

Programming for Training:

A Resource Package for Trainers, Program Managers, and Supervisors of Reproductive Health and Family Planning Programs

USAID
FROM THE AMERICAN PEOPLE

the ACQUIRE project

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Contents

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[1] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health) is a five-year global cooperative agreement awarded in 2003 by the U.S. Agency for International Development. ACQUIRE is managed by EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA).

Acronyms and Abbreviations

ADRA	Adventist Development and Relief Agency International
CBD	community-based distribution
COPE	client-oriented, provider-efficient
FP	family planning
IUD	intrauterine device
LAPM	long-acting and permanent method [of contraception]
NGO	nongovernmental organization
PAC	postabortion care
RH	reproductive health
SWAA	Society for Women and AIDS in Africa
TCNA	training capacity needs assessment
TNA	training needs assessment
USAID	U.S. Agency for International Development

Chapter 1

Introduction

Programming for Training: A Resource Package for Trainers, Program Managers, and Supervisors of Reproductive Health and Family Planning Programs consists of essential information and tools for training health care providers in reproductive health and family planning (RH/FP). It draws on the training experience of the ACQUIRE Project,[2] as well as that of EngenderHealth and other organizations providing training in RH/FP for improving service delivery.

The package is intended for use by:

1. Program managers and staff implementing RH/FP programs
2. Trainers in RH/FP service delivery

This resource package provides an overall approach to programming for training, as well as information, methods, and tools for designing, developing, planning, implementing, and evaluating training. It also provides tools and information for strengthening training systems.

Training as Part of Service Delivery

Training is an essential component of service delivery; it can close gaps in knowledge, skills, and attitudes of RH/FP providers and can help to increase the availability of services. However, while training is often needed to increase the availability and quality of services, it usually cannot accomplish this alone, nor does training by itself necessarily produce more motivated and active service providers.

The conduct and management of training events within a service delivery program is achieved through a functioning training system, one that can assess training needs, plan and implement training, manage its human resources, monitor and evaluate training, develop and disseminate training standards and guidelines, and design and develop training curricula and materials. A well-functioning training system assists in preparing local, qualified providers on an ongoing and sustainable basis. Programmatically, the training system needs to be understood as part of a larger, more holistic "program" or system that includes key service subsystems (e.g., supervision, management, and referral and logistics systems), which together contribute to the availability of good quality services.

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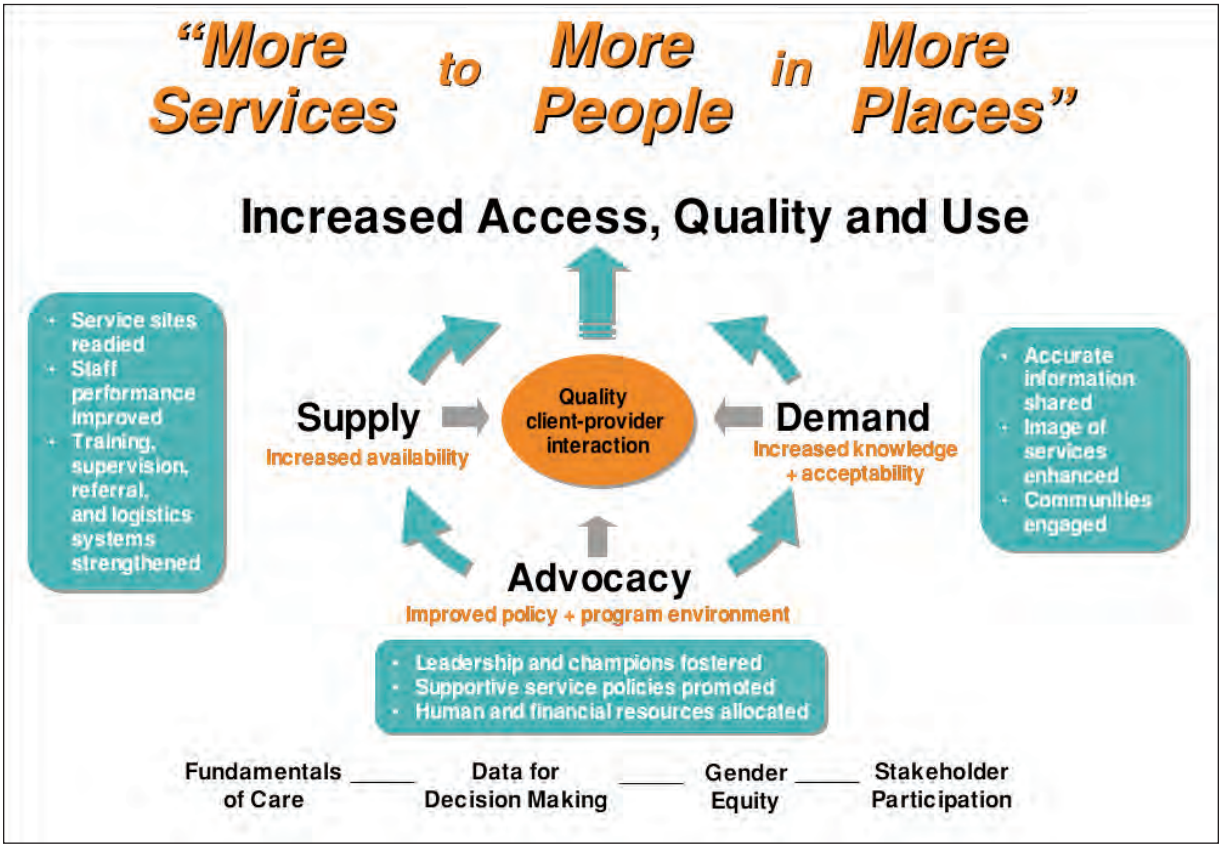
Chapter 1

Chapter 2

ACQUIRE's Program Model for RH/FP Service Delivery

The ACQUIRE Project's Program Model for RH/FP Service Delivery is a useful model for situating training within the larger context of RH/FP programs (and of programming for training). This program model reflects a holistic understanding of the components and dynamics of the health systems that provide RH/FP services and of how their synergistic functioning leads to increased access to and quality and use of RH/FP services. The model applies to RH/FP services in general, as well as specifically to clinical services for such long-acting and permanent methods of contraception (LAPMs) as the intrauterine device (IUD), the hormonal implant, female sterilization, and vasectomy. It is also applicable to national, regional, and district-level RH/FP programs. The model is represented visually in **Figure 1**.

Figure 1. The ACQUIRE Project's Program Model for RH/FP Service Delivery



The service encounter between the client and the provider is at the center of the program model because this is the key event in RH/FP service delivery. A quality client-provider interaction takes place between a knowledgeable, empowered client and a skilled, motivated RH/FP service provider, at an appropriately staffed and well-managed service site,[3] and is enabled by well-functioning supply-side and demand-side program elements operating within a supportive policy and program environment. Such an interaction contributes to improved quality and use of RH/FP services. In the aggregate, constructive client-provider interactions further both the program goal of the ACQUIRE Project and the mission of the health system partners whom it assists: delivering "more (and better) services to more people in more places."

Program Components

The ACQUIRE Program Model emphasizes the importance of supply, demand, and advocacy and holds that a potential synergy among them can be fostered via a coordinated package of mutually reinforcing interventions.

Supply

On the supply side, strengthened service delivery subsystems—training, supervision, logistics, and referral—lead to increased availability of skilled, motivated, well-equipped, and well-supported RH/FP service providers who are more widely deployed within the health system and who perform better. (Other supply-side subsystems—e.g., administrative, financial, and management information systems—must also be in place and functioning, although ACQUIRE usually has not worked on these subsystems.)

Demand

On the demand side, the provision of up-to-date, understandable information via multiple channels of communication—such as interpersonal, community, and mass media—increases the accurate knowledge of clients, potential clients, and communities. Information is provided about specific RH/FP methods and services, including where they can be accessed. When communities are freed of attendant misconceptions and myths, the image of RH/FP methods and services is enhanced, and communities can be further engaged and mobilized to ask more of their health service system. Use of these beneficial RH/FP methods and services becomes the norm, and demand for them is thus increased. Simultaneously, better informed and motivated providers want to help clients meet their RH/FP needs.

Advocacy

Advocacy is an integral part of the ACQUIRE Program Model because the larger sociocultural, economic, and political environment influences the nature and extent of human and financial resources available for RH/FP. In the context of RH/FP service delivery, advocacy entails working: to foster effective leadership for, and championing of, RH/FP at all levels of the health care system, as well as within the community; to promote supportive and rational service policies based on the best available medical and programmatic evidence; and to secure

[3] Service providers may be doctors, midwives, clinical officers, nurses, counselors, peer educators, pharmacists, outreach workers, or community-based distribution (CBD) workers. Service sites may be clinical facilities, health and other outreach posts, pharmacies, or CBD outlets. The ACQUIRE Program Model applies across this range of possible providers and service sites.

greater human and financial resources for RH/FP services (including in-service and preservice training) based on informed estimates of need. The resultant improved policy and program environment is reflected in a better resourced, more productive, higher quality, and more widely supported and sustainable RH/FP program.

Cross-Cutting Elements

Several important cross-cutting programmatic imperatives undergird the ACQUIRE Program Model. These include focusing on the fundamentals of care, using (locally relevant) data for decision making, promoting gender equity, and ensuring widespread stakeholder participation.

The Fundamentals of Care

The fundamentals of care—informed choice, medical safety, and quality improvement—are essential for RH/FP services, especially clinical services. FP clients must be able to exercise their right to make an informed, voluntary choice based on accurate information and a range of contraceptive options, free of provider bias. Methods and services are safe when trained, skilled, and properly equipped providers deliver them according to up-to-date, evidence-based standards, protocols, and guidelines and manage any side effects or complications that may arise. Ongoing quality improvement mechanisms and activities (which rely on local resources and need not be complicated or expensive) ensure the maintenance of quality of and access to RH/FP services over time.

Data for Decision Making

The use of both locally generated and locally applicable international data for decision making in resource allocation, program strategy, design, implementation, and evaluation leads to sounder programs and to greater transparency and ownership. Such data or evidence may result from local needs assessments, quantitative baseline survey data, qualitative consumer research, operations research, forecasting projections and/or other available secondary data, or evidence-based international standards and guidance and best practices and/or models proven effective in other settings.

Gender Equity

Gender equity is a very important aspect of effective RH/FP programming. This entails understanding the ways in which the unequal balance of power between men and women plays out and undertaking activities to overcome the disadvantages and inequalities that women face. Though this may often require women-specific policies and programs, gender equity should not be seen narrowly as a women's issue. It is also important to promote constructive male involvement in RH/FP decision making, services, and programs.

Stakeholder Participation

Widespread stakeholder participation is critical to programmatic success and sustainability. Important stakeholders whose participation in and championship of RH/FP services are needed include political leaders, religious and other opinion leaders, program leaders and managers, the medical community, clinic managers and RH/FP service providers, advocacy groups, community organizations, and individual female and male RH/FP service clients.

Outcomes

The outcome of the efficient and effective functioning of supply, demand, and advocacy is increased access to, quality of, and use of RH/FP services. Access—the degree to which services can be obtained at an effort and cost that is acceptable to and within the means of a majority of the population—is the final common pathway by which supply, demand, and advocacy inputs and activities result in greater quality and use of RH/FP services by more people in more places. Access has a number of dimensions that ACQUIRE helps its partner RH/FP programs to address: cognitive; sociocultural; geographic; financial; and health system–related. Barriers in any of these areas prevent even motivated clients from receiving RH/FP services. Ideally, improvements in access to, quality of, and use of RH/FP services will have a reinforcing dynamic, as satisfaction with and use of such beneficial services becomes a widespread and valued societal norm.

Ultimately, this program model is about effecting change to improve program performance and thus to enable clients to attain better health outcomes. This necessitates changes in the behavior of key stakeholders at multiple levels: donors, policymakers, managers, service providers, supervisors, community members, and clients. The principles and proven practices of fostering and managing behavior change must be factored into the design and implementation of programs if the quality, availability, and use of RH/FP services are to increase and, those higher levels are to be sustained. The history of health care has taught us that change—be it of providers' practices or of communities' behaviors—takes time and sustained effort. Realistic program goals and time frames, coupled with long-term commitment of the resources needed to establish effective programs, are essential to success.

Chapter 3

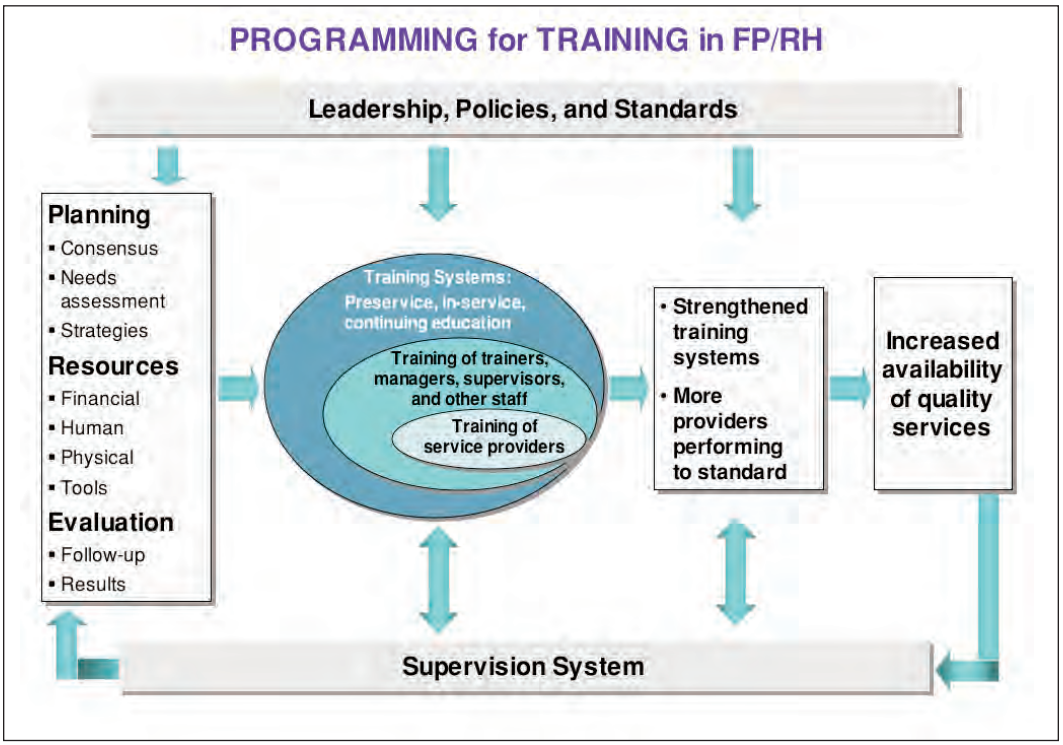
Programming for Training in RH/FP

Introduction

Programming for training is the process of planning, implementation, systems strengthening, and evaluation of training within the larger setting of RH/FP service delivery so as to improve service delivery outcomes. Programming for training reflects a comprehensive and holistic view that considers both the systems in which training and services are provided and the greater social and political environment that influences service delivery.

The ACQUIRE Project's Programming for Training in RH/FP Model, which is presented and discussed below, is a "drill-down" of the training component of the overall ACQUIRE Program Model (see Chapter 2). It also applies both to RH/FP in general, as well as specifically to LAPMs, is applicable to national, regional, and district-level RH/FP programs, and entails a focus on the centrally important fundamentals of care—informed choice, medical safety, and continuous quality improvement. The Programming for Training in RH/FP Model depicts the dynamics of the *inputs* and *activities* that contribute to the desired program *outputs* of stronger training systems and more providers performing to standard, which in turn contribute to achievement of the larger program *outcome* (goal), increased availability of quality RH/FP services.

Figure 2. The ACQUIRE Project's Programing for Training in RH/FP Model



Inputs: Planning, Resources, Evaluation

In this Programming for Training Model, planning consists of three elements:

- **Consensus building** is an ongoing process that engages stakeholders to develop training strategies, take ownership of the program, and commit to its success.
- **Needs assessmen**t confirms that training is the indicated intervention (it may also identify nontraining interventions required to later support the use of skills acquired) and then identifies strengths that can be utilized and/or deficiencies (gaps) to be addressed through appropriate training interventions; it also establishes a baseline against which future progress can be measured.
- **Strategies** based on findings from needs assessments identify priorities and modalities, provide guidance for program implementation, and link to larger service delivery program goals.

Four types of resources are critical for successful implementation of training activities and strengthening of training systems:

1) **Financial resources:** Funding for training needs to be adequate, reliably and regularly available, and well-managed at national, regional, and district levels.
2) **Human resources:** Complements of knowledgeable and skilled trainers, managers, and supervisors need to be adequate in number, well-deployed, and appropriately utilized for desired training activities and outcomes to occur.
3) **Physical resources:** Training venues need to be available and readily accessible, with adequate space, materials, supplies, and equipment for service delivery.
4) **Tools:** Needed tools include evidence-based standards and guidelines, curricula (standardized and regularly updated), job aids, and training plans.

Evaluation is both a program input in the Programming for Training Model as well as a "process" that occurs at every step of the program cycle. As an input, **results** from evaluation inform needs assessments, program design, strategies, activities, and continuous program improvement. As a process, **follow-up evaluation** assesses trainee performance during and after training (i.e., in the workplace). It also measures the extent to which the training event successfully achieved its shorter term and longer term service delivery objectives and results.

Activities: Training Individuals, Strengthening Systems

Three discrete but interrelated elements occupy the three concentric circles in the Programming for Training Model. Two of these elements—**training of service providers** and **training of trainers, managers, supervisors, and other staff**—relate to the type and role of the individual trained. Training of service providers is at the center of the model because they are the direct link between training and improved availability and quality of services. Such training can be provided as part of broader system-strengthening activities or independently, in pursuit of more immediate or shorter term program goals. Trainers, managers, supervisors, and other staff also need to be trained, both to support service providers and to strengthen training systems.

The third element, **training systems**, consists of three "subsystems": **preservice education; in-service training;** and **continuing education**. Together, these three subsystems span the continu-

um from the beginning student to the fully active, experienced RH/FP service delivery provider. Preservice education takes place in professional schools and precedes in-service training, which occurs in the context of RH/FP service delivery programs. Preservice training should endow trainees with the fundamentals of their profession. In-service training and continuing education both focus on currently active providers and may overlap, taking the form of specialized training events at a central location or "on-site" for a specific period or involving apprenticing, coaching, and mentoring over a longer period of time. They may be intended to "refresh" participants' knowledge of existing guidelines, standards, and protocols or to provide new evidence, guidelines, and best practices in service delivery.

Essential components of the three training subsystems that must be in place are: policies, standards, and guidelines; curricula, methodologies, and approaches; institutions and sites; and management and staff. These training subsystems are needed in RH/FP programs to ensure sustainability (i.e., the ongoing resources and technical capacity to provide quality services). Given the nature of its technical assistance provision to RH/FP programs, the ACQUIRE Project has worked primarily (but not solely) in the in-service setting, with much of its focus on training of trainers, for reasons of efficiency and sustainability.

Outputs: More Competent Providers, Stronger Systems

This Programming for Training Model has two outputs: **strengthened training systems** and **more providers performing to standard**. Training systems that have been "strengthened" can plan, manage, implement, and evaluate their training activities on a sustainable basis. They can identify and address emerging training needs and advocate for and secure necessary financial resources for training. A well-functioning training system harmonizes its preservice education and in-service training subsystems with respect to curricula, approaches, policies, and standards, ensuring that these are consistent with and informed by evidence-based best practices for RH/FP training and service delivery. The training system also is supported by, and collaborates closely with, the supervision system. Ideally, the result of this work at the preservice and in-service levels is an increased complement of competent, motivated, well-supported, and well-deployed providers who actively make quality RH/FP services more widely available.

Outcome: Increased Availability of Quality Services

The achievement of the Programming for Training Model's two outputs—strengthened training systems and more providers performing to standard—contributes significantly to the desired program outcome of **increased availability of quality services**. Increased availability of quality services represents the supply side of the Program Model for RH/FP Service Delivery (see Chapter 2), which, together with program advocacy and service demand generation, leads to increased access, quality, and use of RH/FP services.[4]

Overarching Direction: Leadership, Policies and Standards

Leadership, policies, and standards provide overall direction and guidance in this Programming

[4] Training is often necessary to increase the availability of quality services, but it is usually not sufficient by itself to achieve this outcome, nor does increased availability automatically translate into increased access and use. Other important program inputs (e.g., logistics and supervision) are needed to translate the increased availability of competent providers into increased availability (and access and use) of quality services.

for Training Model. Program leaders ideally are also *champions*; they provide the vision, favorably influence the policy environment, and model the commitment to maintaining a robust training system and to making quality RH/FP services available to all who want and need them. Evidence-based, rational, country-specific policies and standards inform both the training and supervision systems, reinforcing the link between RH/FP training and service delivery.

Key, Cross-Cutting Supporting System: Facilitative Supervision

The Programming for Training Model envisions the supervision system as an essential, crosscutting element that operates at all stages of programming for training and largely determines the extent to which training outputs are translated into higher quality and greater availability of RH/FP services. Facilitative supervision (i.e., supervision that provides mentoring, joint problem solving, and open communication with staff) links and reinforces service policies, standards, and approaches that guide the training conducted by the training system. Because supervisors are often also program leaders and managers, the supervision system is an integral means by which feedback from the evaluation and monitoring of service delivery outcomes is used to inform and shape subsequent planning and resource allocation.

Chapter 4

Approach to Training

As used in this Programming for Training Resource Package, **approach to training** refers to the process of creating an environment conducive to learning during and after training, with the aim of creating qualified RH/FP providers who are better prepared and enabled to provide quality services. The approach to training presented here applies adult learning principles, utilizes an experiential learning cycle, is competency-based, applies humanistic training techniques, and is linked to desired performance on the job. (The methods used in following this training approach are presented in Chapter 12: Commonly Used Training Methods.)

Adult Learning Principles

Important adult learning principles are integrated into this approach to training.[5, 6] The application of these adult learning principles fosters opportunities for open discussion, exchange of ideas, willingness to learn from each other, and readiness to apply new knowledge, skills, and attitudes at the earliest possible opportunity after training. The following adult learning principles are integrated into all subsequent chapters of this Programming for Training Resource Package:

- Adults feel valued and respected for the experience and perspective they bring to the training situation.
- Adults learn better when the learning experience is active and engaging.
- Adults prefer a learning experience that is self-directed, where they can take ample responsibility for their actions.
- Adults are more receptive to learning when training builds on what they already know and relates to their job expectations (i.e., when training is "performance-based").
- Adults learn better when the learning is reinforced with a variety of learning activities.
- Adults value learning, and such learning is reinforced when new knowledge and skills can be applied immediately after training in a real-world situation.

