suggestions that are concrete – i.e. give examples
· Specific
· Timely
· Self evaluation

6. Rules for brainstorming
· No discussion now
· All new ideas valued – however wild
· Build on the ideas of others
· Stay focused on the topic
· Only one to talk at a time
· Be visual – use pictures & diagrams
· Quantity – the more the better

7. Timetable for the IDFMP course

	Day 1 Sunday 17	Day 2 Monday 18	Day 3 Tuesday 19	Day 4 Wednesday 20	Day 5 Thursday 21
0815	University President office	Breakfast and faculty meeting	Breakfast and faculty meeting	Breakfast & faculty meeting	Lie-in ☺
0900 (09.30 day 1)	**Welcome** (SM) Warm up activity(GF & AB) Ground rules 9.30-11.00 Overview	Group work: review of day 1 9-9.30 **THEME 1 a** 9.30-11.00(PW , ALK, DJ Generalist practice What is the role of the family practitioner? Patient centred practice	Group work : review of day 2 9-9.30 **THEME 2** Community oriented care 9.30-11.00 Screening (ALK, DJ)	Group work: review of day 3 9-9.30 THEME 3 Professional development CPD 9.30-11.00	Group work ***MANIFESTO*** & OSCE Preparation 9.00-11.30
11.00 - 11.30 COFFEE					
	Goal setting Introducing the Portfolio Forming 4 small groups A **Introduce Manifesto task** (HL) 11-11.30	**THEME 1 b** 11.30-12.10 Doctor-patient communication(AB & ALK) (Stewart overview) rules of feedback (using AB video): (PW & AB)	Prevention CVD (GF) / Diabetes (ALK) 11.30- 13.00 (inc. group work)	THEME 3 (AB) Effective assessment 11.30- 13.00	Set up Mock OSCE 11-11.30 OSCE marked by participants • Circuit A 11.45-12.15 • Circuit B 12.15.12.45 Debrief 12.45-13.00
	Presentations (PW& ALK) ***"A day my life (1) " Participants no.1-9)*** ***11.30-13.00***	12.10- 13.00 The consultation: Dealing with presenting problems - agendas/building rapport **Case study 1 in small groups** **Muna feels tired**		Assessment of the clinical consultation (AB)	
13.00 - 14.00 LUNCH					**Short lunch 13.00-13.45**
14.00	Presentations (HL&GF) ***"A day in my life" (2) Participants no.10-20)*** 14.00 - 15.30	**THEME 1 b** 14.00 - 15.30 The consultation : Rapport building and information gathering (AB & HL) Second half of the consultation - agreeing the problem & sharing decision making	**THEME 2** (b) 14.00 - 15.30 Intersectoral work (GF & HL) Domestic Violence & Child safeguarding (GF)	Group work ***MANIFESTO*** *PREPARATION*	**Presentations** 13.45-15.00 ***MANIFESTO*** (Samar - to Invite additional audience) 15.15 Evaluation a. SEQ (on-line) b. Focus groups (ML-L)
15.30-15.45 SHORT COFFEE / TEA					
Finish 17.00/ 17.30	Small Groups: 15.45-17.00 **Intro : Muna's parents** **Faculty role play**	Small groups : 15.45-17.00 **cases study 2 / role play** **Muna is diabetic**	Small groups: 15.45-17.30 **cases study 3/ role play** **(Muna+Aisha-parents fighting**	Small groups : 15.45-17.30 Planning an OSCE stations (Based on Muna & Bashir)	Prize giving & review, planning for CPD **CLOSE 16.30**
	Faculty meetings				