Experiential Learning Cycle

Adults learn through a process whereby they analyze their experiences, generalize the lessons learned from those experiences, and apply new knowledge, skills, and attitudes in a structured setting or a real-life situation. This experiential learning is continuous and can be seen as consisting of four stages, all of which need to be addressed during training—experiencing, processing, generalizing, and applying, as shown in Figure 4-1 (page 12).[7]

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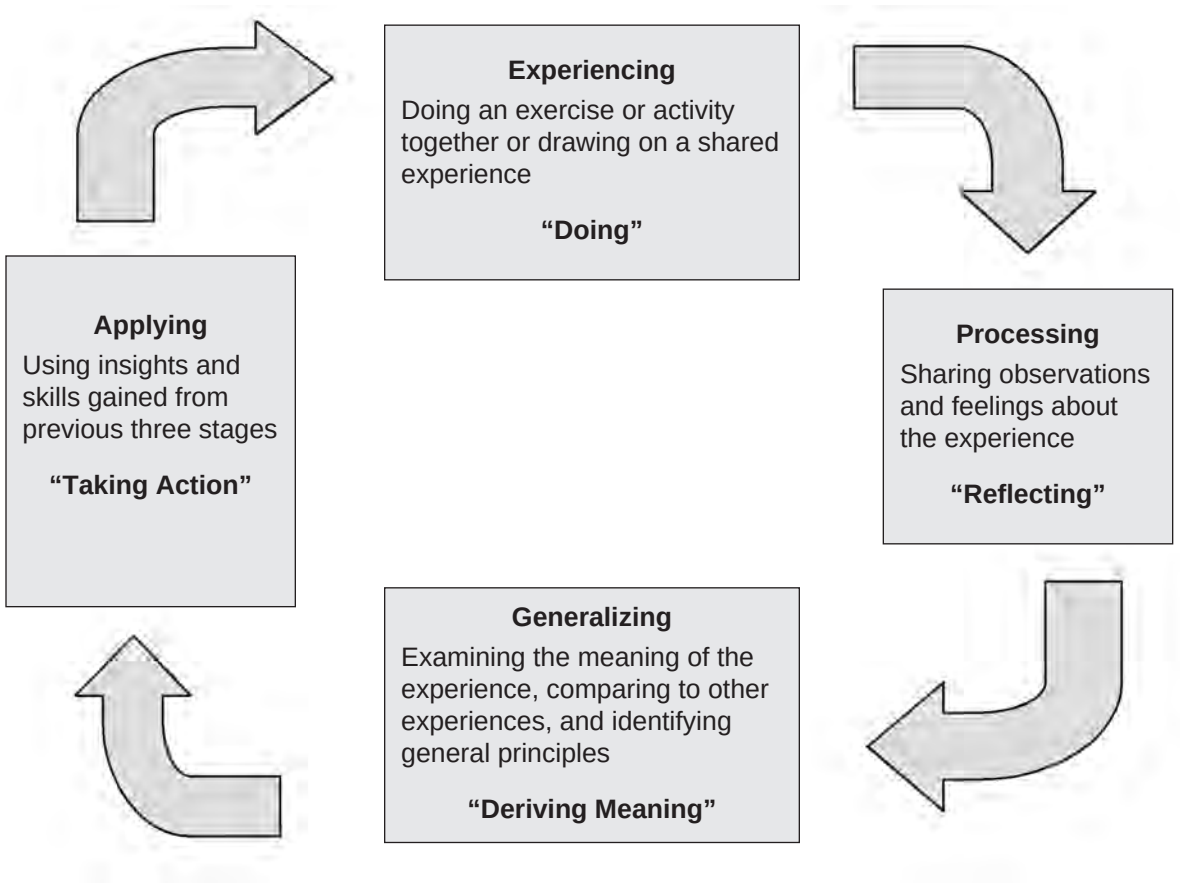
[5] Turner, K., Wegs, C., and Randall-David, B. 2003. *Effective training in reproductive health: Course design and delivery*. Reference Manual. Chapel Hill, NC: IPAS.

[6] Lawson, K. 2006. *The trainer's handbook, 2nd edition*. San Francisco: Pfeiffer.

[7] *Adapted from:* Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

Figure 4-1: Experiential Learning Cycle



Source: Turner, K., Wegs, C., and Randall-David, B. 2003. *Effective training in reproductive health: Course design and delivery*. *Reference manual*. Chapel Hill, NC: IPAS; referred to in Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

Competency-Based Training

Competency-based training aims to train people to perform a given job "competently." *Competency* is defined as *the skill level that a participant is required to demonstrate at the end of training, a skill level that indicates that the participant can provide the services for which she or he has been trained safely and effectively to clients*.

Competency standards specify the required knowledge, skills, and attitudes for acceptable practice. Because training is designed based on posttraining functions (what participants are expected to do on the job), "competency" implies performance levels that conform to national service standards in job functions. Competency-based training involves a trainee's getting a thorough understanding of the essential knowledge required to perform the job and progressing from either lacking skills or having minimal skills to being proficient. Skills development

is supported by one-on-one coaching of the participants until they become competent (i.e., able to perform a skill, such as IUD insertion or vasectomy, independently). Thus, the learner progresses through three stages in this process of acquiring skills:

1. Acquisition
2. Competency
3. Proficiency

Acquisition

The first stage of the process, skills acquisition means that the trainee comes to know the steps to perform the required skill or activity and their correct sequence, but *needs assistance* in doing so. The participant sees others perform the procedure and learns from that experience. The participant then attempts to perform the procedure, under the trainers' supervision.

Competency

At the second stage, skills competency, the trainee knows the steps and their correct sequence and is *able to perform* the required skill or activity *without assistance*. The participant then must practice until he or she feels confident at performing the procedure.

Proficiency

In this, the final stage, the trainee knows the steps and their correct sequence and is able to *efficiently perform* the required skill or activity. Skill proficiency occurs following repeated practice over time.

During training, competency must be assessed by observation of the participants' RH/FP service provision to clients. Simulated practice on anatomic models for LAPM training (discussed below) or during a role play (e.g., in counseling training) is not equivalent to service provision; rather, it is a training/learning tool, and thus it cannot substitute for work with actual clients in the assessment of competency during (or after) training. In special situations like counseling training, simulated practice using role-plays may be used for skills development and assessment to maximize the utilization of time.

Humanistic Training Techniques

Humanistic training in RH/FP involves the use of anatomic models for teaching/learning clinical skills (e.g., use of a pelvic model for insertion and removal of the IUD, or use of an arm model for insertion and removal of the hormonal implant). These anatomic models closely simulate the human body and provide the participant an opportunity to practice and learn clinical skills in a safe, risk-free environment, before moving on to working with clients. In humanistic training, the trainer first demonstrates the clinical procedure and client interaction several times on the anatomic model while explaining the steps involved in performing the procedure. Then, under supervision, the participants practice on the model, using actual instruments and following a learning guide.[8] Only after becoming comfortable with and competent at performing the procedure on the model do participants progress to working with clients. When working with the clients, the trainer again first demonstrates the procedure

[8] A learning guide is a skills development tool that is described in Chapter 7: Implementing Training.

while the participants observe and then clarifies any questions. After this, the participants begin performing the procedure on clients, always under trainer/facilitator supervision. Other training aids, such as learning guides, skills assessment tools, slide sets, and videotapes, can be used in conjunction with anatomic models for an enhanced training/learning experience.

Linking Training to Performance on the Job

Linking training to subsequent performance reinforces the service delivery goal of training, which is to improve provider performance at the workplace. Any training that fails to improve provider performance in the workplace has failed to meet its larger training goal and service delivery purpose. Training by itself often is insufficient to change providers' behavior and enable them to apply skills acquired during training to the workplace; thus, it is important to apply strategies that link training to on-the-job performance, to facilitate the continuing transfer of learning. A few prerequisites that strengthen this link are:

- **Institutional commitment.** The institution is supportive of the participant's training and will provide opportunities for applying newly acquired RH/FP skills. This includes restructuring work, as needed, to support the newly trained provider in providing the service, as well as to reward improved performance.
- **Effective supervision.** A system exists for regularly providing effective supervision to the trainee/participant after training to create and maintain a supportive work environment. This includes providing coaching and mentoring and ensuring the availability of RH/FP equipment, instruments, supplies, and commodities that providers need to utilize their training and perform their job effectively.
- **Individual commitment.** The provider is willing to learn and to apply new skills on the job on a continuous basis.
- **Team support.** On-site supervisors and co-workers are supportive of the provider and create opportunities for her/him to apply the newly acquired skills on the job.

The following strategies assist in linking training to performance on the job:

- **Training follow-up:** For details on training follow-up, see Chapter 8: Linking Training to Performance on the Job, page 53).
- **Facilitative supervision:** *Facilitative supervision is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between a supervisor and those being supervised*. Facilitative supervisors are actively involved in staff training, by helping to identify training needs, ensuring that the work environment is prepared to support the learner when he or she returns from training, coaching the learner, and supporting the application of his or her newly acquired knowledge, skills, and attitudes.[9] (For more details on facilitative supervision, see Chapter 8: Linking Training to Performance on the Job, page 55.)
- **Whole-site training:** Whole-site training is an organizational development approach to training that meets the learning needs of all staff at a service delivery site. An RH/FP service never is provided by one individual alone, but rather is provided by a team or group of

[9] The ACQUIRE Project. 2008. *Facilitative supervision for quality improvement*. New York: EngenderHealth/ The ACQUIRE Project.

individuals. Thus, all staff at a site should understand the services that are provided there and should be oriented to how their roles contribute to the provision of quality services and should receive appropriate training. Needs may be identified through self-assessment approaches, such as COPE®,[10] or other types of needs assessment. Needs are met through different modes of learning (skills training, technical updates, and/or orientations) and are supported by facilitative supervision.[11] (For more details on whole-site training, see Chapter 12: Commonly Used Training Methods, page 95.)

- **Structured on-the-job training:** Structured on-the-job training is a formal training approach that occurs at the provider's worksite and ideally is provided by a trainer who works at the same worksite. Critical elements of structured on-the-job training are the same as those for group-based or other training approaches: stakeholders' consensus on applying this training method; institutional support for implementing structured on-the-job training; appropriate curricula to support this approach; trainers trained in applying it; evaluation plans and other instruments to measure its progress; and a process for qualifying participants upon completion of training. The goal of structured on-the-job training is the same as that for other trainings: to prepare qualified providers to apply their newly acquired knowledge, skills, and attitudes on the job. (For more details on structured on-the-job training, see Chapter 12: Commonly Used Training Methods, page 89.)
- **Transfer of learning:** The transfer of learning is defined as ensuring that the knowledge, skills, and attitudes acquired during a training/learning intervention are applied on the job.[12] (For more details on transfer of learning, see Chapter 8: Linking Training to Performance on the Job, page 56.)

[10] COPE (which stands for client-oriented, provider-efficient services) is a simple self-assessment methodology to help service providers improve the quality of site operations by making them more oriented toward clients' needs and more efficiently organized for the number of clients seeking services. For detailed application and use of the COPE methodology and tools, readers should refer to: EngenderHealth, 2003. *COPE handbook: A process for improving quality in health services, revised edition,* EngenderHealth, 2003.

[11] The ACQUIRE Project. 2008. *Facilitative supervision for quality improvement*. New York: EngenderHealth/ The ACQUIRE Project.

[12] PRIME II and JHPIEGO. 2002. *Transfer of learning: A guide for strengthening the performance of health care workers*. Chapel Hill, NC.

Chapter 4

Chapter 5

Assessing Training Needs

Assessment of training needs is a key step in programming for training, both to ascertain what the training needs may be and to be certain that training is the correct program intervention for meeting service needs or gaps that have been identified. Assessment of training needs primarily applies to two important aspects of the training domain:

1. The performance of service providers
2. The capacity of an institution or a system to conduct training

The performance of service providers is identified following a training needs assessment, in which a range of the most important performance factors are considered. The capacity of an institution to conduct training is investigated using a training capacity needs assessment, which applies a systematic approach to assessing the basic ability of an institution to plan, manage, implement, and evaluate training.

Training Needs Assessment

A training needs assessment (TNA) is a systematic process for identifying the gaps in performance of providers and/or systems, based on an analysis of the desired performance and the actual performance observed among service providers. Desired performance in the aggregate is determined by stakeholders; desired performance of individual providers is based on evidence-informed international and national standards and guidelines.

A TNA can be conducted at the national or regional/district level, depending on the resources available, the extent of the anticipated program intervention, and the need identified by stakeholders for such an intervention. A national-level TNA is more resource-intensive than is a regional-/district-level assessment. National-level assessments also tend to be more inclusive, with greater representation of stakeholders (e.g., Ministry of Health representatives, staff from partner agencies, trainers, program managers, staff from regional-/district- and national-level training organizations, members of other private-sector training organizations, consultants, training experts, etc.). A regional-/district-level TNA is more focused on the needs of the particular region or district and tends to involve fewer stakeholders than does a TNA at the national level. The processes for conducting a TNA are the same, however, regardless of the level at which it is conducted.

Primary Reasons to Conduct a TNA

There are five main reasons for conducting a TNA:

- **To determine whether training is needed.** Training may or may not be the answer to a given service performance gap. *Only a gap in knowledge, skills, and attitudes can be appropriately addressed by a training or learning intervention*. This is a key consideration, as

training is often reflexively chosen to be the program intervention, regardless of whether training is likely to lead to closure of the service performance gap. A TNA helps to identify deficiencies in factors that enable satisfactory service performance, to confirm that training is the indicated intervention to close the performance deficiency or gap, and to explore appropriate interventions (training or otherwise) for closing the gap. Performance factors that enable satisfactory performance are given in **Table 5-1**.

Table 5-1: Performance Factors
1. Clear job expectations
2. Clear and immediate performance feedback
3. Adequate physical environment, including tools, supplies, and workspace
4. Motivation and incentives to perform as expected
5. Knowledge, skills and attitudes to do the job

- **To determine the content and scope of training.** Based on an analysis of the gaps in provider knowledge, skills, and attitudes, the TNA helps to identify and assess such important variables as: the content of the training needed to prepare individuals to perform post-training service functions; the cadres and individuals who need to be trained; the duration of training; and where and how best to carry out the training.
- **To determine the desired training outcomes.** The TNA helps to determine what participants need to know and perform at the end of the training and subsequently in service delivery.
- **To provide a baseline for measurement.** The baseline information is valuable in demonstrating the success of the program, as it can be compared to information subsequently collected during training evaluation.
- **To gain management support.** As a result of the involvement of management representatives and other stakeholders in the TNA process, managers and supervisors are more likely to understand the need for and value of training and to support training activities, especially when they see that these activities are being designed and implemented based on the service needs of their programs.

Key Steps in the TNA Process[13]

1. **Verify that standards of care**, which inform the TNA's performance standards, **are current**, and **update any that are not justified** and may be barriers to service access and quality.

2. **Identify desired performance** in specific, measurable, and observable terms. Definitions of desired performance should:
   - State the accomplishments and/or behaviors of the performer
   - Be observable

[13] *Adapted from:* PRIME II. 2002. Performance improvement: Performance needs assessment framework—Stages, steps, and tools. Chapel Hill, NC: IntraHealth International. Accessed at: www.intrahealth.org/sst/intro.html#subsection1.

- Be measurable
- Be able to be agreed upon by independent observers
- Give a clear, unambiguous, yes-or-no answer to "Do they or don't they perform correctly?"
- Be under the control of the person performing the service

3. **Organize a stakeholders' meeting** to update standards, if indicated; agree on the desired performance for providers and facilities; share opinions regarding performance problems; outline the processes to be followed during and after the needs assessment; and agree on specific indicators for each aspect of the desired performance.

4. **Collect data on provider characteristics and work settings.** While collecting data on provider characteristics and work settings, program managers and trainers should focus the data collection effort on the participants/providers who will be part of the training intervention. Some important characteristics of providers are their job descriptions; their reading and writing levels; their educational background and work experience; and their familiarity with computers and exposure to teaching/learning technology. It is also important to find out about conditions at the providers' workplace (e.g., the resources available to them on the job, the existence of a supervision system, etc.). The information about participants/providers, their work settings, and the resources and requirements for training and subsequent service delivery can usually be collected at the same time. Sample tools for gathering this information are provided in **Appendix 5-1: Provider Characteristics Worksheet** and **Appendix 5-2: Work Setting Worksheet**.

5. **Collect data on available resources and requirements for training.** Information about resources and requirements for training should be collected at the same time as information about the participants/providers and their work settings, through document reviews, interviews, and observation. While collecting data, program managers and trainers should avoid making assumptions about available training resources and requirements, if possible. When it seems necessary to make such assumptions, these should be verified through the use of other sources of information. Useful tools for gathering this information are provided in **Appendix 5-3: Resources and Requirements for Training Worksheet**.

6. **Collect data on actual performance.** Data on the actual performance of service providers and systems should be collected, using the same indicators for performance statements as identified above. Actual performance for service providers should be measured in the three areas of learning: knowledge, skills, and attitudes. **Knowledge** focuses on the facts and information necessary to perform a job. **Skills** are a complex sequence of practical activities that are necessary to perform a job (e.g., communication skills, decision-making skills, or psychomotor skills). **Attitudes** reflect a tendency to behave in a particular way and are associated with beliefs that influence how people perform their job.

   An important step in data collection is to review training information from existing sources. Additional data may be collected using one of the following methodologies: interviews with program managers, trainers, and providers; discussions with a panel of experts; direct

observations of providers and service delivery sites; formal and informal surveys; and reviews of service delivery records. A sample list of data collection methods is given in **Appendix 5-4: Training Needs Assessment Data Gathering Methods**. Similarly, instruments needed for data gathering are given in **Table 5.2**. Samples of data-gathering instruments used for interviewing providers and supervisors and for assessing sites are provided in **Appendixes 5-5 to 5-7**.

Table 5-2: TNA Data Collection Instruments
1. Provider skills observation checklist
2. Provider interview guide
3. Program manager/supervisor interview guide
4. Service delivery site assessment guide

7. **Analyze data.** Program managers and trainers should review and analyze collected data and engage the stakeholders in the review and analysis process. Gaps in performance should be discussed with stakeholders and a "root-cause analysis"[14] should be conducted to identify the factors that impede good performance. Root-cause analysis should be conducted soon after identifying the performance gaps and with the same group of stakeholders who participated in the earlier steps.

8. **Identify performance gaps at the provider and/or system level.** At this stage, the actual service delivery performance is compared with the desired performance. The difference between actual performance and desired performance is the "performance gap."

9. **Select interventions likely to achieve the desired outcome.** Based on the identified causes of performance gaps, select appropriate interventions to close these gaps, remembering that training may not be the solution to many of the identified gaps. Training can only be a useful intervention to close the gap when the gap in job performance is due to a lack of knowledge, skills, or attitude among service providers.

   In addition, more than one performance factor may be responsible for a performance gap, with some performance factors amenable to training and others amenable to other types of management intervention. For best results, training interventions aimed at closing a performance gap must be carefully coordinated with the other needed interventions. For example, if workers do not know how to process surgical instruments correctly and the autoclave is broken, then at least two interventions are needed to improve infection prevention practices at the facility. In this instance, if training is not coordinated with an equipment upgrade, performance posttraining is unlikely to improve.

10. **Write a TNA Report.** Once the TNA is complete, prepare a report that includes the following points:

    • An **overview** briefly describing the purpose and objectives of the TNA

[14] Two commonly used approaches for root-cause analysis are the "multiple whys technique" and the "fish-bone diagram."

- A **description of the process** clearly detailing the current situation and the needs assessment process, including the methodology and tools used to collect the information and the stakeholders and people involved in the process
- All significant **findings** from the needs assessment analysis and a description of the relationship between the analysis and the findings
- Specific **recommendations** for addressing the gaps that have been identified in the TNA findings (If training is recommended, this section should present details of the analysis that support training as an intervention to close the performance gap.)

Training Capacity Needs Assessment

A training capacity needs assessment (TCNA) identifies the gaps in the capacity of a national training system, a training institution, or a service delivery site to plan, implement, and evaluate its training efforts. Important variables considered in the TCNA include the physical infrastructure, human resources, policies and guidelines, adequacy of training curricula, and financial management. The assessment methods and data collection tools used for the TCNA are the same tools that are used for a TNA (see **Table 5-2**), but with a specific focus on the training *capacity* of the system, institution, or facility. This resource package provides guidance on conducting a TCNA for a training institution and or a service delivery site. (Conducting a TCNA for a national training system is a larger undertaking and is beyond the scope of this resource package.)

Training Institution

A TCNA at the institutional level (e.g., at a Ministry of Health RH/FP unit for in-service training) will help to identify gaps in the institution's training capacity. **Table 5-3** contains useful questions that assist in this process. This is not an exhaustive list of questions; service delivery programs may need to supplement and/or adapt them based on individual program requirements.

Table 5-3: Questions for Training Institution Needs Assessment

Training Institution Assessment Questions	Yes	No	Comments
1. Are there established national service delivery and training policies, standards, and guidelines?			
2. Are these standards and guidelines up to date (based on latest evidence-based research findings and World Health Organization recommendations)?			
3. Is there a system for periodically reviewing policies and service delivery guidelines?			
4. Is there a national training and service delivery strategy?			
5. Do central and regional-/district-level training institutions include funds for training activities in their budget plan?			
6. Are standardized training curricula in place to meet the training needs of the system?			
7. Is there training management capacity within the system to plan and implement trainings?			

continued

Table 5-3: Questions for Training Institution Needs Assessment *(cont.)*			
Training Institution Assessment Questions	**Yes**	**No**	**Comments**
8. Is there a training (or human resource) database for recording and managing training-related information?			
9. Is there a standard training-of-trainer (TOT) curriculum to develop trainers and local training capacity			
10. Is there a mechanism for periodically assessing trainers' performance?			
11. Are there adequate numbers of training sites (including clinical sites) for conducting quality RH/FP training?			
12. Are there adequate quantities of teaching aids (overhead projectors, video players, TV screens, anatomic models, etc., for training purposes) to support the training sites?			
13. Are there standards and guidelines for conducting training follow-up and support to providers after training is completed?			
14. Is there a supervisory system in place to support providers after training?			
15. Do working links and communication exist between the training system/institution and the supervisory system?			

Training Capacity Needs Assessment at the Service Delivery Site

Training capacity needs are assessed at the service delivery site to identify sites that have the capacity to conduct and implement training. This is particularly important for training in the delivery of clinical services. The service delivery site must be providing quality services, must support an adequate client load, and must have the capacity to support quality training in RH/FP (e.g., the availability of qualified trainers, training equipment, or space). The training site could be used for group-based[15] training or to support other training methods (e.g., self-guided study, structured on-the-job training, or blended learning) where the development of individual skills and/or client interaction is part of the training design.

The following steps are helpful in conducting a TCNA at the service delivery site:

1) Verify or **establish the standard** for a training site. (See also Chapter 6, pages 29–31, for criteria for selecting a training site.)
2) Identify the **desired performance level** for the training institution or service site.
3) Decide on the **scope and methodology for data collection**, by identifying the areas of training capacity that need to be assessed (e.g., anticipated training content, trainers, and their clinical and training skills, training and clinical facilities in which training will take place), the people who need to be interviewed, and the facilities that need to be assessed.

[15] Group-based training refers to a training method whereby a number of participants of the same provider cadre or service team come together for a training event dedicated to a given service input (e.g., counseling) or method (e.g., female sterilization by minilaparotomy). See Chapter 12, page 87, for more details.

4) **Decide on the assessment tools** to be used (e.g., interview questionnaires; reviews of curricula and job aids, standards, and guidelines, and training materials; and observation checklists for service delivery sites).
5) **Collect data** using agreed-upon methodologies and tools (e.g., interviews with key personnel; service delivery site assessment; review of curricula, standards, and guidelines; and review of service statistics).
6) **Analyze the data**, both qualitative and quantitative, as appropriate.
7) **Identify any gaps** between the actual capacity of the proposed institution/service site to support training and the set (or desired) standards for institutional training performance.
8) **Summarize findings** based on the analysis and present significant findings to the stakeholders.
9) **Recommend interventions** to stakeholders for strengthening the training capacity of the institution and service delivery site, as appropriate.

A list of questions for assessing the suitability of service delivery sites to serve as training sites is given in **Table 5-4**. Additional questions should be included to explore specific requirements, depending on program needs. The "comments" column should be used to present additional information gathered from the closed-ended questions. The information collected at this step will supplement the information collected earlier in the assessment process.

Table 5-4: Questions for Assessing Training Capacity Needs at the Service Delivery Site

Training Capacity Needs Assessment Questions for the Service Delivery Site	Yes	No	Comments
1. Are relevant RH/FP services offered at the facility to support the clinical practicum component of training?			
2. Does the facility provide these RH/FP services on a regular basis?			
3. Do facility staff provide RH/FP counseling according to standard?			
4. Do facility staff carry out infection prevention practices according to standard?			
5. Are there adequate numbers of clinical staff to manage regular RH/FP services during training time?			
6. Are there staff who demonstrate capacity and willingness to function as clinical preceptors?			
7. Would training disrupt regular clinical services? Could staff, space, and workload be adjusted to accommodate training?			
8. Are there qualified trainers at the facility?			
9. Are adequate and reliable commodity supply/resupply mechanisms in place for FP commodities to support service delivery and training?			

continued

Table 5-4: Questions for Assessing Training Capacity Needs at the Service Delivery Site *(cont.)*			
Training Capacity Needs Assessment Questions for the Service Delivery Site	**Yes**	**No**	**Comments**
10. Does the facility have the necessary training equipment and materials for training (e.g., flipcharts, markers and pens, a TV screen with video/DVD player/recorder, overhead projector, anatomic models for training)?			
11. Is there a classroom facility for conducting the theoretical portion of the training?			
12. Is there a mechanism to obtain training manuals when needed?			
13. Is there an adequate supply of materials for maintaining service and training records?			
14. Does the training facility have the capability to select and invite training participants for specific RH/FP trainings?			
15. Does the facility have a system for following up participants/trainees posttraining to provide ongoing support and supervision?			
16. Does the facility have a mechanism for maintaining training records?			
17. Does the facility report the training records to a central training system?			

Chapter 6

Planning for Training

Planning for training is a series of activities performed in advance of the training event to facilitate a smooth implementation of training activities. Planning for training consists of the following:

1. Trainer selection
2. Participant selection
3. Training curricula and materials
4. Timelines
5. Training session preparation
6. Training site selection and preparation
7. Logistics
8. Follow-up of training
9. Evaluation of training

The planning of and preparation for the training event should start well in advance of the event and should involve trainers, supervisors, and program managers in the planning and preparation phase of training activities. Introducing a new training course or introducing a course in a new setting requires more planning and longer preparation time than does an ongoing training course.

Trainer Selection

Trainers are critical to the overall success of a training event. A trainer must be technically competent in the content area of the training (whether the training is for a clinical topic, counseling skills, supervisory skills, or training of trainers), as well as being a skilled trainer. The first task during the planning phase for a training event is to ensure that qualified trainers are selected (and available) to conduct the training. The trainer then assumes responsibility for planning other aspects of the training event, in consultation with supervisors and program managers. Ideally, trainers should be selected from the training sites or from the local area where training is going to be held.

To be able to provide quality training, a trainer should:

- Be knowledgeable about and an experienced provider in the type of service for which the training is to be conducted
- Have participated in a skills standardization workshop/course
- Have completed a training of trainers course

Training events often require more than one trainer, especially for a training in LAPMs.[16] In such cases, one trainer usually assumes the overall responsibility for the training event and is designated the "lead trainer," with the other trainer(s) being designated as "co-trainers." Co-trainers may be experienced trainers or new trainers. All trainers require the same basic qualifications. Pairing new or less-experienced trainers with experienced trainers for training events affords opportunities for the new trainers to receive coaching and mentoring.

Participant Selection

Selecting the right candidates for training is crucial to the success of all training events. The following criteria should be taken into consideration while **selecting participants** for a training event:

- Participants should be working at a facility that provides (or is planning to initiate) the type of RH/FP services that are the subject of the planned training.
- Participants should have the minimum technical qualifications required to provide the services for which the training is planned. (The minimum technical qualifications can be found in the respective national RH/FP service delivery standards and guidelines.)
- Participants should be interested in providing the RH/FP service at their workplace.
- Participants should have support from their workplace supervisor or manager to participate in the training, and to later provide the service.

The trainer should communicate with the participant's supervisor/manager regarding the training and get support (i.e., "buy-in") for the training event. Ideally, participants should be informed 2–3 months in advance of their selection to the training event. In certain circumstances, this advance notice may need to be given even earlier, especially when the participants are expected to complete self-guided tasks as part of the training activity. While informing the participants, the trainers should provide key information regarding the training event (e.g., the length of the training, and the goal and objectives of the training). This information will guide the participants' expectations of the training event and also help the program managers/supervisors decide if the prospective participants/trainees are the right candidates for the training.

Training Curricula and Materials

A **training curriculum** is a collective description of the technical content, training goals, and teaching, learning, and assessment methods and tools to be used for any given training intervention. **Training materials** are a variety of objects or media used during training to enhance the teaching and learning experience. Training materials are usually grouped under the following categories:

- **Printed materials**—reference manual, trainers' manual, participant handbook, handouts, posters, learning guides, checklists, assessment instruments, flipcharts, photos, and worksheets
- **Projected materials**—transparencies, slides, computer-generated presentations, videotapes, DVDs, audio tapes (audio projection)

[16] The four LAPMs are: the intrauterine device (IUD), hormonal implants, female sterilization (tubal ligation), and vasectomy.

- **Real objects, models, and equipment**—anatomic models, clinical equipment, samples of family planning methods, overhead projectors, LCD projectors
- **Computer-based and web-based materials**—online learning materials, e-learning materials, CD-ROMs
- **Audio-conferencing/video-conferencing**—distance-learning conference materials

During the planning phase, trainers should ensure that training curricula and materials required for the training event will be available. Trainers should also adapt materials, depending on the local situation. When doing so, trainers should be careful not to compromise the critical elements of the training. A number of situations may necessitate adapting training materials. For example:

- The number of days available to conduct the training may differ from the number of days anticipated for the training event.
- The number of participants may be significantly larger or smaller than the anticipated number of participants.
- New information or skills may need to be added to a course.
- The client caseload may be inadequate for training purposes.
- Clients may be available only at specific times.
- Participants may need to finish early each day because of organizational or institutional commitments.

When standard training curricula and materials are not available, trainers will need to plan to design and develop the needed curricula and materials. (This is discussed in greater detail in Chapter 10: Design and Development of Training Curricula and Materials.)

Timelines: Planning for Training

Planning for a training event should start well in advance, to ensure that the trainers have sufficient time to prepare all components of the training event. A **Sample Training Timeline** is given in **Appendix 6-1;** it shows a typical timeline needed to plan for a training event. Training preparation should generally start at least six months in advance and should include getting and maintaining stakeholders' agreement. This timeline may be shorter if the training cycle is already in place and if there is strong support from stakeholders (at the national and district levels). However, a number of components of planning for a training event may be time-consuming—e.g., identifying participants, identifying trainers (especially if new trainers are going to be part of the effort), ensuring the site's readiness for the training and compliance with national training standards, and identifying and adapting training materials.

Training Session Preparation

The trainer should assume full responsibility for ensuring that everything is prepared for the successful implementation of training. The trainers should coordinate with other members of the training team to prepare for and implement the training. Each training event is organized into multiple training sessions, each of which covers a specific training topic or activity.

Trainers should ensure that every training session has a clearly written session plan, so that they can follow the session plan during implementation of the training. **Appendix 6-2** gives a **Sample Training Materials Checklist**.

Session Plans, Flipcharts, and Presentations

A **session plan** is a written instruction that assists the trainer in conducting training in a structured way, ensuring that essential aspects of the training are adequately addressed. For self-directed or individualized training, the session plan should have instructions for the participant or learner to facilitate self-study. Usually, a well-designed training package has a model session plan that the trainers can use to conduct training, adapting it as needed for classroom sessions as well as for clinical practicum sessions. During the planning and preparation phase, trainers should:

- Ensure that session plans are created and personalized for every session of the training event.
- Contact participant(s) in a self-directed or individualized training, to ensure that that they have the necessary instructions (and materials) to continue with their individualized training or learning.
- Review the training materials, reference manual, and trainers' manual before preparing the session plan.
- Update the training materials as needed, adding available national- or local-level information to strengthen the materials' relevance.
- Prepare personal notes for session introductions, activities descriptions, and session summaries.
- Share the session plan with the co-trainers and agree on basic training and technical content to be presented during the training.
- Update each other on new developments/evidence/guidelines/best practices in RH/FP that might pertain to the training event.
- Prepare presentation graphics for sessions, as needed.
- Gather any other relevant materials appropriate for the training, such as job aids (e.g., Family Health International IUD checklists) and international guidelines (e.g., WHO Medical Eligibility Criteria).

Session-specific **flipcharts** should be prepared ahead of time, even if electronic PowerPoint presentations are being used. Some relevant considerations include the following:

- Flipcharts are reliable back-ups for a successful training event.
- If it is not possible to make back-up flipcharts for all sessions, at least prepare them for the most important sessions (especially in areas with an unreliable power supply).
- Use flipcharts for advance preparation of drawings and of group exercises for delivering interactive presentations.
- Overhead projectors can serve the same functions as flipcharts for making presentations. However, they depend on a reliable and regular power supply.
- Review slide sets in advance and have them readily available for later use.
- If videos are being used, review them and have them readily available for later use.

Classroom presentations are usually an integral part of RH/FP training events. Some relevant considerations include the following:

- Once the flipcharts, computer-generated slides, or any other visual presentations are ready, the trainers should practice making these presentations before the training event. If co-training, the lead trainer should practice with the co-trainers; if not, the trainer should practice alone, speaking aloud to simulate a classroom setting.
- In planning for sessions, trainers should build in time during the presentation for asking questions of participants and for engaging them in the ensuing discussions, as interactive sessions are more interesting and memorable for participants/trainees than are purely didactic sessions.
- Trainers should plan for and practice using other tools and exercises for making effective interactive presentations (e.g., oral quizzes for reviewing session content; visuals relevant to the session; and/or a short review by the group of the content to be discussed).

Details on conducting a classroom presentation are given in Chapter 7: Implementing Training.

The **clinical practicum session** is usually separate from classroom session activities (although simulated practice on models often takes place in classrooms). The clinical practicum may be conducted concurrently with classroom activities or subsequent to them, and it may be conducted at the same site or off-site by other preceptors and coaches. The trainer/preceptor should organize the clinical practicum area to accommodate additional people as observers or assistants as comfortably and unobtrusively as possible, minimizing the likelihood that the training participants will hinder the regular staff from performing their normal duties.

When organizing clinical practicum sessions, trainers should consider the number of participants who will be attending the training event, the number of trainers and coaches/preceptors needed and available, the client load (including fluctuations by day and time of day), and the organization of services at the training site. Clinical practicums should have their own set of objectives, identified supplies and equipment, checklists, and trained auxiliary staff. Contingency plans should be made for how to use the training time most productively in the not unlikely case of too few clients.

Training Site Selection and Preparation

The trainer(s) should visit the training site(s) 5–6 months before the training event to ensure that it meets the site selection criteria for the RH/FP clinical service component, as well as for the didactic (classroom) component of the training.

At a minimum, an RH/FP **clinical training site** needs to meet the following criteria:

- It should be **providing the clinical service** for which the training is to be conducted.
- The clinical services being provided should meet **updated national service delivery standards** (which should be based on international standards).
- The **client load or caseload** at the site should be **sufficient** to allow participants to perform enough procedures to attain competency within a relatively short period of time (e.g., five days for IUD training).

- It should be providing the **counseling services** for the given clinical service.
- It should be following standard **infection prevention** practices.
- The site should have **adequate staffing**, so that the training event does not disrupt routine activities.
- It should have **adequate examination rooms, procedure rooms,** and **recovery rooms/areas.**
- The site should have the necessary **training equipment and supplies** for conducting training.
- It should be fully equipped and staffed to **handle any immediate procedure-related complications.**
- Ideally, the site should have a **qualified trainer**, in-house, available to help implement and/or assist with the training.

Any **classroom teaching facility** used should be large enough to accommodate the anticipated number of participants, with ample space for them to move about in the room. The seating arrangement should encourage face-to-face participant interaction (e.g., a standard U-shaped or circle seating arrangement). The classroom site should preferably have 2–3 breakout rooms for smaller group work. Ideally, classrooms should be in the same building as the clinical training facility, but it is also possible to have the classroom teaching facility in a nearby venue that allows easy commuting to and from the clinical training facility.

When the client load at the main clinical training site is insufficient to allow all participants to receive adequate clinical practice—which is often the case—the use of **additional practicum sites** will become necessary. Additional practicum sites are other clinical facilities selected to provide participants with an increased opportunity to perform procedures and thus attain competency. Such additional sites may be in the vicinity of the main clinical training site, or they may be in a location farther removed from the training site where participants go after completing the didactic component of their training. Additional practicum sites should possess all of the needed characteristics of a clinical training site, but they do not need to have a classroom facility (as the participants will have already completed the didactic portion of their training). Ideally, such sites should have a qualified trainer present at all times during the clinical practice sessions; however, in the absence of a qualified trainer, an experienced clinical service provider may act as a mentor or coach to guide the participants during the practicum sessions. Additional sites also need to be organized in terms of the timing of training, transportation, and necessary support to the site.

A critical criterion for the selection of a training site is the **adequacy of the client load** during training. Long-term strategies for maintaining an adequate client load include the following:

- Providing high-quality services at the training site, including maintaining a respect for clients' rights; this will foster client satisfaction, increase client volume, and enhance the reputation of the institution.
- Organizing services so those in low demand (e.g., IUD, vasectomy) are available on one or two days of the week; this will make scheduling the clinical practicum component of training easier (and can make services more regularly and reliably available on an ongoing basis).
- Focusing training and service delivery efforts on sites with developed or potential capacity, and directing interested clients there through referral mechanisms.

In addition, shortly before and/or during a training, the site can do the following:

- Ensure that clients' rights are respected by trainers and trainees. This includes the client's right to be informed of any training taking place, to participate voluntarily, and to receive services even if declining to participate in the training.
- Advertise (in the clinic and via mass media) expedited, "reduced cost," and/or packaged services on specific days while the training is occurring.
- Conduct outreach in the training site's catchment area, informing local service sites that the training will be conducted, especially for services (e.g., LAPMs) for which referral may be routine.
- Ensure that normal referral mechanisms are operational.

Logistics

The trainers should be actively involved in the **travel and accommodation arrangements** of the participants in the training event. Though the trainers may not actually be *making* these arrangements, it is important that they supervise and be knowledgeable about all of the arrangements being made. It is important that trainers (in collaboration with program managers) should designate a person (or persons) to manage these tasks (including problem solving, if and when any problems arise. The trainers should coordinate closely with that designated person, checking to ensure that the following actions have been adequately completed:

- Letters of invitation for the training have been sent to all participants.
- Letters of invitation have been received by all of the participants.
- Letters of release (from daily work obligations) have been issued to the participants by their supervisors/managers.
- Necessary hotel or other accommodation arrangements have been made.
- Payment for hotel rooms or other accommodations has been taken care of.
- Arrangements have been made for the participants to receive a per diem or allowance.
- The official full names and personal information of the participants are known and available for preparation of the diplomas or certificates that they are to receive upon completing the training.
- The training team has emergency contact information for the training participants.
- Templates for training completion certificates are ready, and enough copies are available to match the number of participants.
- A person is designated to prepare the training completion certificates and bring them to the training site upon completion of the training.

A **Sample Planning for Training Checklist** is given in **Appendix 6-3**.

Follow-Up of Training

Follow-up of training provides continuing support to participants (and can be used to evaluate and document the impact of training on service delivery); the importance of follow-up cannot be overemphasized. Follow-up of training needs to be planned, and budgeted for, from the early

stages of the "planning for training" process onward, so that the participants get the full support they need after training to allow them to apply their newly acquired skills at their workplace.

The following steps are helpful in planning follow-up of training:

- Build in time during the training event to prepare **participant action plans** to facilitate on-the-job application of newly acquired skills.
- Identify **job aids** for participants to carry back with them, to help them apply their new skills on the job.
- **Communicate** with the participants' on-site or off-site supervisors to make training follow-up plans.
- Allocate **time and budget** for travel to conduct training follow-up. (This is a very important aspect of training follow-up; unfortunately, it is often beyond the trainer's control.)

Evaluation of Training

Plans should be made for the training to be evaluated, both during the event and afterward, at the participants' service delivery setting. For evaluation within the training event, trainers should plan to do the following:

- Ensure that adequate quantities of pretest and posttest questionnaires are available.
- Confirm the availability of skills checklist to assess participants' skills, and practice using the skills checklist, when needed.
- Prepare a template for participants to write their action plans (and make copies, if necessary).
- Prepare an assessment plan to assess all participants on their clinical skills at the end of the training.

For more details on training evaluation during and after the training event, including the development of assessment instruments, see Chapter 9: Evaluation of Training.

Chapter 7

Implementing Training

Training implementation consists of two-way interactions between trainer(s) and participants and among participants that enhance the teaching-learning process in a structured training event. A variety of techniques can be used to create an environment that facilitates learning. This chapter addresses the processes and skills required to implement training, using a traditional group-based training approach, but the training principles presented are largely applicable to other training approaches as well (e.g., self-paced training, distance learning, and structured on-the-job training). The trainer is responsible for conducting the training smoothly, for guiding the trainee through the structured processes of the training event, and for enabling the participants at each step to gain confidence and attain competency in the knowledge, skills, and attitudes required to perform the tasks for which they are being trained.

In implementing training events, the trainer needs to be effective in the following areas[17]:

- Creating a positive learning environment
- Making effective presentations
- Understanding group dynamics
- Using interactive training techniques
- Functioning as leader and coach
- Providing feedback to participants
- Promoting skills development
- Reviewing the day's activities
- Reporting on the training event

Creating a Positive Learning Environment

Training participants learn best when they feel comfortable in the environment in which they learn. At the start of any training event, it is common and natural for the participants to feel a little distanced from what is to ensue and/or anxious about having to interact with trainers and other participants and to perform during the training. Understanding these feelings can help the trainer to take steps toward creating a safe environment where the participants feel welcomed and encouraged to share their knowledge and experiences, which enhances the learning process.

[17] This chapter builds on the information given in Chapter 4: Approach to Training.

Following the adult learning principles described in Chapter 4, to create a positive learning environment, trainers need to:

- *Link training activities to what people do at their work*. Learning should directly contribute to improved performance; this increases the likelihood that participants will be engaged in the training and will be motivated to learn.
- *Link training sessions to the participants' real-life experiences,* using a variety of learning methods.
- *Keep their teaching techniques simple but diverse* and *use interactive methods* to help maintain participants' interest and involvement in the learning process.
- *Recognize the participants' individuality* and provide them with opportunities to contribute to the training sessions/discussions.
- *Treat everyone with respect*, thus setting an example to the participants.
- *Provide positive feedback*.
- *Provide corrective feedback when necessary*, taking care not to embarrass the participants while doing so.

Before starting the first session, trainers should introduce themselves and should also allow the participants to introduce themselves. If time permits, a good approach is to use an interactive method to allow the participants to introduce themselves. One common way of doing this is by pairing participants and giving them time (about five minutes) to gather basic information about their partner. They could collect information regarding their name, title and place of work, their hobbies, and other interesting facts about their lives. Once everyone has completed this step, each member of each pair introduces his or her partner to the whole group. This approach helps to ease any communication barriers that might exist and gets the participants talking to each other at a personal level from the very beginning of the training event.

Ground rules—norms that participants agree to abide by during the entire training event—should be established at the beginning of the training event. This allows the participants to take ownership of the norms and to get involved in the training from the very first hour. The trainer should invite the participants to suggest the ground rules and can use a piece of flipchart paper to write down the ground rules as the participants suggest them. The trainer may start by setting the first norm (e.g., be punctual for every session). After the participants generate the norms that they would like to see followed during the training event, the trainers may add any other specific norms that they think are also important. The filled-out flipchart sheets should be placed on the wall of the classroom in a visible and prominent place, so that the ground rules can be referred to whenever needed. Trainers and participants should also agree on tea, coffee, and lunch break times, if applicable.

Making Effective Presentations

An effective presentation has a brief and lively *introduction* that captures the participants' attention and transitions smoothly into a well-organized and relevant *body* of training content, which concludes with a concise *summary* that reinforces the key points made during the body of the presentation. Presentations that are interactive (i.e., that engage the audience with questions) and that use a variety of audiovisual aids (e.g., flipcharts, overhead transparencies,

PowerPoint graphics, slide sets, or training videos) and appropriate props (e.g., models) are generally more effective than are wholly didactic lectures. Considerations and suggestions about these various aspects of effective presentations are discussed in greater detail below.

Effectively Presenting Information

Some overall suggestions for how to make effective presentations include the following[18]:

- **Prepare trainers' notes for each training session.** The trainers' notes should include the session objectives, tips on introducing the presentation, the body of the presentation, associated activities, audiovisual reminders, a summary of the main points of the presentation, and notes on evaluating the participants' understanding of the content.
- **Communicate in a language that is easy to understand.** Explain any technical terms, jargon, and acronyms, and avoid the use of slang.
- **Maintain eye contact with the participants.** Eye-to-eye contact helps trainers to stay "connected" with the participants. Other ways to stay connected include listening attentively to participants' questions, always facing the audience, and not speaking to the flipchart or PowerPoint slide.
- **Project vocally so that those in the back of the room can hear clearly.** Vary the volume, pitch, tone, and inflection of the voice to maintain the participants' attention. Avoid speaking in a monotone.
- **Display enthusiasm about the topic and its importance.** Smile, move with energy, and interact with the participants. This helps to keep the participants interested and engaged in the presentation.
- **Move around the room.** Moving around the room helps ensure that the trainer is close to each participant at some time during the session. Participants are encouraged to interact when the trainer moves around them and maintains eye contact with them.
- **Use appropriate audiovisual aids** during the presentation (e.g., flipcharts, blackboards or other writing boards, overhead transparencies, and PowerPoint presentations). Do not block the participants' view of a flipchart or any projected information.
- **Use the participants' names as often as possible.** This helps to keep the participants focused on the presenter and helps to build rapport with the participants.
- Display a **positive sense of humor** related to the topic. Trainers may show cartoons on an overhead display or use humorous stories to make a point.
- Be sure to ask both **simple** and **more challenging questions**.
- **Provide positive feedback** to the participants during the presentation.
- **Provide smooth and clear transitions between topics** when moving from one related topic to another within a given presentation. Summarize the topics or ask questions to ensure that the participants understand before moving to the next topic.
- **Be an effective role model.** The trainer should be a positive role model in dress, appearance, enthusiasm, and timeliness (both in being on time and in finishing at the scheduled time).

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[18] JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

A **Sample Presentation Skills Self-Assessment Guide** is provided in **Appendix 7-1**.

Effectively Introducing Presentations

Techniques to help trainers make effective introductions to their presentations include the following[19]:

- **State the session objectives clearly and succinctly.** This helps the participants focus on what to expect from the presentation. For example, "By the end of this session, you will be able to describe the advantages and common side effects of hormonal implants."
- **Ask a series of questions on the subject,** to allow the participants to be involved in the presentation (see also further discussion in the next section). The trainers should take note of the general knowledge level of the participants (already suggested by the results of the pretest questionnaires) and should select those questions likely to generate widespread participant contribution to the session. This builds the participants' confidence and helps to foster a more engaged and relaxed learning environment.
- **Relate the topic to any previously covered content.** This helps the participants understand the continuity of the presentations and how a given session relates to the overall topic. For example, one might say: "In the last presentation, we talked about counseling IUD clients. Now, in this presentation, we will discuss the steps needed for medical screening of IUD clients."
- **Use a case study or a problem-solving activity.** Case studies or problem-solving activities focus attention on a specific situation related to the training topic. Allow the participants adequate time for reading the case study and for reporting back to the group.

Effectively Summarizing Presentations

Summaries of presentations should be brief, should focus on the key points, and should engage the participants in the summary process. Ways to include the participants include the following:

- Asking a number of questions focused on the main points of the presentation
- Asking the participants in an open-ended fashion what they thought were the main "take-away messages"
- Conducting a short quiz among the participants, if time allows, whereby one team may ask questions to the other team about the subject covered in the presentation, with the trainer acting as the moderator
- Giving a short written test covering the highlights of the presentation and discussing the answers with the entire group

Questioning Techniques

Use of good questioning techniques during presentations helps to maintain the participants' interest in and engagement with the topic of discussion. Questions should be thought-provoking, should focus on the key issues of the training session, and should be prepared in advance of the session. Some helpful considerations and suggestions for asking questions during a training session include the following:

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[19] JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

- Questions may be either **closed-ended** or **open-ended**. Closed-ended questions are those that may be answered by a "yes" or "no" answer, while open-ended questions cannot be answered by a yes-no or a one-word answer. Closed-ended questions save time and direct learners to a single answer. Open-ended questions require the participants to be more expressive and are meant to stimulate thinking and generate ideas. An example of a closed-ended question is: "Have you understood the side effects of the IUD?" An example of an open-ended question is: "What are the steps you would take to create a good learning environment?"
- **Start with easy questions** before progressing to more difficult questions.
- Trainers may **ask questions of the entire group** and may expect answers from any of the participants, or trainers may **direct questions to specific individual participants**. Questioning the entire group engages all of the participants, although it may exclude those participants who do not feel comfortable speaking in a group and may allow others to dominate the discussion.
- When directing questions to an individual, **use the person's name**. The name of the specific participant can precede the question, or the question can be asked first and then directed to a specific participant for an answer. Either way, using the participant's name helps to build rapport and to focus the participants' attention.
- **Avoid a repetitive pattern of questions** by maintaining a variety of questioning techniques.
- Identify **participants who may have some unique experience** relevant to the question, and call on them to share that experience.
- When a participant answers the questions correctly, **reinforce the participant's correct response**. If the response is only partially correct, reiterate the correct portion of the answer and redirect the remaining part of the question to the other participants. If the participants are unable to provide the correct answer, the trainer should do so. Trainers should avoid answering questions if the initial question is followed by no response. Wait for the participants to provide a response, even if it means dealing with silence for some time.
- If a participant's response to a question is incorrect, make a noncritical comment and **redirect the question to another participant**. If a question is particularly difficult, address it to the entire group. Trainers may need to start the discussion, if time permits, to allow a more in-depth consideration of a difficult topic.
- Trainers should **encourage questions from the participants.** When a participant asks a question, consider redirecting the question to other participants (which models the use of the participants as resources within the training and embodies the principles of adult learning). Certain questions may be redirected back to the group, while others may need to be answered by the trainer.
- **Avoid asking trick questions,** as they can embarrass participants and discourage them from answering future questions.

Audiovisual Aids

Audiovisual aids are useful tools that can enhance the quality of presentations. Some of the most commonly used audiovisual aids (in addition to blackboards and whiteboards) include the following:

1) **Flipcharts**

Flipcharts are easy-to-use, low-technology tools for giving an illustrated lecture. Flipcharts are large sheets of (usually unlined) paper that are cheap, widely available, and easily portable for training purposes. Flipcharts can be used to display text at a session, as well as for text that should remain on the wall for future reference during the rest of the workshop. They can be mounted on easel boards or hung on classroom walls. Flipcharts may be prepared in advance and brought to the classroom on the day of the training.

Some useful suggestions for preparing flipcharts include the following:

- Use block letters and wide-tipped pens to write on flipcharts, so that they can be easily read from the far end of the sitting area.
- Use adequate space between lines to keep whatever is written clear.
- Use bullet marks to express a new idea and, if possible, use alternate colors for different ideas.
- Draw borders, boxes, and cartoons with colored ink to enhance their visual appearance.
- When preparing flipcharts in advance, place white sheets between the written sheets. This helps to mask the writing from the sheet below, which help distract training participants.
- Use two sheets (one on top of another) while writing on flipcharts placed on a table or desk. This helps to prevent the table from becoming unnecessarily marked up.
- Face the audience while making a presentation from the flipchart; avoid facing the flipchart.

2) **Overhead transparencies**

Overhead transparencies are displayed on a screen via an overhead projector. Although they have been replaced by computerized (e.g., PowerPoint) presentations in more sophisticated settings, overhead transparencies can be effective visual aids for training purposes and can be reused for teaching the same subject (until changes in content are needed). In addition, overhead projectors are relatively low-tech and low-cost, though their use requires a reliable source of electricity.

Here are some useful suggestions for preparing transparencies:

- Prepare transparencies in advance.
- Familiarize yourself with how the overhead projector works.
- Keep a spare projector bulb on hand as a back-up for the existing bulb.
- Update transparencies as needed to include new topics and current developments in the subject.
- Use permanent or nonpermanent colored marker pens to create text or drawings on plastic or acetate sheets.
- Use special transparency sheets made for photocopying.

- Use special transparency film specifically designed for printing.
- Use one transparency to express one main idea, with no more than five or six lines of large type.

3) **PowerPoint slides**

Computerized preparation and projection of presentations in slide-show format is effective and efficient. A commonly used computer software program for this purpose is PowerPoint. PowerPoint slide shows are easy to prepare and easy to adapt; thus, new audiences can be readily accommodated, and new technical and programmatic information can be easily added. A special projector is required to display PowerPoint slides onto a projection screen, and a reliable supply of electricity is needed.

Here are some useful suggestions for preparing a PowerPoint presentation:

- Use easily readable, standard-font type, and make sure that the font size is large enough (18 points or larger) to be read from the far end of the sitting area.
- Limit the information on each slide to one main idea.
- Do not overcrowd a slide—limit the number of lines to 5–6 on a slide.
- Keep within 2–3 lines above the bottom of the slide.
- Split material between two slides rather than forcing everything onto one slide.
- Use "bullet marks" to separate different points.
- Use text and graphics that support the content of the presentation.
- Do not use graphics only to fill space.
- Use background contrast for the slide in a way that will show the text clearly on the slide as well as on a printout.
- Make effective use of clip art, pictures, and charts to enhance information on a slide.
- Do not use distracting font animations.
- Have the trainer/presenter advance the slides personally while making a presentation.
- Have co-trainers assist in special situations to help in the presentation (e.g., if the trainer is conducting a demonstration simultaneous to the presentation.

Understanding Group Dynamics

A group's behavior is the sum of different interrelated components that constitute and influence its growth and development. When a number of individuals come together into a group for a group-based training event, the trainer is responsible not only for interacting with the individual participants, but also for managing the behavioral dynamics of the group as a whole. That is, the trainer needs to manage the training's *process* (how the individuals interact and work together to accomplish the goals of the training) in addition to its *content*. (The content consists of the information to be delivered and the activities conducted within the training sessions.) Some of the group behaviors that emerge, whether in a large single group or in smaller subdivided task groups, include sharing a common purpose, becoming competitive,

building trust, and questioning each other's and the trainers' actions. The trainer needs to understand and be sensitive to these group dynamics to help facilitate the development of an effective group that reinforces a positive learning environment.

The following are some considerations about the characteristics of an effective group, the stages it undergoes in its process of development, and the management of difficult behaviors and situations:

1) Characteristics of an effective group

An effective group demonstrates the following characteristics[20]:

- The group understands its goals (overall and immediate).
- It is flexible in deciding how to work toward those goals.
- It has a high degree of communication and understanding among its members.
- The members communicate directly and openly.
- The group has a high degree of cohesiveness.
- The members share leadership responsibilities.
- The group is able to make effective decisions by considering all viewpoints and securing the commitment of all members to important decisions.
- It achieves an appropriate balance between the productivity of the group and the satisfaction of individual needs.
- It makes intelligent use of the differing abilities of its members.
- It is objective about reviewing its own processes, identifying problems, and changing processes, as needed.

2) Stages of group development[21]

The process of group development starts from the very first day, as different individuals come together for the training event. Group development then progresses along a continuum of stages of growth, moving from an early stage of **apprehension** on to **cohesion** and then to **creation**, **achievement**, and **closure**. Some salient considerations about these progressive stages of group development include the following:

Stage I: Apprehension

- The group is not yet a group, but a set of individuals nervous and excited about the training course.
- Individuals want to establish a personal identity within the group and to make a positive impression.

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[20] *Adapted from:* Schaefer, L., et al. 2000. *Advanced training skills for reproductive health professionals*. Baltimore: JHPIEGO; and Curtis, R. 1995. Group development and leadership. In *Outdoor action program leader's manual*. Princeton: Princeton University Press.

[21] Turner, K., Wegs, C., and Randall-David, B. 2003. *Effective training in reproductive health: Course design and delivery*. Reference Manual. Chapel Hill, NC: IPAS.

- Participation is initially limited, as individuals become familiar with the setting, the trainer, and each other.
- Individual participants begin to focus on the task at hand and to discuss its purpose.
- Individuals tend to have high expectations of themselves and of the trainers and are as yet unsure about other members of the group.
- The group is essentially evolving ground rules on which future decisions and actions will be based.

At this stage, trainers should:

1. Evaluate the trainees' needs and expectations.
2. Provide a context for, set the objectives for, and establish the tone of the training event.
3. Explain what the group will do and how they will do it.
4. Closely supervise activities.

Stage II: Cohesion

The members of the group:

- Become more familiar and comfortable with each other and begin to form interpersonal relationships.
- Begin to develop respect for the intellect and abilities of the other participants.
- Begin to have a sense of themselves as a group. (Group cohesion begins.)
- Become more satisfied as the training event design and activities make clear the ways in which the participants will master skills and the group will work together, toward what goals.
- Begin to experience the results of interactive techniques and to realign their expectations to fit the reality of the training event.
- Take pleasure in their accomplishments as more activities are completed successfully.

At this stage, trainers should:

1. Assume more coaching behaviors and be less directive in communicating with the group.
2. Make observations that acknowledge the group's progress in assuming responsibility for its own learning.
3. Know when to intervene in the group and when to transfer responsibility to the participants as they gain more autonomy and confidence.
4. Be able to let go of total control of the group.

Stage III: Creation

The members of the group:

- Integrate concepts learned during training by applying them in group work and in individual skills practice.
- Regard their fellow team members positively.
- Support other team members by recognizing their strengths and competence.

- Challenge one another without fear of damaging their relationships.
- Communicate with each other and with the trainers with candor and directness.
- Recognize each other's contributions to the success of the training event.

At this stage, trainers should:

1. Be aware that the special status of the trainer has been eliminated as the group has mastered the content and progress of training.
2. Treat group members as colleagues, yet remain aware that they continue to need support in their newly discovered autonomy.

Stage IV: Achievement

The members of the group:

- Have strong positive feelings about their accomplishments.
- Have new reactions to clear, direct feedback about their performance.
- Practice flexible and functional roles.
- Channel their collective energy into solving identified tasks.
- Apply new insights and solutions to solve problems.

At this stage, trainers should:

1. Acknowledge the accomplishments and skills the participants have gained.
2. Review and discuss items that may have been set aside (for future discussion), thus leaving no unfinished business.

Stage V: Closure

The members of the group:

- May experience both a sense of accomplishment about knowledge and skills gained and a sense of loss about the end of the training event.
- May deny their sense of loss by joking, leaving the training event early, or dismissing other participants' statements about their feelings.
- Should make follow-up plans to use their new skills.

At this stage, trainers should:

1. Design a special activity to create a sense of closure for the training event.
2. Share their personal feelings about the end of the training event with the participants, and allow the participants to share their personal feelings, as appropriate.
3. Contribute to follow-up plans when needed.

3) Managing difficult situations and behaviors

A trainer may encounter problems with the training site, the equipment, the materials, the logistics, and/or the participants' behavior. When undesirable circumstances arise during training, it is the trainer's responsibility to manage them early on, to maintain an environment that is conducive to learning.

Some helpful considerations for dealing with difficult situations or behaviors in a training setting include the following:[22]

- When deciding on a course of action, the best decision is one that benefits the group as a whole.
- Often, participants will "test" the trainer to see how the trainer will handle an uncomfortable situation. Be aware of this possibility and avoid getting into a struggle of wills with a participant.
- Adults do not like to feel incompetent in front of their peers. Sometimes, participants make themselves feel competent by challenging the trainer. Trainers should not take this behavior personally, but they should respond in a way that defuses the situation without meeting the challenge directly.
- Trainers should keenly watch out for potentially difficult patterns of behavior in the training room. Knowing when to respond and when to let something pass is a skill learned over time. The norm of doing what is best for the group as a whole will serve the trainer well in this situation.

Various aspects of group processes and suggested possible interventions are further presented in **Appendix 7-2: Group Process: Behavior and Interventions**.

Using Interactive Training Techniques[23]

A number of interactive training techniques are available to the trainer for implementing an interesting and engaging training event and for enhancing experiential learning. Some of these techniques include small-group work, case studies, role plays, brainstorming, and group discussion. When used, these techniques should be followed by a structured discussion—i.e., first a set of questions to elicit participants' direct reaction (e.g., What did they observe? How did they feel? Was it easy or difficult? Were they surprised?); and then a set of questions for "deriving meaning" (e.g., What does this experience mean for my work? How can I adapt this? What should I do differently now? Can I do this on my own?). These techniques are discussed below and are summarized in **Appendix 7-3: Interactive Training Techniques**.

Small-Group Work

Small-group work provides an opportunity to more fully engage all of the participants, to promote the participants' learning from each other, and to foster their working as a team. Small-group work also can save time (when a large task can be divided into subtasks addressed by different small groups), can generate more ideas, and can enable the expression and consideration of a greater variety of viewpoints. Small-group work can be applied in a variety of situations (e.g., solving a problem presented by the trainer, discussing a case study, or preparing a role play). It is frequently used in, and is particularly well-suited for, RH/FP clinical skills training.

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[22] Schaefer, L., et al. 2000. *Advanced training skills for reproductive health professionals*. Baltimore: JHPIEGO.
[23] JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

Some useful suggestions for working with small groups include the following:

1. Keep the composition of the groups varied and take measures to ensure that participants do not fall into the same group at every selection. Some ways to vary the small groups include:
   - Assigning the participants to a given group
   - Asking the participants to count off "1, 2, 3," etc., with all of the "1's" meeting together in a small group, all of the "2's" meeting together in another small group, and so on
   - Asking the participants to form their own small groups
   - Asking the participants to draw a group number (or group names) from a basket

2. Assign small-group activities that are challenging, interesting, and relevant; such activities should require only a short time to complete and should be appropriate to the participants' backgrounds.

3. Include the following **instructions** for any small-group activities:
   - Directions on what to do
   - Time limits for when to complete the group work
   - A situation or problem to discuss, resolve, or role-play
   - Questions for a group discussion

4. Provide instructions for small-group activities via handouts, flipcharts, transparencies, and/or oral instructions.

5. Bring the participants together after the activity is completed for discussions in the form of:
   - **Reports** from each group
   - **Responses** to activity questions
   - **Role plays** developed and presented by participants in the small group
   - **Recommendations** from each group

Case Studies

A case study is a description of a real-life situation that is used in a training activity to foster discussion of a given RH/FP problem or topic related to the training event. Participants are required to study and react to the case study orally during a group discussion or to react to the case study in writing.

Some advantages of using case studies are that they:

- Actively engage the participants and provide opportunities for greater interaction among participants.
- Allow participants to present different perspectives and to explore many solutions to the problem.
- Provide an opportunity for participants to hone their critical thinking and problem-solving skills.

Some useful suggestions for using case studies include the following:

1. Allow time for participants to **read** and **react to** the case study.
2. Ask the participants to **analyze the problem** in the case study.
3. Ask focused questions when you want to bring out **specific issues** in the case study.
4. Ask **open-ended questions** when you want to elicit a wide range of responses and solutions to the problem presented in the case study.
5. Bring the participants together after the completion of the activity for discussions in the form of:
   - **Reports** from each group
   - **Responses** to activity questions
   - **Role plays** developed and presented by participants in the small group
   - **Recommendations** from each group

Role Plays

A role play is a training/learning technique in which participants play out roles in a simulated setting (with or without the trainer's participation). Although prior knowledge is required to conduct an effective role play, its purpose is to influence the subsequent **behavior** of participants. Some of the advantages of using role plays are that they can:

- Expose different attitudes and abilities of the participants
- Foster greater sensitivity to the ways in which providers' behavior affects clients and other staff
- Help participants understand a client's situation (i.e., foster empathy)

Some useful suggestions for using role plays include the following:

- Identify beforehand the objectives of the role play.
- Create a simple situation within the role play.
- Keep the role plays short and to the point (as long role plays tend to distract participants).
- Explain the roles to the role-play participants and explain to the audience what aspects of the role play should be the main focus of audience observation.
- Discuss important issues that emerge from the role play.
- Summarize the session, what was learned, and how this new learning applies to the clinical skill or activity that is the focus of the training session or event.

Brainstorming Sessions

Brainstorming is a technique that allows participants to generate a wide variety of ideas, thoughts, and alternative solutions to a specific topic or problem. Brainstorming requires that participants possess some prior or background information related to the topic.

Some useful suggestions for facilitating a brainstorming session include the following:

- Establish ground rules:
  - Everyone may contribute.
  - No evaluation of ideas offered by participants will be permitted (as this inhibits wide-ranging thought and generation of ideas and alternatives).
- Keep a written record of all ideas on a flipchart (to be done by the trainer or by someone designated by the trainer).
- Identify a topic or problem for brainstorming (e.g., managing the supply and logistics of family planning methods at the district hospital, or improving the structure of work for LAPM service providers).
- Involve all of the participants and provide positive feedback, to encourage more input.
- Review written ideas and suggestions periodically, to stimulate additional ideas.
- Review all suggestions at the end of the brainstorming, and conclude the session.

Group Discussions

Group discussion is a training technique in which most of the ideas, thoughts, questions, and answers are developed by the participants, in a group setting. The trainer typically serves as the facilitator and guides the participants through the discussion. Group discussion may be useful in a variety of situations (e.g., after a clinical demonstration, a case study, or a role play; following a brainstorming session; or at any other time when participants have prior knowledge or experience related to the topic at hand).

Some useful suggestions for facilitating group discussions include the following:

- Arrange seating to encourage participant interaction (e.g. in a U shape, a square, or a circle, so that participants face one another).
- State the topic as part of the introduction.
- Shift the conversation from the facilitator to the participants.
- Act as a referee and intervene only when necessary.
- Summarize the key points of the discussion periodically.
- Ensure that the discussion stays on the topic.
- Use the contributions of each participant and provide positive reinforcement.
- Minimize arguments among participants.
- Encourage all participants to get involved.
- Ensure that no one participant dominates the discussion.
- Conclude the discussion with a summary of the main ideas, and relate the summary to the session objective(s) presented during the introduction to the session.

The Trainer As a Leader and a Coach[24, 25]

While conducting and managing a training event, one of the trainer's most important roles is that of a **leader**. As a leader, the trainer guides the participants and helps them to evolve into an effective, mutually supportive group that is clear about its learning objectives and is able to realize them.

As a leader, the trainer:

- Establishes an atmosphere of safety, honesty, and trust
- Listens to others and shares their fears and concerns
- Acts as a role model
- Serves as the authority for the group
- Functions as an advisor, friend, and/or advocate, as needed
- Makes decisions
- Resolves disagreements
- Initiates action
- Motivates the group
- Facilitates group interaction
- Moves the group from one level of achievement to the next
- Is sensitive to the needs of the group
- Responds to the expectations of others

Another important role of the trainer is that of a **coach**—an enthusiastic mentor who inspires and instills self-confidence in the people being trained. As a coach, the trainer focuses on the participants, encourages two-way communication, continually evaluates participant learning to provide useful feedback, supports collaboration among group members, and encourages participants to manage themselves. This interactive training approach often requires a change from traditional trainer behaviors, as described in **Table 7-1**.

Table 7-1: Becoming an Interactive Trainer

Requires changing from…	To…
Teaching, instructing	Facilitating, coaching
Centering on the instructor	Focusing on the learner
Lecturing	Interacting
Being detached, distant	Collaborating, cooperating
Exercising power over others (acting as the only authority)	Empowering learners to be the source of their own authority
Maintaining tight control of the group	Encouraging participants to manage themselves
Telling participants "the one best way"	Helping participants to discover the answers
Believing that the participants are the only learners	Believing that everyone in the group, including the trainer, is a learner

[24] Schaefer, L., et al. 2000. *Advanced training skills for reproductive health professionals*. Baltimore: JHPIEGO

[25] Curtis, R. 1995. Group development and leadership, in *Outdoor action program leader's manual*. Princeton, NJ: Princeton University Press.

Providing Feedback to Participants

It is essential for trainers to provide feedback to participants throughout the training event, during theory sessions as well as during counseling and clinical skills practicum sessions, whether in simulated practice or in direct provision of services to clients. Provision of feedback during client sessions can be a delicate task that needs to be thought through carefully, as trainers face the dual challenge of building participants' confidence as well as ensuring that clients are comfort and receive quality services.

Some helpful considerations for providing constructive feedback to participants, co-trainers, and co-workers include the following:

- **Do not wait too long** after the given behavior to provide positive feedback. Delayed feedback is less effective than feedback that is provided immediately after a behavior.
- **Choose an appropriate time.** Choose a private moment as soon as you think the participant is ready to listen.
- **Convey a positive intent.** While providing constructive feedback, begin with a neutral statement about what you want to talk about. Point to a common goal. This helps the participant understand the importance and constructive value of the feedback and encourages team spirit.
- **Be specific.** Focus on the behavior or action, not on the person, and avoid "you" statements. For example, instead of saying "You did a poor job of preparing the set of instruments for the IUD insertion procedure," say, "The instruments were not prepared properly."
- **State the impact of the behavior or action.** Describe the consequences of the behavior; do not judge the participant. For example, instead of saying "Your infection prevention practices need serious improvement," say: "If good infection prevention practices are not being followed, HIV may be transmitted."
- **Ask the participant to respond.** Invite a response from the participant: "What do you think?" "What is your view of this situation?" Ask participants how they would have done things differently to meet the training objectives.

Skills Development

In training, a skills development session involves a series of sequential steps organized to teach or learn psychomotor skills and/or counseling skills through the use of skills demonstration, coaching, and practice. (Skills development is particularly important for the clinical skills needed to provide LAPMs.) A skills development session can be divided into three parts: an introduction; a body; and a summary. During the **introduction**, the trainer orients the participants to the desired skills-set and checks the participants' current knowledge with respect to the skills. During the **body** of the skills development session, the trainer first demonstrates the skill or activity on a model and the participants practice the skill on the model(s); then, the trainer demonstrates the skills with a client, after which the participants (having become competent on the model) provide the service under the trainer's supervision, coaching, and assessment. Finally, at the end of the skills development process, the trainer **summarizes** the skills development session by reviewing the essential points and clarifying any questions the participants may have. **Table 7-2** amplifies upon this progression of performance and the respective roles of the trainer and the participant.

Table 7-2: Progression of Performance during Skills Development			
Role	**Level of Performance**		
	Skill Acquisition	**Skill Acquisition/ Competency** (with models)	**Skill Competency** (first with models, then with clients)
Trainer	Demonstrates skill/activity	Coaches the participant and assesses the participant's performance	Evaluates the participant's performance
Participant	Observes the demonstration	Practices and performs the skill/activity	Performs the skill/activity
The participant progresses from skill acquisition to skill competency using anatomic models. After the participant reaches skill competency using a model, the process begins again as the skill/activity is performed with clients. *Adapted from:* JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition.* Baltimore.			

Use of Anatomic Models in Clinical Training[26]

Anatomic models can be used to teach and to learn clinical skills, both simple and complex, in a safe environment. Trainers can use anatomic models to demonstrate and explain various clinical steps, while participants can use models for learning these clinical skills through repeated practice before moving on to working with clients. (Use of anatomic models is the central feature of the "humanistic approach to teaching and learning.")

Some of the most important reasons for use of anatomic models are that:

- The quality of service provision to the client receiving RH/FP services in a clinical training situation is not affected (e.g., clients are not adversely affected if a trainee makes a mistake when acquiring skills on models).
- Difficult clinical task steps (e.g., isolating the fallopian tube during female sterilization, or inserting an IUD high in the uterine fundus) can be practiced repeatedly on a pelvic model without actually performing the procedure on a client.
- Practice is not limited to the hours when a clinic is open or an operating room is available.
- Practice does not depend solely on the availability of clients.
- Several participants can practice simultaneously, reducing training time.
- The number of actual clients needed for practice is reduced.

Some helpful suggestions for using anatomic models include the following:

- Trainers should be as proficient in demonstrating the skill on a model as they are with providing the actual service to clients.
- The trainer should ensure that adequate numbers of models are available for training events. (One model is recommended for use by every 2–3 participants.)

[26] JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

- The trainer should ensure that conditions during simulated practice replicate the real situation as closely as possible (e.g., that instruments used to perform the procedure and that infection prevention practices to be followed in the simulation are the same as those needed during the real procedure).

Demonstration of Skills: Helpful Suggestions

Trainers should use a slide show or training video (if one is available) to demonstrate the sequence of steps in the activity or skill before actually demonstrating the sequence of steps on a model. The sequence of tasks and steps for a skill set is usually presented in a **learning guide**, which is a detailed and comprehensive list of **all** of the tasks and steps required to perform a clinical procedure (or counseling session) correctly (i.e., per national standards). When demonstrating the skill on a model, the trainer should follow the sequence of tasks and steps outlined in a learning guide and also follow the suggestions in **Table 7-3**. The **Demonstration Skills Self-Assessment Guide** in **Appendix 7-4** should also be used.

Table 7-3: Tips for Skills Demonstration and Practice
1. State the **objective** of the step while progressing from one main step to the next (e.g., "The purpose of providing local anesthesia in non-scalpel vasectomy is…," or "The next step will demonstrate how to fix the vas deferens using the three-finger technique before applying the ringed forceps.")
2. Ensure that **all participants can see** the steps involved.
3. **Never** demonstrate the skill or activity incorrectly.
4. Demonstrate the procedure in as **realistic** a manner as possible, using actual instruments and materials in a simulated clinical setting.
5. Follow all steps of the procedure in the **proper sequence**, according to approved performance standards (following the appropriate learning guides), including nonclinical tasks and steps, such as conducting preoperative and postoperative counseling, communicating with the client during surgery, and using recommended infection prevention practices.
6. **Take enough time** so that each step can be observed and understood.
7. **Keep the participants engaged** by asking questions regarding the procedure and ensuring their understanding of the skill.
8. After the trainer has demonstrated the skill, the participants should **practice the skills** in the simulated setting on the model, with one participant playing the role of provider and another participant playing the client, and then with the participants switching roles.

Providing Feedback during Skills Development Sessions

Provision of feedback is very important in the skills development component of the training (most of which will be taking place in the presence of a client who is awake). Some useful suggestions for trainers in providing feedback during the skills development process include the following:

- Set aside time for feedback sessions, as provision of feedback is a central part of the coaching process.
- Provide feedback before and after skills development sessions, to emphasize the critical steps of the procedure.
- Decide during these feedback sessions what roles the participants will take (i.e., that of primary provider, assistant, or observer, or of a counselor, during counseling training)

- Decide on types of nonverbal communication to be used by trainer and participants during trainer-guided sessions with clients.
- Ask the participants to identify their personal strengths and the areas in which they need to improve.
- Provide specific, objective feedback that includes suggestions of what and how to improve.
- Decide with the participants what to focus on during the practice session, including how they will interact with clients.
- Provide discussion and feedback to the participants (as far as practical) before and after the clinical procedure in which the training is being given.
- Keep such feedback to the bare essentials during client sessions.
- Keep your positive feedback restrained and low-key.
- Use nonverbal feedback to show approval or to intervene when needed. For example, a gentle touch on the hand or shoulder should prompt the participant to stop the procedure and wait for instructions.

Clients' Rights during Training[27]

Trainers are responsible for protecting clients' rights during training events. To maintain a client's rights, trainers should routinely do the following:

- Ensure that the client's right to bodily privacy is protected, especially during physical exams and clinical procedures.
- Make every effort to keep the client's information confidential. As far as practical, all client-provider interactions should have visual and auditory privacy.
- Obtain the client's permission before allowing a participant to assist in or perform a procedure on the client. The client has the right to refuse care from a training participant (trainee) without fear of being denied services or any other prejudice from the trainer or other regular providers. If the client refuses permission for the trainee to perform the procedure, the trainer or some other service provider should perform it.
- Be present during any client contact in a training situation. The client should be made aware of the trainer's role, as well as of the role of any other person involved in providing the service.
- Select clients for training purposes carefully, ensuring that the clients do not pose any unusual and difficult clinical situations (e.g., inguinal hernia in a vasectomy client or extreme obesity in a female sterilization client).

Reviewing the Day's Activities

Review of the day's activities is an important step in a training event, as it helps to elicit feedback from the participants and co-trainers on the conduct of the training. The trainer should allocate time for the review process at the end of each day's training activities. The review process provides the opportunity to clarify any questions that the participants may have regarding sessions conducted during the day. The review time also allows the trainer to connect the different topics covered during the day, to show their relationship to the overall training event and to set the stage for the next day's activities.

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[27] *Adapted from:* JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

Reviewing the Day's Activities with the Participants

The trainer should record the participants' reactions to the day's activities, as this information will assist the trainers in either refining the training course or modifying it for the future. This review can be done using written forms or through discussions with participants as the training event unfolds. A sample **Daily Participant Feedback (Reflection) Form** is provided in **Appendix 9-1**. Feedback about all aspects of the training, including its administration and logistics, is valuable and should be solicited. The trainer should ask questions like "What was the most useful activity for you today and why?" "What from today's activities would you take back with you and share with colleagues?" At the end of the training event, provide evaluation forms to the participants so they can fill these out anonymously before leaving. The trainers should collect these forms and analyze the information with the co-trainers. A **Sample End-of-Training Evaluation Form** is given in **Appendix 9-3**.

Reviewing the Day's Activities with Co-Trainers

If two or more trainers are conducting the training event, the lead trainer should conduct daily trainers' meetings. The trainers can discuss participants' reactions (feedback) to the day's activities and make adjustments to the following day's activities, if needed.

Some helpful suggestions for conducting a review meeting with co-trainers include the following[28]:

- Get each trainer's perspective on the activities covered during the day (e.g., what went well and what did not go well) and identify ways to improve the activities, if needed.
- Discuss each trainer's role for the following day's sessions, and assign sessions for each trainer (if not already done) or make any changes, if needed.
- Prepare the classroom, rearranging seating (if necessary) and setting out participant materials and name tents (or rearranging name tents to facilitate mixing among the participants).
- Set up audiovisual equipment (flipcharts, markers, overhead projectors, PowerPoint presentations, videos) and check that the anatomic models and other items needed for simulated practice are present and functional.

Reporting on the Training Event

The lead trainer for all training events should complete a training event report, with assistance from the co-trainers. The training event report should capture the salient points of the training event (e.g., the name of the training, the number of days for the training, the names and number of participants and trainers, and the name of the training site, including district, region, or country). The training event report should also capture the number of participants who successfully completed the training and the scores that they achieved in the pretest and the posttest, including the outcome of the skills assessment for each participant. The training event information should be organized in a standard format that will assist in recording the information in a standardized training database. A **Sample Training Report Outline** is given in **Appendix 7-5**.

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[28] *Adapted from:* Schaefer, L., et al. 2000. *Advanced training skills for reproductive health professionals*. Baltimore: JHPIEGO.

Chapter 8

Linking Training to Performance on the Job

Introduction

Linking training to on-the-job performance is very important for ensuring that the participants apply the knowledge and skills acquired during the training when they return to their jobs. Trainers, supervisors, and participants (providers), as well as training systems, are stakeholders in this effort, and they should work together to achieve better training outcomes. Unless the knowledge and skills learned during training are applied subsequently on the job, the training will not have been effective. The more time that elapses between the training and the use of what was learned, the less likely it is that the knowledge and skills acquired during the training will be applied.[29]

Several useful strategies for linking training to performance are discussed in this chapter:

- Follow-up of trainees/participants by the trainers
- Facilitative supervision
- Transfer of learning

Training Follow-Up

Training follow-up offers the opportunity to reinforce the trainees' knowledge, skills, and attitudes through coaching, provide feedback and encouragement, help ensure the availability of needed equipment and supplies, and problem-solve other workplace issues that hinder the application of newly acquired knowledge and skills. However, one consistent challenge of training interventions has been instituting regular training follow-up. The expectation that the trainers will perform this follow-up has often not been met (nor has this been a realistic goal), due to funding constraints and other demands on the trainers' time. Programs often properly look to the supervision system to perform this function of linking training to subsequent service performance.

Some useful considerations for follow-up of training include the following:

- Ideally, training follow-up should be conducted no later than 2–6 months after the training event; the more frequent and/or immediate (after the training event) the follow-up is, the more likely it is that it will support the link between training and performance.
- Ideally, all participants should be followed up (although it may not always be possible to achieve this extent of follow-up, for a variety of programmatic reasons).

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[29] For example, studies in the United States have shown that only 40% of skills learned in training are transferred immediately, only 25% of skills remain after six months, and just 15% persist after one year (Broad, M. J., and Newstrom, J. W. 1992. *Transfer of training: Action-packed strategies to ensure high payoff from training investments*. Reading, MA: Perseus Press).

- Training follow-up should be jointly provided by the trainer and by the provider's on-site or off-site supervisor(s).
- The action plans that were created during training should be used as a tool for structuring the training follow-up.
- The assessment and on-the-job coaching that occur during follow-up visits should be guided by and be consistent with national standards and/or evidence-based practice

Planning for and Conducting Training Follow-Up

Trainers, program managers, and supervisors should jointly plan for training follow-up well in advance of its conduct. Important aspects to consider in planning for training follow-up include the following:

- The purpose and objective of follow-up
- The budget for follow-up
- The schedule and length of time needed for follow-up (For clinical services, this depends heavily on client volume; in general, at least 2–3 days are needed at a facility for follow-up of LAPM skills developed during training.)
- The participants' action plans developed during the training
- Competency levels attained by the participants during training
- The skills needed to conduct the follow-up (If needed, local skilled service providers can be used to assess and support newly trained providers.)
- The tools needed to conduct the follow-up at the work place (e.g., interview guides, observation checklists, facility assessment guides)
- The relevant national standards and guidelines
- The specific equipment, supplies, and commodities needed at the facility to provide the specific service

Table 8-1 presents in detail the elements of training follow-up and the suggested actions that should be taken during the follow-up visit(s).

Facilitative Supervision[30]

Facilitative supervision is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and those being supervised. Facilitative supervision, like training follow-up, supports the application of skills on the job, although training follow-up is focused specifically on providers who have recently completed training, whereas facilitative supervision is a more regular, more routine, and broader function that can be applied to improving the performance of all providers at the workplace. Facilitative supervision also addresses other impediments unrelated to the provider's skill level (e.g. stock-outs of FP methods, a lack of equipment needed for services, or a lack of adequate support from existing systems or other workplace-related factors).

[30] The ACQUIRE Project. 2008. *Facilitative supervision for quality improvement*. New York: EngenderHealth/ The ACQUIRE Project.

Table 8-1: Follow-Up of Training	
Elements of Follow-Up	**What to Do during Follow-Up**
1. Communication with facility manager/ supervisor • Schedule of visit • Purpose/objective of follow-up • Posttraining competency and service-activity level of provider	• Meet with the facility manager/supervisor and review follow-up schedule, purpose, and objective. • Review the provider's performance on the job.
2. Provider's action plan	• Review progress on the action plan with the facility manager/supervisor (see sample action plan, **Appendix 8-1**).
3. Communication with provider	• Meet with the provider and share the purpose, objective, and schedule of follow-up. • Review the provider's application of skills at the workplace and his or her progress on the action plan. • Note and try to address obstacles (see **Sample Training Follow-Up Form**, **Appendix 8-2**).
4. Standards and guidelines	• Ensure the availability of and adherence to standards and guidelines at the workplace. • Address any shortcomings.
5. Provider skills and coaching support	• Observe the provider's skills on clients, using an observation checklist. • Provide encouragement, coaching support, and constructive feedback (see **Sample Skills Observation Checklist**, **Appendix 8-3**). • Address any shortcomings.
6. Logistics, supplies, equipment	• Assess the adequacy of logistics, supplies, and equipment (see sample **Follow-Up Facility Observation Form**, **Appendix 8-4**).
7. Physical facility	• Note the physical state of the facility and the availability of needed spaces, such as surgical areas, recovery rooms, and instrument-processing areas, including storage areas for equipment and supplies (see **Appendix 8-4**). • Share findings with the facility manager/ supervisor.
8. Review of findings with facility management and staff	• Share major findings with facility manager/ supervisor and staff. • Address means of solving problems that have been identified.
9. Preparation of report	• Write draft follow-up report. • Share draft with stakeholders to get input, and finalize report. • Make/discuss recommendations to enable provider's application of skills, knowledge, and attitudes at the workplace.

Facilitative supervision may be conducted by on-site or off-site supervisors. In either situation, facilitative supervisors help to establish the link between training and the application of skills on the job through the following planned activities:

- Orienting site management and staff to the principles of quality and the quality improvement process, and explaining how training is linked to this process.
- Training staff to define, develop, and use objectives and workplans and discussing how service delivery is affected by these processes.
- Ensuring the availability of, and adherence to, national service standards, norms, and policies, and relating them to services actually being provided.
- Ensuring the availability of, and access to, RH/FP equipment, supplies, and commodities, including following correct reporting and ordering procedures.
- Identifying ways to improve the physical aspects of the site.
- Observing providers while performing clinical skills and providing constructive feedback and encouragement. (If the supervisor does not possess the clinical skills being assessed, he or she should call upon locally available trainers or experienced clinical service providers to do so.)
- Facilitating joint problem solving through the use of COPE®.[31]

Transfer of Learning[32]

"Transfer of learning" is defined as *ensuring the knowledge, skills, and attitudes acquired during a training/learning intervention are applied on the job*. The transfer of learning process is an interrelated series of tasks performed by supervisors, trainers, participants/learners, and coworkers before, during, and after a learning intervention to maximize the transfer of knowledge, skills, and attitudes to improve job performance. The details of this process are presented in a matrix in **Table 8-2**. The different items in the matrix can be adapted to fit many different training/learning situations, including the use of different types of training/learning methods (e.g., classroom, on-the-job, self-directed) and of supervisory arrangements (e.g., internal on-site, periodic external visits). The more items from the matrix that can be implemented, the stronger the transfer of learning is likely to be.

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[31] COPE (which stands for client-oriented, provider-efficient) is a simple self-assessment methodology to help providers of health services improve the quality of clinic operations by making them more oriented toward clients' needs and more efficiently organized for the number of clients seeking services. For detailed application and use of the COPE methodology and tools, readers should refer to: EngenderHealth, 2003. *COPE handbook: A process for improving quality in health services, revised edition*. New York.

[32] PRIME II and JHPIEGO. 2002. *Transfer of learning: A guide for strengthening the performance of health care workers*. Chapel Hill, NC.

Table 8-2: The Transfer of Learning Matrix

	Before Learning	During Learning	After Learning
Supervisors	• Understand the performance need • Participate in any additional assessments required for training • Influence the selection of learners • Communicate with trainers about the learning intervention • Help learners create a preliminary action plan • Support and encourage learners	• Participate in or observe training • Protect learners from interruptions • Plan posttraining debriefing • Provide supplies and space and schedule opportunities for learners to practice	• Monitor progress of action plans with learners and revise these as needed • Conduct posttraining debriefing with learners and co-workers • Address any impedement to the provider's application of skills (space, time, supplies, etc.) • Serve as a coach and role model, providing encouragement and feedback • Evaluate learners' performance • Stay in contact with trainers
Trainers	• Validate and supplement the results of the performance needs assessment • Use instructional design and learning principles to develop or adapt the course • Send the course syllabus, objectives and precourse learning activities in advance	• Provide work-related exercises and appropriate job aids • Give immediate and clear feedback • Help learners develop realistic action plans • Conduct training evaluations	• Conduct follow-up activities in a timely manner • Help strengthen supervisors' skills • Facilitate review of action plans with supervisors and learners • Share observations with supervisors and learners • Maintain communication with supervisors and learners
Learners	• Participate in needs assessments and planning • Review course objectives and expectations and prepare preliminary action plans • Begin establishing a support network • Complete precourse learning activities	• Participate actively in the course • Develop realistic action plans for transferring learning	• Meet with supervisors to review action plan • Apply new skills and implement action plan • Use job aids • Network with other learners and trainers for support • Monitor own performance
Co-workers and others	• Participate in needs assessments and discussions of the training event's intended impact • Ask learners to bring back key learning points to share with the work group	• Complete learners' reassigned work duties • Participate in learning exercises at the request of learners	• Be supportive of learners' accomplishments

Adapted from: Prime II and JHPIEGO, 2002. *Transfer of learning: A guide for strengthening the performance of health care workers*. Chapel Hill, NC.

Chapter 8

Chapter 9

Evaluation of Training

Introduction

Evaluation of training is a systematic process of collecting, processing, analyzing, and interpreting data related to training and its effects on service delivery. It begins with the training needs assessment, when baselines are established against which training results will later be measured, both during and after training. Evaluation of training continues when follow-up of training is conducted to assist and support trained providers to better apply their knowledge, skills, and attitudes on the job. Evaluation of training helps to:

- Determine if training has achieved its objectives
- Identify any aspects of training that need to be improved
- Identify the contributions made by training in strengthening service delivery (increased availability, accessibility, and quality of services)
- Identify any aspects of the training intervention that need to be improved

The results of training evaluation can be used as an input to inform and strengthen the RH/FP program.

Levels of Evaluation of Training

Evaluation of training takes place at two stages: *during* the training and *after* the training.

During the training, evaluation consists of two levels of assessment:

1. The participants'/trainees' reaction to the conduct of training
2. The learning that took place as a result of the training

After the training, evaluation also consists of two levels of assessment:

1. Whether the participants/trainees have been able to apply the knowledge, skills, and attitudes acquired during training at their work sites
2. Whether the training made an impact on larger service delivery outcomes

These four levels of evaluation of training are presented in **Table 9-1 (page 60)**.

Table 9-1: Evaluation of Training	
Types of Evaluation	**Suggested Methods**
During and at the end of the training event	
Level 1: Participant Reaction Did the participants like the course?	• Daily participant feedback (oral or written) • Daily trainers' meeting • End-of-session/trainer evaluation • End-of-training surveys • End-of-training informal discussions (see **Appendixes 9-1, 9-2, 9-3,** and **9-4** for Level 1 assessment tools)
Level 2: Participant Learning What knowledge, skills and attitudes did the participants acquire?	• Knowledge-based assessments (e.g., pretest and posttest questionnaire; see **Sample Pretest Questionnaire, Appendix 9-5**) • Competency-based skills assessment checklists (e.g., see **Appendix 8-3** for **Sample Skills Observation Checklist**)
After the training event (at the work sites)	
Level 3: Participant Behavior Are participants/providers applying the newly acquired RH/FP knowledge, skills, and attitudes at their work sites?	• Site visit evaluation • Interview with provider(s) who completed training • Interview with supervisor/facility manager • Competency-based skill assessment (see **Appendixes 5-5, 5-6,** and **5-7**)
Level 4: Results or Impact Change in availability, accessibility, quality, and utilization of RH/FP services	• Service delivery statistics • Client exit interviews • Client record reviews • Observation at the facility

Adapted from: Sullivan, R., and Gaffikin, L. 1997. *Instructional design skills for reproductive health professionals*. Baltimore: JHPIEGO; and Kirkpatrick, D. L. 1994. *Evaluating training programs*. San Francisco: Berrett-Koehler Publishers, Inc.

Level 1: Evaluation of Participant Reaction

An evaluation of the reaction of training participants helps to measure their satisfaction with the training event. It is important to assess participants' satisfaction with the content and delivery of the training event (or session) because they are more likely to apply what they have learned at their workplace when their satisfaction and engagement have been higher. Suggested methods for getting participants' reactions to training are shown in **Table 9-1**. Feedback on training often is collected on a daily basis, as well as at the end of the training. Daily training evaluations are used to modify the training as it is in progress. End-of-training feedback enables trainers to make modifications for future training events.

Some helpful considerations for developing Level 1 assessment tools include the following:

- Be clear about what you want to measure, why you want to measure it, and what you are going to do with the information obtained.
- Do not ask for information about something you cannot change.

- Strike a balance in your questions among the different areas you want to evaluate at this level (e.g., content, materials, methods, trainer, environment, logistics).
- For an end-of-training survey, include closed-ended questions so that information may be easily tabulated. Use a rating scale for questionnaire items so that responses can be easily categorized into "yes/no" categories.
- Use different question formats to collect information regarding participants' reactions (e.g., yes/no, rating scale, short answers, sentence completion).
- Keep the participant response form simple and short.
- Ensure that the participants have sufficient time to complete their response forms.
- Try to obtain an immediate response from participants after the classroom sessions (i.e., before they leave the training room/area).

Level 2: Evaluation of Participant Learning

Level 2 evaluation should be used by trainers to assess the participants at the end of training to determine if they have acquired the knowledge, skills, and attitudes necessary to provide safe, quality services. Ideally, both the knowledge and skills of participants should be assessed at the beginning of training to establish a baseline for future comparison. A knowledge test at the end of the training will demonstrate the change in knowledge achieved by the participant. Although skills should also be assessed at the beginning of a training event, this is usually not done in training for LAPMs, because such training is based on the assumption that the provider lacks the requisite clinical skills (as identified by the TNA). In the event that skills assessment is to be conducted to establish baseline pretraining skill levels, then such an assessment should be performed using anatomic models (or in simulated settings) rather than using clients. When knowledge and skills are assessed toward the end of training, standardized knowledge and skills assessment tools (e.g., checklists) should be used to assess the participants' competency (see **Appendix 8-3** for a **Sample Skills Observation Checklist**). The assessment of competency is based on the correct performance of the "critical steps"[34] in the observation checklist and a score of 80% on a knowledge test.

Knowledge assessment tools

Knowledge can be assessed using knowledge assessment tools (pretests and posttests) at the beginning and at the end of the training. The difference in the test score demonstrates the knowledge gained by the end of the training. Knowledge tests should assess the learning as specified in the learning objectives, and each test item should link back to the training objectives. The test should be **valid** (i.e., it should measure accurately what it is supposed to measure), and each test item should be **reliable** (i.e., it should give consistent results from one measurement of a given participant to the next).

Commonly used knowledge tests employ such test question formats as true-false, multiple choice, and/or matching. Some common advantages and disadvantages of these test types are given in Table 9-2 (page 62).

[34] Refer to Chapter 11: Strengthening Training Systems for a description of the "critical steps."

Table 9-2: Level-2 Evaluation—Methods of Testing Knowledge		
Question Type	**Advantages**	**Disadvantages**
True-False	• Possible to sample large amount of information • Easy to score • Inexpensive to use	• 50% chance of simply guessing the correct answer • Low reliability
Multiple Choice	• High validity and reliability • Guessing reduced, compared with true-false format • Easy to score	• Difficult to write
Matching	• Easy to score • Maximum coverage of knowledge level	• More time-consuming for participant to answer than other methods of testing knowledge • Difficult to write

Some helpful considerations regarding the development of knowledge test questionnaires include the following:

True-false statements

- Avoid using words like *more, few, large,* and *good,* as these are relative and may confuse the participant.
- Avoid using words or expressions that may identify a statement as true or false. Words often found in false statements that should be avoided are: *only, never, all, every, always, none* and *no*. Words often found in true statements that should be avoided are: *usually, generally, sometimes, customarily, often, may, could,* and *frequently*.

Multiple-choice questions

- All multiple-choice questions must consist of a **stem** and a set of possible **response(s)**.
- The stem may be an **incomplete sentence** or a **question** that represents a clearly stated central problem.
- The set of possible responses should be brief, and all must be **plausible**.
- Try to create choices of equal lengths.
- Limit the use of such answer options as "'all of the above" and "none of the above."
- Maintain grammatical consistency or parallel structure for both the stem and the responses.

Matching tests (Matching tests are used less frequently than the previous two methods of testing knowledge, because they are difficult to do well.)

- A matching test consists of two lists of words and phrases that are to be matched.
- Matching tests are often presented in two columns, with a list of words in one column to be matched with a list of words or phrases from the second column.
- Matching tests should have an equal number of items in both columns. (Having an unequal number of items in the two columns makes it more difficult for the test-taker to correctly match the two sets and makes the test more time-consuming.)

After developing the knowledge test questions, **review** them for the following issues:

- Are all training objectives addressed?
- Do the questions directly relate to the achievement of these objectives?
- Does each question address a meaningful or important topic?
- Does each question address only one topic?
- Have tricky, obvious, or irrelevant questions been avoided?

Field-test (or pilot-test) the questions whenever possible before using them for regular training activities.

Skills assessment tools

Skills assessment tools or skills checklists are performance-based **assessment instruments** used by trainers to measure progress in learning and to objectively evaluate the competency of participants during and at the end of a training event. Skills checklists are generally derived from a more detailed **skill development** instrument, usually called a **learning guide**, which breaks a skill or activity down into its essential component steps. Progress in developing a skill is measured in terms of various levels of performance. The three levels of performance used in competency-based training (described more fully in Chapter 4) are:

- **Skills acquisition** is the **initial phase** in learning a new RH/FP skill or activity. Coaching and assistance are necessary to achieve correct performance of the skill or activity. Learning guides are the principal tools at this stage.
- **Skill competency** is the **intermediate phase** in learning a new skill or activity. Learning guides are still the main learning instrument at this stage. Trainers and peers may also start to use a skills checklist to measure the progress of learning as participants become increasingly confident of their skills. The skills checklist may also be used to assess competency at the end of the training.
- **Skill proficiency** is the **final phase** in learning a new skill or activity. Skill proficiency occurs after the training with repeated practice over time. Competency-based skills checklists are used during follow-up at the workplace to measure participants' or providers' proficiency, based on the performance standards needed to accomplish the task at the workplace.

Advantages of skills assessment tools include the following:

- They ensure that training is based on a **standardized procedure**.
- They help to **standardize training materials**.
- They can function as a **self-assessment** or a **peer-assessment tool**.
- They ensure that all participants have their skills **measured according to the same standard**.
- They provide a basis for **follow-up evaluation** of trained providers.

Two types of **skills assessment rating scales** are commonly used with competency-based skills development and assessment instruments: **numeric** or **multilevel** scales, and **pass/fail** or **yes/no** scales. Numeric or multilevel rating scales are usually used with learning guides,

because they allow participants and trainers to rate the degree of improvement in the performance of a skill. A commonly used numeric scale has three levels:

1 = **needs improvement**

2 = **competently performed**

3 = **proficiently performed**

A **pass/fail** or **yes/no** rating scale is generally used with evaluation **checklists** or **assessment instruments**. Trainers or supervisors use this rating scale to evaluate participant or provider performance and to check or confirm whether a step has been performed satisfactorily. A commonly used pass/fail or yes/no rating scale would be:

Yes = Satisfactory—task performed according to standard procedure

No = Unsatisfactory—task not performed according to standard procedure

N/O = Not observed—step or task not performed by provider/participant during evaluation

Some helpful considerations regarding development of skills assessment tools include the following:

- Identify the tasks and steps needed to perform the skill. This can be achieved by conducting a standardization workshop or activity, which involves observing and working with skilled providers/experts, or it can be achieved by adapting an existing learning guide to a particular RH/FP training event.
- Place the tasks and steps needed to perform the skill in the correct sequence.
- Identify the standard or minimum acceptable level of performance for each of the tasks and key steps to be measured.
- Select a rating scale that best fits the types of items that are to be measured.
- Write clear and concise directions for using the skills assessment tool.
- Field-test the skills assessment tool to ensure that all steps or tasks are included, are understood, and are in the correct order.
- Make adjustments, as needed, and finalize the tool.

Level 3: Evaluation of Participant Behavior after Training

A Level-3 evaluation measures the program result at the individual participant/provider level and is conducted after the training event, when the participants have returned to their worksites and have had the opportunity to apply their new knowledge, skills, and attitudes on the job. From the programming for training perspective, Level-3 evaluations (i.e., evaluation of a participant's **change in behavior in applying new knowledge, skills, and attitudes on the job**) address the most important question about the training event: "How has the training affected and improved the way that participants perform their jobs?"[34]

[34] As noted in Chapters 2 and 3, many other factors also affect the application of skills on the job (e.g., the availability of commodities and equipment to provide RH/FP services, and the structure of work at the workplace).

On-the-job assessment of providers' skills should be conducted at least 1–2 years after the training event, to allow time for providers to apply their knowledge, skills and attitudes. A change in provider practice can be documented by comparing Level-3 evaluation data with baseline data collected during the TNA. Data collection tools used during the TNA can be and should be used later during the performance evaluation, to document the change in provider performance. Program managers, supervisors, and trainers should plan and budget for a Level-3 evaluation initially, to capture the contribution of training to service delivery outcomes (at whatever scale is feasible, given the program's financial and human resource constraints). Programs should seek assistance from a monitoring and evaluation expert to plan and implement a Level-3 evaluation.

A Level-3 evaluation covers the following areas:

- Application of skills on the job according to standards
- Availability of related resources that affect services (e.g. equipment and supplies, commodities, physical infrastructure, etc.)
- Structure of work that supports or impedes service delivery (e.g. rewards, incentives, restructuring to accommodate greater workload).

Planning a Level-3 evaluation

Some helpful considerations in planning a Level-3 evaluation include the following:

- **Purpose and objective of the evaluation.** Typical Level-3 purposes and objectives include:
  - ➤ To demonstrate the knowledge and skill levels of the providers at their worksite
  - ➤ To demonstrate the increased readiness of their facilities to support quality services
  - ➤ To demonstrate clients' reaction/response to the services provided
- **Indicators.** List the indicators that will be used to demonstrate the findings. (Match them with the indicators identified during the TNA.) Typical Level-3 indicators include:
  - ➤ Number and percentage of providers who applied their knowledge, skills, and attitudes on the job according to standard
  - ➤ Number and percentage of trainees who retained their knowledge, skills, and attitudes posttraining at worksite (time since training)
  - ➤ Number and percentage of clients satisfied with services
  - ➤ Number and percentage of clients adopting FP methods.
- **Methodology.** Outline the following:
  - ➤ What will be done in the evaluation (e.g., site visits to institutions/facilities; interviews with trainees, providers, clients, etc.; review of existing service information)?
  - ➤ How will the evaluation be done (e.g., is it going to be retrospective or partially prospective)?
  - ➤ Which data collection instruments will be used (e.g., observation forms, self-administered questionnaires, interview guides)?
  - ➤ Who will conduct the evaluation (e.g., trainers, supervisors, program managers, outside consultants, etc.)?
  - ➤ Where will the evaluation be conducted (e.g., at one or more sites, at clinics, training sites, etc.)?
  - ➤ Who will clean, enter, and analyze the data?

- **Timeline.** Provide an estimate of the time it will take to complete each step and activity of the evaluation process.
- **Responsible person.** List the names of people who will be responsible for each step and activity in the evaluation process.
- **Recommendations.** Develop a plan for how the recommendations produced by the evaluation will subsequently be used.
- **Budget.** Provide an estimate of how much the evaluation will cost, including costs of travel, staff, and materials.

Some helpful tools used in a Level-3 evaluation include the following samples:

- Skills observation checklist—**Appendix 8-3**
- Facility observation guide—**Appendix 9-6**
- Provider interview guide—**Appendix 5-6**
- Supervisor/facility manager interview guide—**Appendix 5-7**

Level 4: Evaluation of Results or Impact

A Level-4 evaluation measures the impact or result of the training intervention at the program level. For FP/RH programs, a Level-4 evaluation helps to answer the question "Did the training result in improved quality, availability, and utilization of services?" Level-4 evaluations are undertaken a few years after program implementation, to allow time for changes to have an impact at the program level. A Level-4 evaluation is a larger evaluation undertaking, with active involvement of monitoring and evaluation experts. It may have difficult to measure the impact of training per se with a Level-4 evaluation, because of the influence of other program variables besides training on service delivery outcomes. Level-4 evaluations are expensive and resource-intensive, and for these reasons they are rarely done for training (alone).

Nonetheless, a review of program statistics can provide indications for a positive effect of training on service delivery (in comparison with baseline measures of the same variables). Variables often measured include:

- Number of service delivery sites with trained providers
- Number of service delivery sites with trained providers offering a broad method-mix of FP services
- Utilization of FP services from sites with trained providers
- Client satisfaction with FP/RH services at sites with trained providers

Other tools/processes that may help in gathering data for Level-4 evaluations include:

- Client exit interviews
- Client record reviews
- Observation of RH/FP services at the facility

Chapter 10

Designing Training Events

Introduction

Designing a training event is a critical step in the overall programming for training process. Designing a training event consists of 1) developing an instructional plan and 2) developing training materials, both of which are essential for implementing the event. The development of an instructional plan consists of identifying the overall training objective, the individual session objectives, and the major job tasks, based on performance standards; conducting a training content analysis; and evaluating teaching and learning methods, learning activities, and assessment methods. The training materials needed may include a trainers' manual, participant handbooks, trainers' notes, presentation slides, training videos, web-based training sessions, and CD-ROM–based sessions.

This chapter discusses how to develop a few of the basic training materials essential for implementing training in RH/FP (e.g., the training schedule, a session plan, a case study, and a role play). The design of a training event is influenced by a number of variables, such as the availability of existing training materials, the findings of the TNA, and the number of available training days. Designing a training event requires complex training skill-sets and usually falls into the domain of advanced and master trainers.

Development of an Instructional Plan for RH/FP Training[35]

An instructional plan is a design document that outlines the plan for delivering a training event. Findings from the TNA (see Chapter 5) inform both the instructional planning process and the finished instructional plan. Trainers, program managers, and supervisors who work on this process of instructional planning are called "instructional designers" in this resource package to distinguish this function from other training functions.[36] Whoever is designing the instructional plan should revisit the TNA findings at this stage to ensure that training is the right intervention, because instructional plans (and the training that ensues) will not be able to successfully address service performance gaps not due to gaps in provider knowledge, skills, and attitudes.

Developing an instructional plan involves the following eight steps (which are discussed sequentially below): writing the training objective; identifying major job tasks; conducting training content analysis; writing session objectives; selecting training activities; selecting

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[35] The following steps in the instructional design process have been adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

[36] In the broader usage of the term, an *instructional designer* is a person who applies instructional learning theory to the organization and design of learning programs. *Instructional design* itself is a systematic approach to course development that ensures that specific learning objectives are accomplished.

training materials; selecting training methods; and selecting assessment methods. After completing each step of the instructional plan development process, the instructional designer should use the **Sample Instructional Planning Worksheet** (**Appendix 10-1**) to record the product from each of the steps, until the entire worksheet is compete. When the worksheet is complete, the instructional plan for the training event will have been developed.

1. Writing the **training objective**. The training objective is a general statement that clarifies, in broad terms, what the participants/trainees will be able to do after the training event is completed (e.g., "By the end of the training, the participants will be able to provide no-scalpel vasectomy services according to national standards").
2. Identifying **major job tasks**. Major job tasks are a set of skilled activities that, when performed together, help to achieve the training objective. Major job tasks should be written based on what the participants (providers) are expected to perform on the job, after training is completed. In determining major job tasks, instructional designers should use action verbs to demonstrate action (e.g., provide, examine, counsel). (See **Table 10-3**, page 70, or a more complete list of action verbs.) Using the same example given above for a training objective to provide NSV services according to national standards, the major job tasks would be:
   - Counsel clients on advantages of and precautions for NSV
   - Perform client screening for NSV
   - Perform surgical procedure for NSV
   - Practice standard infection prevention procedures
   - Provide postprocedure counseling

   Appendix 10-2: Job Tasks Worksheet can be used to identify major job tasks for a given training objective.
3. Conducting a **training content analysis**. The purpose of the training content analysis is to identify the **essential knowledge and skills** that providers (participants) "must know" and "must be able to do" to perform their major job tasks.

   The instructional designer should identify those skills that providers "must be able to do" and then arrange that group of skills in the sequence they are performed. These are the *essential skills* required to perform the major job task competently. The instructional designer should also identify the *"must know"* information—i.e., the *essential knowledge* required to perform the major job task competently.

   Together, the essential skills and knowledge provide the *essential training conten*t for the training event. Existing training curricula and materials are important resources for identifying the essential training content. Instructional designers should ensure that these resources are up to date in their technical information. Subject matter experts and providers who have been trained in the job task play an important role in streamlining the training content and in keeping it current. Instructional designers should avoid adding any skills and knowledge that are nonessential and are only "good to know" or "nice to know," as this may lead to an inflated curriculum, resulting in longer training events and ineffective utilization of limited training time.

   Appendix 10-3: Essential Skills and Knowledge Worksheet provides a tool for identifying the skills and knowledge required to perform each major job task. Designers should remove from the worksheet list any skills and knowledge that are "nice to know" but are not

essential to performing the major job task. Instructional designers should also refer to current technical resources for guidance while working on this step (e.g. World Health Organization's *Medical Eligibility Criteria for Contraceptive Use* and *Selected Practice Recommendations for Contraceptive Use*, and other published standards and guidelines, standard training materials, and service delivery protocols).

When **attitudes** are important (e.g., nondiscrimination toward women with postabortion complications), designers should list the behaviors, steps, or skills that demonstrate a positive attitude. Attitudes or beliefs can often be written in the context of interpersonal skills or self-management skills, but they may have a knowledge component as well. **Table 10-1** gives examples of behaviors/skills that demonstrate positive attitudes.

Table 10-1: Sample Behaviors and Skills that Demonstrate Positive Attitudes

Sample Behaviors *(These behaviors also include a knowledge component.)*	**Attitude**
• Ensures privacy and that the client is comfortably seated. • Encourages the client to indicate if she becomes too uncomfortable during the procedure.	Positive attitude and empathy toward clients
• Employs a variety of learning techniques. • Creates an accepting rather than defensive climate for learning.	Openness to different styles that encourage learning
• Changes practices to prevent a client's HIV status from becoming known (e.g., does not segregate clients or color-code records, etc.). • Models respectful treatment of postabortion patients during all patient care.	Decreased discrimination against/ increased empathy toward a particular stigmatized group (e.g., HIV clients, postabortion care [PAC] clients, refugees, poor people, or youth)

Adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

4. Writing **session objectives. Session objectives** state what participants (trainees) will be able to do as a result of having completed a training session. A number of training sessions contribute to a training event. Each training session is focused on delivering the content of one major job task. Session objectives are based on the essential skills and knowledge required to perform the major job tasks according to standard. Achievement of a number of session objectives supports the achievement of the overall training objective. Writing clear session objectives is crucial in the design process. Session objectives help to identify the session content and to determine the session activities and methods that will be used in the training event; they also provide the basis for assessing the event's success.

   A well-written session objective should have the following three **components:**

   - **Performance** that is observable/measurable—what the participants will do
   - The **condition** of performance—the circumstances under which the participants will perform the activity
   - **Criteria** for the performance—how well the performance must be demonstrated for the provider to be deemed "competent"

Table 10-2 provides examples of session objectives and their respective components.

Table 10-2: Examples of Session Objectives			
Session Objectives (By the end of the session, the participants will be able to …)	**Performance That Is Observable/Measurable**	**Condition of Performance**	**Criteria for Performance**
On a written test, list at least two important client characteristics for screening vasectomy clients	List client characteristics for screening vasectomy clients	On a written test	At least two correct responses
During a simulated model practice, demonstrate the correct use of the "three-finger technique" to isolate and fix the vas deferens for performing vasectomy	Demonstrate the ability to isolate and fix the vas deferens for performing vasectomy	During a simulated model practice	Correct use of the "three-finger technique"
In an FP counseling role play, demonstrate at least two actions that ensure the client's privacy	Demonstrate actions that ensure the client's privacy	In an FP counseling role play	At least two correct actions

The instructional designer should write one or more session objectives for each major job task by focusing on the essential skills and knowledge required to perform that major job task. To be effective, session objectives should have the following characteristics (represented by the acronym SMART). They should be:

- **Specific:** The objective should precisely describe the behavior that needs to be achieved.
- **Measurable:** The objective should describe a behavior or action that is observable and measurable.
- **Attainable:** The objective should be attainable and achievable given the circumstances and resources.
- **Relevant:** The objective should pertain to the job tasks of the provider/participant and lead to the desired results.
- **Timely/time-bound:** The objective should specify a realistic time-frame for performance.

As when writing major job tasks, instructional designers should use action verbs in writing session objectives. **Table 10-3** provides many useful action verbs that relate to skills, knowledge, and attitudes, as well as verbs to avoid.

Table 10-3: Common Verbs for Writing Session Objectives		
Knowledge	**Skill**	**Attitude**
adopt, analyze, categorize, classify, compare, compile, contrast, describe, devise, differentiate, estimate, evaluate, explain, interpret, organize, predict, show, solve, summarize, tabulate	adjust, arrange, assemble, demonstrate, follow, identify, insert, inspect, locate, model, organize, perform, place, point to, practice, prepare, recognize, remove, sort	accept, ask, assist, attend to, choose, comply, conform, contribute, cooperate, defend, demonstrate, display, follow, help, initiate, join, listen, observe, participate, practice, propose, report, share, suggest, support, use
Verbs to Avoid While Writing Session Objectives		
appreciate, believe, comprehend, consider, develop an awareness of, internalize, know, realize, understand		

5. Selecting **training activities**. The next step in designing an instructional plan is to select activities that assist in achieving the training objectives. This should be done after taking into consideration the available resources for the training (collected during the TNA). The selected training activities should at a minimum:
   - Provide sufficient **practice and feedback** to develop the required skill.
   - Allow participants/trainees to work with **new information or situations**.
   - Require participants/trainees to **use the knowledge, skills, and attitudes** in the environment where they work, or in a similar environment.

Examples of training activities are given in **Table 10-4**.

Table 10-4: Examples of Training Activities

Types of Skills and Knowledge	Suggested Training Activities
Knowledge	• Self-study of training materials (books, slides, materials posted on the website, etc.) • Presentation/lecture • Reference to a job aid or service protocol • Group project (read, discuss, and report)
Skills	• Demonstration by trainer • Simulated practice (with anatomic models and equipment, as appropriate, e.g. pelvic model for IUD insertion or arm model for implant insertion) • Guided practice with clients
Attitude	• Guided reflection based on personal experience • Role play • Discussion • Respected guest speaker
Decision-making and problem-solving skills	• Case studies • Clinical exercises • Problem-solving exercises

6. Selecting **training materials**. After selecting the appropriate training activities, designers should identify and select **training materials** that support the session objectives. The selection should be based on the training activities selected, the participants' backgrounds (e.g., level of education, level of comfort in working with technology), and the available resources (e.g., funds, mechanism for distribution). Training materials may be:
   - **Printed materials**—reference manuals, participant handbooks, trainers' manuals, posters, charts, graphs, photographs, handouts, flipcharts, learning guides, checklists, training schedules, session plans, and assessment instruments
   - **Projected materials**—overhead transparencies, slides, presentations prepared on computers, videotapes, DVDs, audiotapes (audio projection)
   - **Real objects, models, and equipment**—anatomic models, clinical supplies, and equipment
   - **Computer-based training/Internet-based training**—online learning, e-learning
   - **Audio-conferencing/video-conferencing**—trainer-participant interaction using telephone, satellite connection

Instructional designers should fill out the **Sample Instructional Planning Worksheet** (**Appendix 10-1**), indicating the training activities and materials selected for use in the training session/event.

7. Selecting training **methods**. Instructional designers should select those training methods that will be most effective in supporting the training objectives. Commonly used training methods are summarized in **Table 10-5**; Chapter 12 addresses these individual training methods in more detail. Instructional designers should fill out the **Sample Instructional Planning Worksheet** (**Appendix 10-1**), indicating the training methods selected for use in the training session/event.

Table 10-5: Commonly Used Training Methods (for Counseling or Clinical Services)

Training Methods	Situations Where They Can Be Best Used
Classroom-based (or group-based) training	When training/learning requires significant face-to-face interaction with groups and/or trainers (e.g., discussion, role play, client contact requiring supervision
Structured on-the-job training	When participants are unable to leave their worksites for a long duration to attend group-based training. Structured on-the-job training provides the opportunity for increased trainer-participant interaction time, which could be of advantage in clinical training that requires one-on-one coaching.
Self-paced or independent study	When participants can facilitate their own learning with little or no input from the trainer or facilitator, or when the participants need or want to work at their own pace.
Technology-assisted training	When programs want to mutually maximize trainers' and participants' time in learning new knowledge, skills, and attitudes, but limited face-to-face time between trainers and participants is acceptable, technology-assisted training can be part of a self-paced and/or a distance learning/training intervention.
Distance learning	When training/learning and communication can occur in any location without extensive face-to-face contact between the trainer and other participants; can be based on print or electronic media.
Blended learning	When types of training objectives vary widely and are best facilitated by a variety of approaches that can efficiently use existing systems and resources
Whole-site training	When training/learning requires meeting the learning needs of all staff at a health care facility, depending on the staff's role on the service delivery team

Adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

8. Identifying **assessment** methods. Instructional designers should identify and select an assessment method or methods for each session objective that will measure the participant's performance described by the objective. **Table 10-6** lists a range of examples of assessment methods that could be used. Once selected, the desired assessment method should be entered into the Instructional Planning Worksheet.

Table 10-6: Examples of Assessment Methods	
Types of Performance	**Assessment Methods**
Knowledge	• Written tests (multiple choice, matching, yes-no • Participant interview • Participant questionnaire
Skills	• Observation (simulated practice on models, supervised practice with clients)
Attitude	• Participant and supervisor interview • Participant questionnaire • Observation (simulated practice on models, supervised practice with clients) • Client records
Decision-making and problem-solving skills	• Written tests • Participant and supervisor interview • Participant and supervisor questionnaire • Observation (simulated practice on models, supervised practice with clients) • Participant action plan

Adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

Development of Training Materials

As noted above, training materials support the achievement of session objectives within training events. Certain concepts may be better presented and certain skills may be better acquired using specific types or categories of training materials (e.g., lectures, videos, case studies, role plays). For example, knowledge of the advantages and disadvantages of the IUD may be better presented using lectures and discussion, whereas IUD insertion skills may be better acquired by means of a model demonstration using learning guides. In addition, different training materials help to meet the learning needs of different participants, and a combination of training materials is almost always needed for any training event.

The development of a few essential training materials—the training schedule, session plans, case studies, and role plays—is described below. A few other training materials used in RH/FP training have been described in Chapter 7 (e.g., flipcharts, PowerPoint slides, and overhead transparencies) and in Chapter 9 (e.g., knowledge and skills assessment instruments). A full discussion of the development of other, more complex training materials (e.g., videos, DVDs, slide sets, job aids, trainers' manuals, and participant handbooks) is beyond the scope of this resource package.

Training Schedule

A training schedule (also referred to as a training agenda) is a day-by-day description of all training activities for a given training event. The training schedule is usually developed from individual session plans for the given training event. A training schedule provides information on the number of training days and the time allocated for each training session or activity, as well as a brief outline of the training activities. Instructional designers may prepare a training schedule first and then start working on the session plans (see page 74). The training schedule should also have designated time for clinical practicum sessions. As the session plan evolves, the training schedule may change to reflect the session plans (e.g., time changes for specific activities). A sample training schedule is given in **Appendix 10-4**.

Session Plans

A "session" is a subdivision of a training event that delivers specific training content in a given time frame. A *session plan* is a set of instructions for conducting a training session that meets the session objectives. Session plans should be written for the person who coordinates the training activities. For trainer-led group-based training, the session plan should have instructions for trainers on the conduct of the training activities within a given session. For a self-paced or individualized training/learning exercise, the session plan should have instructions for the participants or trainees that will help facilitate their own learning. For structured on-the-job training, the session plan should have instructions for each responsible person involved in the training/learning activities (e.g., a set of session plans for the trainers/supervisors who facilitate the training at certain times, and a set for the participants, who pursue self-learning at other times).

A session plan may be presented in different formats, but a typical session plan usually contains the following essential components:

1. The **session objective**, indicating what a participant will be able to know and do at the end of that training session (One or more objectives may be grouped together for a training session.)
2. The **time** allocated for completing the training session
3. The **resources and materials** needed for conducting the session, with information on where they can be accessed
4. **Advance preparation**, which describes the activities and preparation the trainers should undertake to successfully conduct the training session (More details on advance preparation are provided in Chapter 6: Planning for Training, pages 27–31.)
5. A step-by-step **description of activities** that lays out what the trainers and participants should do to achieve the session objectives (Instructional designers should apply the **experiential learning cycle** in developing the session activities. More details on the experiential learning cycle is provided in Chapter 4: Approach to Training, pages 11–12.)
6. The **assessment strategy**, which describes the methods and techniques that will be used to assess the achievement of the session objective

A **Sample Session Plan** is given in **Appendix 10-5**.

Case Studies and Role Plays

Case studies and *role plays* are important training approaches that can be used to encourage participants' engagement in the learning process during clinical or counseling training. (Practice on models and clients is also a crucial part of skills acquisition, and is discussed in Chapter 7: Implementing Training, page 49.)

A *case study* is a training/learning activity consisting of a description of a real-life situation that can be used to foster discussion of a given RH/FP problem or topic. Case studies may be developed from a trainer's or a participant's experiences or from an analysis of clients' service records. Case studies may also be developed from information collected from in-depth interviews of service providers regarding their work situations. Participants using a case study are required to analyze and discuss the case description, focusing on the main learning points and topics of a given training session and event. Case studies are best used for teaching or learning problem-solving and decision-making skills.

In developing a case study, instructional designers should:

- Identify the problem or issue on which participants will focus.
- Create a scenario that represents a realistic situation where the participants can easily connect with the characters of the case study. This helps to engage the participants in the training/learning activity. A single sentence or two-sentence case study may not be adequate to explore the situations and problems that need to be addressed.
- Specify if the case study is to be completed by the participants individually or while working in small groups.
- Provide the participants with discussion questions or guidelines that will enable them to focus on the main issues being presented in the case study.
- Determine if the participants should present their case-study discussion findings orally or as a written report to the rest of the group.

A *role play* is a training/learning activity in which participants play out roles in a simulated setting (with or without trainer participation). Traditionally, a role play allows participants to apply the knowledge, skills, and attitudes that they have learned during training in a simulated situation. Role plays also help participants to gain insight into their own behavior. Role plays are good teaching/learning tools for exploring and clarifying personal attitudes toward specific topics or service-provision issues and for promoting empathy based on clients' situations and perspectives.

There are four types of role plays:

1. **Informal or spontaneous role play:** The role players are given a general situation and asked to "act it out" with little or no preparation time. This type of role play is not prepared in advance and therefore is not developed by an instructional designer.
2. **Formal or scripted role play:** The instructional designer should prepare the instructions for the role play in advance, outlining the scope and sequence of the role play. Specific roles should be outlined for the provider, for the client, and, when appropriate, for the observer(s).
3. **Clinical demonstration role play:** This type of role play usually involves the trainer and participants and may be supported by an anatomic model as part of a teaching/learning session. Clear instructions should be written for the role of each of the "role players." In the role play, a trainer and one or two of the participants assume the role of the provider and the client. In a training for surgical services (female sterilization and vasectomy), there are three role-play participants, with a third participant playing the role of the surgical assistant. During this role play, any participant can assume the role of a male or a femaile client; this may help the male providers better understand women's issues and perspectives.
4. **The rotating-trio role play:** This type of role-play gives each participant a chance to play a different role. The participants are divided into groups of three, and the role-play consists of three rounds with three different scenarios. In the RH/FP setting, the roles are usually those of a service provider, a client, and an observer. The group of three will repeat the role play until all three of them has played the role of each of the characters. The observer's role is to comment on the role play conducted by the service provider and the client.

While developing a role play, an instructional designer should:

- Be brief and to the point.
- Describe a problem or point of conflict in the role play.
- Identify the roles that will be acted out in the role play.
- Provide the participants with discussion questions or guidelines that will enable them to focus on the main issues being presented in the role play.
- Provide instructions on whether participants should present their discussion findings orally or as a written report to the rest of the group.

Chapter 11

Strengthening Training Systems

Introduction

A training system is a set of interdependent training functions that contribute to an integrated whole encompassing planning, managing, implementing, and evaluating the training process. In the RH/FP program setting, the training system consists of three primary subsystems:

- Preservice education
- In-service training
- Continuing education

Together, these three subsystems span the continuum from beginning student to fully active and experienced RH/FP service provider. **Preservice education** provides the foundation for service delivery—after completing it, graduating students (now "providers") will be equipped with the basic knowledge, skills, and attitudes that are required to perform as physicians, clinical officers, midwives, nurses, auxiliary nurses, or medical assistants. **In-service training**—which is addressed in the remainder of this chapter—affords providers opportunities for further consolidation and improvement of these skills, as well as for receipt of more specialized training in a new RH/FP service approach, method, or procedure. **Continuing education**, whether in the form of conferences and congresses or of specialized training events given for "credit" or provided on-site for a specific period, provides experienced health care providers (who may or may not be outside of the in-service system) the opportunity to maintain and upgrade their knowledge and skills.

Health systems that are decentralized usually have a matching decentralized training system. In a decentralized training system, the national (or central) level usually coordinates the national training activities and also supports the regional and/or district levels in their implementation of training (sometimes in coordination with universities.) At the national level, the system oversees the development and implementation of training policies, standards, and assessment guidelines; selection criteria for trainers and participants; selection criteria for training sites; and guidelines for training implementation, follow-up, and supervision. The national-level system also provides guidance and tools for conducting evaluations of training and fosters the implementation of activities for strengthening training systems. The national-level training system works in consultation and coordination with the service delivery system. Parts of these system functions are shared by the regional- and district-level training systems, based on their individual capacities and responsibilities to manage training implementation. The regional- and/or district-level training systems directly support their local training sites; ensure selection of appropriate participants and trainers, and application of national policies, standards, and guidelines; implement facilitative supervision; and maintain an effective training reporting system.

An in-service training system consists of the following four major components:

1) Human resources
2) Training management
3) Training institutions and sites
4) Training information system(s)

These components are summarized in **Table 11-1** and are discussed in the remainder of this chapter.

Table 11-1: Components of an In-Service Training System

Human Resources	Training Management	Training Institutions and Sites	Training Information Systems
• Trainers • Providers • Trainee certification policy and criteria • Trainee support	• Management capacity for training at national and district levels • Policies, standards, guidelines, and strategies • Curriculum development • Assessment, monitoring, and evaluation • Financial management/budget	• National- and district-level training centers • NGO training sites and institutions	• Gathering, processing, analyzing, and sharing information (feedback)

Human Resources

At the national level, the RH/FP training system plays a pivotal role in increasing the quantity and quality of human resources available to provide RH/FP services. This includes projecting the need for and training service providers, trainers, program managers, and supervisors, as well as ancillary support staff. The need for qualified service providers is based on an inventory of RH/FP service providers and their skills as well as of the demand for services and the estimated provider attrition rate. Such an analysis should provide an estimate of the number of providers who need to be trained for quality RH/FP services; it will also help to determine if more trainers are needed to meet the demand for training health care providers. Established RH/FP programs usually build on an existing network of trainers, whereas new programs usually need to build a network of trainers.

Trainers and Providers

The goal of RH/FP training is to ensure the availability of qualified RH/FP providers to meet service delivery needs; to achieve this, trainers and supervisors also need to be trained, and champions and leaders need to be engaged and supported.

Qualified trainers should be deployed at national-, regional-, and district-level training institutions and sites and should have access to updated training curricula and materials and to national service standards and guidelines. The training system should also have a mechanism

for updating trainers' skills on a regular basis. Trainers and service providers should be trained using standardized training curricula, to ensure the delivery of uniform and high-quality services once providers return to their worksites.

Trainer development

Establishing a trainer development pathway within a training system helps to strengthen RH/FP training capacity. Proficient providers are selected to take a "training of trainers" (TOT) course that focuses on classroom presentation, demonstration, and mentoring skills. These budding trainers also may take skills-standardization courses, to ensure that they have the appropriate technical knowledge and skills required to provide good-quality RH/FP services. Over time, these developing trainers gain experience in applying training skills as they train RH/FP service providers.

The trainer development process continues when experienced trainers receive instruction in "advanced training skills," to learn how to conduct TNAs, design and develop training materials, conduct training evaluation, and manage training as it relates to the larger service delivery program. Over time, these advanced trainers gain experience in all of the advanced training skills and are able to serve as *master trainers*, training and mentoring other trainers, who in turn train service providers. (This process of training trainers and then having the trainers train providers is sometimes referred to as *cascade training*.) A flow diagram for trainer development is given in **Appendix 11-1**.

Certification policy and criteria

A **certification policy and criteria** for trainees/participants should be developed and applied to all training events. Certification of trainees/participants is the responsibility of national training systems. The national training system should coordinate with the national service delivery program to match certification criteria with service delivery performance standards.

The assessment of training participants' competency is an important aspect of the certification policy and criteria. The following terms are closely associated with the concept of assessment of competency:

- *Performance to standard* in the RH/FP service delivery setting is the measure of performance based on established standards of care.
- *Posttraining functions* refer to the jobs or functions that the participants/providers will carry out based on the performance standards. Performance to standard is assessed at some point posttraining and on an ongoing basis through supervision.
- The *critical steps* of a given RH/FP service procedure are the essential steps within a complete procedure that serve as proxy indicators in assessing a participant's/provider's competency for the overall task (e.g., IUD insertion). Correctly performing all of the critical steps allows the evaluator to infer that all steps in the procedure were performed competently (i.e., safely and effectively). Critical steps are designed for evaluation purposes and should not be used as a teaching/learning tool.

Assessment of participant/provider competency requires use of the following tools:

- **Pretest** and **posttest questionnaires** (see Chapter 9: Evaluation of Training)
- **Learning guides:** detailed and comprehensive lists of *all* tasks and steps required to perform a clinical procedure correctly (per quality standards)
- **Skills observation checklists**

A **plan for supporting participants/providers** posttraining should be designed and implemented to strengthen facilitative supervision that supports the application of skills at the work site. Participant follow-up checklists should be developed to help trainers and supervisors in providing adequate support to providers at their worksites. (See **Appendix 8-2** for a sample **Training Follow-Up Form**.)

An overview of possible interventions to strengthen the training system with regard to human resource issues and needs is given in **Table 11-2**.

Table 11-2: Interventions for Strengthening Training Systems for Human Resources

Human Resource Issues/Needs	Possible Training System Strengthening Interventions
Production of correct number and mix of health care providers by medical, nursing, and supportive services	• Timely planning and coordination with service delivery program/unit to identify training needs for different areas of RH/FP providers, for trainers and advanced trainers, and for related support staff
Management and supervision for quality assurance, worker motivation, and production and use of health information	• Organizational development at the central-level training system, job descriptions and provider performance assessment system, and links to training and improved service delivery outcomes
Compensation, including provider payments and benefits, to improve retention and performance	• Provider payments that reward quality and productivity or reward deployment to specific geographic areas (This may need to be coordinated with the general human resource development system.)
Continuing education, facilitative supervision, and refresher training for public, private nonprofit, and organized private sector (for-profit) health care providers	• Investment in health training institutions • Linking training to job responsibilities, supervision, and compensation, to ensure that new skills are applied and reinforced
Ensuring the availability of supplies, FP commodities, equipment, and facilities so service providers can perform	• Strengthening of national-, regional-, district-, and site-level procurement and logistics systems • Coordination of donor and implementing agencies for planning and investment in facilities

Note: A more in-depth description of a human resource management system is beyond the scope of this resource package. A deeper treatment of human resource management can be found in: Islam, M., ed. 2007. *Health systems assessment approach: A how-to manual.* Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reform*plus*, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health (MSH), and in MSH. 2005. *Human resource management—A guide for strengthening HRM systems.* Cambridge, MA.

Training Management

Training system management consists of:

1) Training policies, standards, guidelines, and strategies
2) Management capacity at the central and the regional or district levels
3) Development and updating of training curricula
4) Assessment, monitoring, and evaluation
5) Financial management of training activities

Policies, Standards, Guidelines, and Strategies

The training system at the central (national) level should develop the policies, standards, guidelines, and strategies for training and service delivery, in collaboration with the RH/FP service delivery program. The central level should identify and implement the needed standards and guidelines, in close coordination with regional- and district-level training systems. A national training strategy should be developed based on the national training and service delivery policies and guidelines. The training strategy should provide guidance on training implementation and should link to larger program goals for RH/FP service delivery.

Management Capacity at the Central and Regional or District Levels

A training management unit should be created at both the central and the regional or district levels, depending on the extent to which the health care system is decentralized. This unit should have the capacity to manage the following key functions of the training system:

- **Planning**—Key tasks in planning include: TNA, implementation of training, and evaluation of the training intervention. As part of the planning function, the system should collect and organize training-related information from the regional-/district-level systems, which can be used in planning future training. In turn, at the central level, the system should share (feed back) this organized training information with the regions and/or districts to enable them to plan training activities at their respective levels, in furtherance of the overall central-level training plan.
- **Coordination and collaboration**—Coordination and collaboration of activities are key functions of the training system, ensuring clarity of the roles and responsibilities of different RH/FP program stakeholders and partners. At the central level, the training system should support regional- and/or district-level training systems in managing training activities by developing and sharing a common base of information about the scope and purpose of the training system. Similarly, the training system should engage local and national nongovernmental organizations (NGOs) working in RH/FP, orienting them to the components of the training system and engaging them in training activities, as appropriate and strategic.[37] The training system should also work closely with other subsystems (e.g., supervision, logistics, and referral). Such an integrated and holistic approach is critical for trying to ensure that gaps and deficiencies in these related service-support systems do not diminish or impede the improved quantity and quality of RH/FP services that should result from training.

[37] Igras, S. 2001. Capacity building for training and human resource development: The case of RH services in Tanzania. *PRIME Technical Report No. 27.* Chapel Hill, NC: Intrah, PRIME II.

- **Resource management capabilities**—The training system should establish a mechanism for managing resources that includes human resources, training materials, training data, and financial resources. At the central level, the training system should identify and determine the need for training and refresher training for trainers, master trainers, providers, and other staff supporting service delivery. The training system should maintain clear guidelines for managing training logistics (maintaining the inventory of training materials, procuring and distributing training materials) and ensuring the availability of essential commodities, such as anatomic training models, audiovisual projectors, and instruments and supplies needed for clinical training in RH/FP service provision (e.g., IUD insertion and removal instruments, vasectomy procedure instruments).

  In its resource management role, the RH/FP training system should disseminate the national standards and guidelines and otherwise help trainers, providers, and service delivery sites to comply with these standards and guidelines. In managing training data, the training system should collect, organize, and (when appropriate) analyze training-related data and should make these data available for use at the central level, as well as by regional- and/or district-level training and service delivery systems.

- **Financial management**—Overall financial management within a training system is a direct extension of the financial management practices of the health care system. Although it is beyond the scope of this resource package to deal with the overall financial management system or with the details of financial management as it relates to RH/FP training, here in outline are the important elements of training that need to be taken into consideration in budgeting and otherwise managing finances for training:
  - ➤ Allocating funds for training curricula, standards, and guidelines:
    - Design, development, and printing of training curricula, standards, and guidelines
    - Dissemination of training curricula, standards, and guidelines
    - Translation of training materials into local languages, as appropriate
  - ➤ Allocating funds for implementing training events
    - Trainers' and participants' time
    - Preceptor and consultant fees
    - Travel and logistics costs
    - Training equipment, instruments, and anatomic models
    - Training materials and supplies (consumables)
    - Training site preparation (for group-based and structured on-the-job training, including specific preparation for other training methods like technology-assisted training and blended learning)
  - ➤ Allocating funds for training follow-up and support
    - Travel and logistics costs
    - Trainers' and supervisors' time
    - Cost sharing with other subsystems (e.g., supervision system, logistics systems, etc.)

- **Curriculum Development**—The RH/FP training system should assess the need for developing training curricula and should design and develop standardized curricula and related training materials. This includes revising existing curricula based on the evolving needs of the program. The newly developed or revised training curricula should be disseminated to relevant stakeholders and partners, to ensure their appropriate adoption and implementation at regional and district levels. The training curricula should be standardized based on national policies and guidelines for service delivery and training. These RH/FP training curricula should also be integrated into appropriate preservice education and training curricula whenever possible.

- **Assessment, Monitoring, and Evaluation**—The training system should be able to conduct TNAs, monitor the progress of training activities at the macro level, and support the application of skills acquired during training at the worksites. Training systems should also be able to evaluate the output and outcomes of training interventions. Details on conducting a TNA are given in Chapter 5: Assessing Training Needs, pages 17–21, and details on conducting training evaluations are given in Chapter 9: Evaluation of Training. Follow-up of training activities and monitoring of subsequent service delivery should be conducted on an ongoing basis. Such training data should be well-maintained and should be used continuously to improve future training activities.

Training Institutions and Sites

Training institutions and training sites are essential components of a training system. The training institutions and training sites can be at the national level or regional/district level of the public sector (i.e., Ministry of Health institutions and sites, and Ministry of Education and its universities) or in the private sector (nonprofit or for-profit).

National- and District-Level Training Sites

A national-level training unit usually has more of a training management, coordination, collaboration, and/or resource management role than a direct training implementation role (as described above). Some national-level training institutions, however, do conduct training (e.g., secondary- or tertiary-level hospitals conduct preservice and/or in-service training in LAPMs and other clinical services). On the other hand, district-level training sites conduct the bulk of the training of front-line workers that results in an increased number of competent RH/FP providers and thus increased availability of services. Training sites are usually service delivery sites, especially for LAPMs and other RH services (e.g., PAC, HIV and AIDS treatment and care, and obstetric fistula repair). For more details on selection and preparation of training sites, see Chapter 6: Planning for Training, pages 29–31.

NGO Training Institutions and Sites

In many health care settings, NGOs contribute significantly to providing good-quality RH/FP services. These NGO service delivery sites have the potential to be training sites (especially for clinical training), where they can train their own providers as well as providers from the public sector. Integrating NGOs into the national training system provides an opportunity for expanding national training capacity at the central, regional, and district levels. Wherever possible, the national-level training system should include NGOs in its training plans, and NGOs

should be part of the planning process, with the training responsibilities for the respective organizations identified at the beginning of each planning cycle. If necessary, the national-level training system should build NGOs' training capacity at the beginning of their collaboration and should continue to support them in implementing ongoing training activities.

Training Information Systems

A training information system is a set of components and procedures organized with the objective of generating information that will help to improve management decisions about training and service delivery at all levels of the training system. The training information system helps to collect information regarding the training inputs, activities, and outputs critical to the service delivery system. This information-gathering should take place at the beginning of the training intervention (as part of the TNA), during the intervention (as part of training monitoring), and toward the end of the intervention (as part of the training evaluation). A **Sample Training Event Information Form** is given in **Appendix 11-2**.

Some useful considerations for maintaining a training information system include the following[38]:

- What data will be collected (e.g., the number and type of training events, number and type of trainees trained, training follow-up data)?
- Where are the data collected (national, regional and/or district levels)?
- Who receives the data?
- How frequently are the data collected, aggregated, and reported?
- Who manages the information? (What unit is responsible for data collection, analysis, and reporting?)
- What standards and classification are used?
- Which indicators are captured?
- What are the intended uses of the data?

Once data are collected, processed, and analyzed, the training information system should incorporate the findings of the analysis into its training management and planning activities. The system should also provide guidelines on how frequently training reports are submitted (monthly, quarterly, and/or annually). It is very important that the training information system also have a mechanism for sharing information with the regional, district, and facility levels, and that such feeding back of information be regularly provided by the national level to the more peripheral levels of the system. This aspect is often neglected, yet such "return feedback" is important in allowing all levels of the system to utilize findings to make management decisions and adjustments that improve training and subsequent service provision. In addition, as a practical matter, providing such feedback to lower levels is important for maintaining their sense of connection to the larger program and their motivation to achieve and report results.

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[38] Islam, M., ed. 2007. *Health systems assessment approach: A how-to manual*. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reform*plus*, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health (MSH),

Data generated by training information systems can be effectively used to forecast training goals (done in collaboration with the service delivery system); estimate the capacity of the training system to meet the projected training goals; identify the need to develop training sites (and institutions); identify the need to decentralize training sites; schedule training events; plan for training of trainers; compare training data with service delivery data; and prepare aggregate training reports.

Chapter 11

Chapter 12

Commonly Used Training Methods

Introduction

There are many commonly used and useful training methods for RH/FP, including group-based training, structured on-the-job training, self-paced training, technology-assisted training, distance learning, blended learning, and whole-site training. (Some of these methods overlap.) Use of any or all of these training methods should lead to the successful achievement of a training's four goals—transfer of knowledge; transfer of skills and attitudes; provision of supervised practice with coaching; and assessment of the competency of participants/learners, to ensure that performance standards are met and to provide feedback for improvement.

Although group-based training (with a classroom component and a practicum component) remains the most commonly used training method in RH/FP, not all settings and situations are best suited to group-based training. RH/FP programs commonly and increasingly face the challenge of having fewer trainers, fewer available training days, and/or less ability to send their providers to training for long durations. In many instances, a provider who needs training may be the only provider at a given facility, and sending him or her to off-site training would disrupt ongoing services. In other instances, not all providers from different facilities may be able to leave for training at the same time. These are situations that require an alternative training method aimed at the same objective: to prepare competent RH/FP service providers. Wider application of a range of training methods should help in better planning and programming for training and should consequently strengthen service delivery. This chapter provides a description of group-based training, as well as of various other training methods (some categories of which overlap), and discusses their advantages, limitations, and situations of greatest utility.

Group-Based Training

In group-based training, a number of participants are brought together at a training venue, spend time acquiring knowledge, skills, and attitudes under trainer supervision in classroom and practical sessions, get assessed on their performance level, and upon completion of the training, return to their worksites to apply their newly acquired knowledge, skills, and attitudes. The trainer or trainers in group-based training do the following: set the pace of training; guide the participants through the training activities using lectures, interactive classroom sessions, hands-on practice, and clinic-based practicums (especially for LAPMs); assess the participants on their mastery of the new knowledge and skills; and complete the training with plans for posttraining follow-up and support to the participants at their individual worksites. Group-based training is commonly used for RH/FP training in such technical and programmatic topical areas as FP counseling; hormonal implant insertion and removal; IUD insertion and removal; voluntary sterilization (female and male); facilitative supervision; PAC; voluntary counseling and testing for HIV; and training of trainers.

Group-based training has the following advantages, limitations, and favoring situations:

Advantages of Group-Based Training

Group-based training has the following advantages:

- Participants' being able to interact brings richness to the training experience and helps them learn from each other.
- Group-based training helps to deliver standardized training to different groups of people.
- The trainer is able to ensure the quality of training, because the trainer has a great deal of control over the content and progress of the training.
- Group-based training events are visible and often provide positive recognition for trainers as well as for participants. For example, certificates awarded to participants who have successfully completed the event may be prominently placed by the provider at his or her workplace. Group-based training also provides a natural venue for engaging national-level personalities at the training event and for increasing awareness of the importance of RH/FP services.
- Group-based training can allow training of a large number of providers, using a "cascade training" approach.

Limitations of Group-Based Training

Group-based training also has the following limitations:

- Providers who need training must wait until the next scheduled training event.
- There are minimum and maximum limits to the number of participants that can be accommodated (to maintain group-based training effectiveness and efficiency).
- Participants need to leave their worksites temporarily to attend training, which can interrupt services at the participants' worksites, especially if the number of other providers at their worksite is limited.
- Accommodating a large number of participants at a clinical facility being used for training may disrupt regular service delivery there.
- A relatively large client load is needed at one time so that all participants can have adequate clinical practice to achieve competency; this is a particularly important need with LAPM training.
- It may be difficult for trainers to accommodate each participant's learning style.

Situations Favoring Group-Based Training

Finally, there are certain situations or times that favor group-based training:

- At the start-up of RH/FP programs
- When training needs to be seen as a visible part of the larger RH/FP program
- When a large number of participants need to be trained using the cascade training approach (e.g., for training in "short-acting" FP methods such as the pill or the injectable, for counseling in RH/FP and/or voluntary counseling and testing for HIV).
- In situations where skills standardization is an important component of the program, especially in the early stages of the program
- When a steady flow of clients is available in a service site to support skills building and attainment of competency

Structured on-the-Job Training

Structured on-the-job training is a training method that allows individual participants to receive training and acquire new knowledge and skills while they remain working on the job, without having to travel to a different training venue. Structured on-the-job training provides step-by-step instructions for trainers and participants to follow as they progress along the different steps of the training. Having and following a clearly articulated "structure" and process for on-the-job training is a critical element that prevents structured on-the-job training from becoming simply a "see one, do one, teach one" activity. Ideally, the trainer(s) should also be working at the same site where the participants work. However, there are a number of variations to "pure" structured on-the-job training[39]; for example, temporary structured on-the-job training can be used to train staff for other clinics, and on-site training can be used for hospital rotation needs.[40]

Any structured on-the-job training should have clear instructions regarding the following:

- How participants will acquire knowledge (e.g., by reading training manuals, viewing instructional videos, accessing information on the Internet or via DVD, and taking self-administered tests)
- How participants will develop skills, especially clinical skills for LAPMs (e.g., practice on anatomic models, guided clinical practice with clients, or counseling practice using role plays and supervised practice with clients)
- Which activities participants will perform individually and which with trainers
- How trainers and participants will know which activities to engage in and at what times
- When skills practice will be conducted
- How and when the participants will be assessed on knowledge, skills, and attitudes

Advantages of Structured on-the-Job Training

Structured on-the-job training has the following advantages:

- Participants get trained at their regular worksites, under the conditions that they normally and routinely face.
- Regular service interruption is reduced (compared with group-based training).
- Facility staff are more likely to take ownership of the training.
- Structured on-the-job training offers more opportunities for facility staff to be trained.
- Structured on-the-job training can overcome the problem of low caseload during (group-based) training.
- New knowledge and skills can be applied immediately on the job; thus, structured on-the-job training can lead to more immediate improvements in services.
- Participants do not have to wait for a scheduled training event.

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[39] *Adapted from:* Sullivan, R., Brechin, S., and Lacoste, M. 1999. *Structured on-the-job training: Innovations in international health training*. Alexandria, VA: American Society for Training and Development (ASTD).

[40] Hospital rotation involves medical staff (e.g., interns, specialists-in-training/residents) working in a particular department or unit (e.g. obstetrics and gynecology) for a given time to learn the essential skills required to provide services for that department/unit/faculty. As new interns/residents move through the different departments/units/faculties, structured on-the-job training can be applied to train these providers in new skills and knowledge.

Limitations of Structured on-the-Job Training

Structured on-the-job training has the following limitations:

- Establishing a structured on-the-job training program may require more resources and planning than would conducting group-based training.
- Structured on-the-job training requires a more intensive design and development process.
- Structured on-the-job training has the potential pitfall of being simply a "see one, do one, teach one" activity if trainers are not vigilant in maintaining training standards.
- There is a greater possibility of distractions from the demands of the everyday work situation, for trainers as well as for participants.

Situations Favoring Structured on-the-Job Training

There are certain situations or times that favor structured on-the-job training:

- When training for FP methods takes place in low-caseload situations (e.g., vasectomy or IUD)
- Where trainers, preceptors, and/or coaches are available to participants/trainees on a regular basis
- Where facilities have a limited number of providers, so that participants can receive training without leaving their worksites and thus minimize service interruption
- Where facilities have an ongoing need for trained providers (e.g., hospitals with anticipated rotation duties for providers)
- Where a large number of LAPM providers need to be trained
- When training is for RH/FP services that are time-dependent and the availability of clients is unpredictable (e.g., PAC, or immediate postplacental placement of IUDs [within 10 minutes after delivery])

Self-Paced or Individualized Training/Learning

Self-paced or individualized training/learning is a training method that requires participants to take much greater responsibility for their personal learning. The trainer and participant could be working in the same worksite, or they could be working at different sites. The pace of training is controlled or set by the participants. Ideally, participants/learners should follow a "learning structure" that guides them through the learning process, but that at the same time provides them the flexibility to control the pace of learning/training. Self-paced or individualized learning could take place utilizing a variety of learning media (e.g., by reading books, training manuals, or information posted on the Internet; by listening to prerecorded audio information; by accessing information from an interactive CD-ROM; or by watching video presentations).

Self-paced training has the following advantages, limitations, and favoring situations:

Advantages of Self-Paced Training

Self-paced training has the following advantages:

- It allows participants/learners to learn at a pace that is most comfortable for them.
- Participants assume greater responsibility of their own learning/training.

- It offers the opportunity for more efficient use of training/learning time, as participants/learners can start and end training at any time.
- It allows trainers to devote time to participants who require more assistance.
- Self-paced training/learning sites can be established with minimum essential materials, supplies, and equipment, as self-paced training involves training only one or two participants at any given time.
- It may be used as a tool for decentralizing training and building local training capacity when conditions for it are favorable.

Limitations of Self-Paced Training

Self-paced training has the following limitations:

- It is very dependent on the participant's motivation for learning.
- It may be more difficult to implement than group-based training when the participants/learners have poor reading skills, especially when the training manual or training materials are not in their primary language.
- Trainers may feel that they do not have time to manage a self-paced training intervention.
- The design and development of self-paced training/learning curricula and materials is usually more challenging and time-consuming than for group-based training.

Situations Favoring Self-Paced Training

There are certain situations or times that favor self-paced training:

- When trainers and participants want to better manage their training and service delivery time
- When electronic technology such as computers and Internet access are readily available
- Where training is decentralized
- When used in conjunction with group-based training, to allow participants to complete knowledge acquisition before attending a group-based skills training event

Technology-Assisted Training/Learning

Technology-assisted training/learning is a training method that utilizes information technology for teaching/learning purposes. Technology-assisted training depends on the use of technologies such as computers, the Internet, and various audio and video applications. Technology-assisted training may be used in group-based training, in structured on-the-job training, or in fully self-paced training/learning. The rationale for using technology for training is to increase the efficiency, effectiveness, and cost-effectiveness of training by using a variety of teaching/learning methods and by reducing the number of days that participants need to leave their worksites for training purposes.

Technology-assisted training generally falls into three categories: 1) computer-based; 2) Internet-based; and 3) video/audio-based.

Some considerations about each category include the following:

- **Computer-based:** Computer-based training uses CD-ROM technology that allows participants to progress through the various topics in the CD-ROM in a sequential manner. The technology also allows participants to jump from one topic to another, without following a sequence, depending on the participant's/learner's personal interest. Each training topic (similar to a session in a group-based training) may be followed by a knowledge test questionnaire that either requires learners to achieve a minimum score before they progress to the next topic or simply provides the results feedback (i.e., the answers) so that learners know where they stand in terms of their mastery of knowledge on the specific topic. The participants/learners should be able to review a topic until they achieve mastery of knowledge on that topic. On completing the interactive topics, participants can then spend time with trainer(s) to develop their RH/FP service provision skills (e.g., LAPM insertion/provision, or counseling).

  A simpler version of this CD-ROM-based training method could also be implemented by a trainer without using a CD-ROM, but instead using e-mail technology. The trainer would send self-study training materials (covering specific topics, each topic constituting a "module") by e-mail to participants, who are expected to review and study the training materials on their own until they complete all of the topics included for the training. After each module, the participants would complete a written test, to demonstrate mastery of the knowledge from that module. Once a module was completed, the trainer would then send the next module, and so on, until all of the modules are completed. In this approach, a time frame for completion of the training should be established; this time frame needs to be feasible and comfortable, given the participants' preferences and workload. Any clinical skills component (practicum) that would be needed once the knowledge section of the training was completed could then be done via group-based or individualized on-the-job training, depending on such variables as trainer and participant availability, client load at the training facility, and resources available for training.

- **Internet-based:** The availability of the Internet has enabled many useful innovations in addressing RH/FP training needs. The Internet can provide increased access to a wealth of current, written information; greater opportunity for (virtual) real-time interaction between participants and with trainers; knowledge assessment and instant feedback opportunities; online training video modules; and online audio conferencing and/or video conferencing.

  Internet-based training requires a computer and the software and hardware needed to connect to the Internet. Internet-based trainings are similar to CD-ROM–based trainings, but they differ usefully in that they can be accessed from any venue that provides a reliable Internet connection. Visual or text-based training materials need to be created and posted by the trainer on the Internet. Participants can then access these training materials from many geographic locations and complete the training. As with other self-paced training, this training method requires face-to-face time with the trainer at a training center for development of clinical skills (e.g., inserting and removing an IUD). There is a huge potential for using the Internet for training purposes in RH/FP, and many of the needed training materials are already available on-line; for example, the Global Health e-Learning Center offers 22 modules on RH/FP and related topics at www.infoforhealth.org/elearning/,[41] and the World Health Organization (WHO) offers a number of e-learning modules at www.afro.who.int/dsd/dhm-training/.

[41] Maintained by The INFO Project of the Johns Hopkins Bloomberg School of Public Health.

- **Video/audio-based modules:** Video training modules are useful media for demonstrating standard clinical procedures (e.g., no-scalpel vasectomy, or female sterilization via minilaparotomy and conscious sedation, or infection prevention), as well as standard counseling practices. Audio training modules are useful for conducting segments of training that focus on knowledge and information.

Advantages of Technology-Assisted Training

Technology-assisted training has the following advantages:

- It can greatly increase providers' access to information.
- Participants can control the pace of training.
- Technology-assisted training allows real-time virtual interaction between trainers and participants.
- It offers potentially increased instructional effectiveness, as learners can review each topic as much as they need to and do not have to progress to the next topic until they feel ready.
- Technology-assisted training allows consistent standardized presentation of materials.
- It also allows easy updating of technical information (when training information is Web-based).

Limitations of Technology-Assisted Training

Technology-assisted training has the following limitations:

- The design and development of technology-based training requires more time and resources in comparison to group-based training.
- The technology needs to be available, familiar to the user, and easy to use.
- Trainers and participants may need an orientation to the technology that is to be utilized, and easily accessible and ongoing technical support for the users is required.
- Technology-assisted training may be intimidating to certain learners who have not been exposed to the use of modern technology for training/learning purposes.

Situations Favoring Technology-Assisted Training

Finally, there are some situations or times that favor technology-assisted training:

- Where technology (computers and internet access) is easily available
- When traditional training needs to be supplemented by additional training methods

Distance Learning

Distance learning refers to any training approach where learners and trainers are not together in a classroom for most of the training time and that presents content in a preproduced instructional package. Distance learning programs use a variety of methods and media to deliver instructions to participants/learners and to connect participants for mutual interaction. Distance learning can be delivered anywhere, anytime, and thus increases access, promotes flexibility for training/learning interventions, assures quality learning, and empowers the participants/learners to take charge of their own learning.

In one model of distance learning, the participants/learners are given an instructional package that provides them with the outline of activities that they should follow to progress through the intervention. These are supported with regular planned visits by locally available facilitators/trainers for demonstration of, and coaching in, clinical skills (for LAPMs and other skill-oriented activity). At a later point in the intervention, when the participants feel confident of their knowledge and skills, the facilitators assess the participants/learners for knowledge and skills to ensure that they are capable of providing services according to performance standards. When the participants/learners are assessed as competent, they may then start to provide services independently at their service facilities. Each facilitator/trainer may work with more than one team of participants/learners. Participants at a work site where more than one is participating may be paired to assist each other in the learning process; this is *peer-assisted learning*.

Advantages of Distance Learning

Distance learning has the following advantages:

- Participants can acquire knowledge and skills without long absences from their worksites.
- Participants can self-pace their learning within established time limits.
- Learning can be applied immediately on the job.
- Distance learning increases the training intervention's flexibility by allowing trainers and participants to schedule interaction times that meet their learning and work needs.

Limitations of Distance Learning

Distance learning has the following limitations:

- The design and development of distance learning materials takes longer and may be more resource-intensive than a group-based training would be.
- Success is highly dependent on participants/learners' level of motivation.
- Without a strong participant support system in place, distance learning will be incomplete, as the participants will not be able to easily acquire clinical skills.

Situations Favoring Distance Learning

Finally, there are some situations or times that favor distance learning:

- When a strong central-, regional-, and/or district-level training coordination unit (or function) is present to manage implementation (and follow-up) of the distance learning intervention
- When an existing provider support system can be utilized to support distance learning activities
- When an entire cadre of providers needs to be trained at the national or regional level to expand and strengthen service delivery
- When district-level service delivery sites are supportive and willing to participate in the distance learning intervention for developing clinical skills.

Blended Learning

Blended learning is a training approach that combines different training methods to help transfer knowledge, skills, and attitudes to participants/learners. Blended learning usually combines traditional training methods (group-based or classroom-based training) with the use of

modern technology to enhance the training/learning experience. This approach provides greater flexibility and range to the participants in how they learn from the training intervention. Participants may acquire knowledge via a mix of different media: print (e.g., training manuals), CD-ROMs, the Internet, e-mail, audio and video conferencing, and/or prerecorded audio training materials. Knowledge acquisition is supplemented by periodic face-to-face interactions (or at times virtual real-time interaction) between the trainer and the participants/learners to reinforce knowledge acquisition and to build clinical skills (or other hands-on skills) through demonstration and coaching. All of the technology-assisted training methods discussed above can be used as parts of a blended learning approach, depending on the availability of each method, as well as on its appropriateness for a given training situation.

Advantages of Blended Learning

Blended learning has the following advantages:

- Blended learning allows participants/learners to learn from different technologies and methods, thereby accommodating different learning styles.
- Other advantages (as noted in the section above on technology-assisted training) include that it affords trainees greater access to information and allows participants to pace their own acquisition of knowledge.

Limitations of Blended Learning

Blended learning has the following limitations:

- The design of blended learning materials requires more time and resources in comparison with group-based training.
- The technology needs to be available, familiar to the user, and easy to use.
- Trainees will need an orientation to the technology that is utilized for the trainer and the participants; this may be intimidating to certain learners who are not exposed to the use of modern technology for training/learning purposes.

Situations Favoring Blended Learning

Finally, there are some situations or times that favor blended learning:

- Where technology (computers and Internet access) is easily available
- When traditional training would be improved by additional training methods.

Whole-Site Training

Whole-site training is a training method that meets the learning needs of all staff at a health care service delivery site. Whole-site training considers the service facility as a "system" and considers the staff as a team working together to provide RH/FP services, but whose individual members have different learning needs depending on their role on the team. Whole-site training includes a service orientation, knowledge updates, and skills training, and may be comprised of a number of training events, not all of which will necessarily take place at the facility implementing whole-site training. For example, service providers may go to an off-site training site for skills training, while other staff (e.g., administrators, managers, referral workers, CBD workers, or clerks) may receive orientation and training at the facility. An LAPM or

PAC provider (a physician, midwife, or nurse) may go to an off-site training for clinical training, while other facility staff are trained in infection prevention at the facility. (When hormonal implant or PAC or other clinical services are institutionalized at a facility, then training can be conducted at the same facility, as an on-the-job training, eliminating the need for off-site training.) Whole-site training is especially effective when new FP methods (e.g., IUDs or implants) or a new RH/FP service (e.g., PAC services) are being introduced at the facility. While whole-site training may be more expensive than group-based training (because all levels of provider and staff need to be trained and/or oriented to the new method or service), it may address service system barriers that group-based training does not, and thus it may be more effective in increasing service access.

Advantages of Whole-Site Training

Whole-site training has the following advantages:

- Selection of training participants is based on the needs of the service delivery site, which reduces the likelihood that inappropriate participants will be selected.
- It allows the level of training to be tailored to the needs of different cadres of staff.
- It focuses on the needs of the entire teams, not just on those of the individuals engaged in service provision per se.
- Whole-site training helps to establish linkages between different units within a service delivery site, potentially improving clients' access to various RH/FP, maternal and child health, and HIV and AIDS services.
- It helps to expand the number of locales where training occurs.
- It also helps to build local capacity to conduct training and thus strengthen service delivery.

Limitations of Whole-Site Training

Whole-site training has the following limitations:

- It requires more time for the preparation of the training materials and curricula for different levels of providers and staff at a facility.
- Whole-site training is generally more expensive than group-based training, as all levels of providers and staff need to be trained or oriented to service provision.
- It may result in isolated trainings at individual service delivery sites, if adequate measures are not taken to link them with national- and district-level training systems.

Situations Favoring Whole-Site Training

Finally, there are some situations or times that favor whole-site training:

- When RH/FP services are being newly introduced or integrated
- When services cut across units within a facility (e.g., postpartum IUD is offered with maternity services, FP is offered with PAC, or FP is integrated into HIV and AIDS programs)
- In clinical service delivery programs that utilize standard cross-cutting practices, across all services (e.g. infection prevention)

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Appendixes

Appendix 5-1: Provider Characteristics Worksheet

Provider Characteristics Worksheet

Suggested use: Use this worksheet to collect and organize data about each cadre of health care provider who will participate in the training.

Instructions: Complete this form using the information gathered from training information data reviews, interviews, and observations with providers, supervisors, and other knowledgeable informants.

Identify provider categories who may need training and their characteristics.

A. Provider category and numbers per category	B. Characteristics to consider
❒ Medical officer _____ ❒ Medical assistant _____ ❒ Nurse _____ ❒ Midwife _____ ❒ General practice physician _____ ❒ Specialist physician _____ ❒ Other provider type _____ _____ ❒ Other special category (trainer, preceptor, supervisor, etc.) _____ _____ _____	**Background** • Reading and writing level; language(s) • Educational background • Gender, sociocultural issues, geographic location • Similarity to the persons who use services • Work experience • Job responsibilities that include job tasks similar to those included in this training/learning intervention • Membership in professional organizations **Training and learning** • Recent in-service training received (last three years) • Preferred training approaches and methods (group-based, individual, technology, on-the-job, etc.) • Motivation to complete training (certification, recognition, job expectation, interest, etc.) • Willingness to experience different training approaches and methodologies • Barriers to full participation in training (logistical, motivational, etc.)

List and describe each type of provider here. Attach job descriptions if available.

Adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

Appendix 5-2: Work Setting Characteristics Worksheet

Work Setting Characteristics Worksheet	
Suggested use: Use this worksheet to organize information about the participants'/providers' work setting. **Instructions:** While conducting site visits, use one sheet for each service delivery site. Check information that may have been collected in previous assessments, evaluations, and program planning, and supplement it with the information collected with this worksheet.	
Describe the facilities where the providers work. Include the considerations that are listed to the left.	
A. Service Delivery Setting • Name and location • Sector (public-sector, NGO, faith-based, private for-profit, community-owned, etc.) • Level of care (primary, secondary, tertiary) • Staffing (number, positions vacant, etc.) • Population/community served (number, other known characteristics) • What is the range of services offered at the work site, including referral and outreach services? • What is the referral system for services not provided at the worksite? Which cases do they refer, and to whom or to where? • What is the size and condition of the facility (number and type of rooms, privacy, access to clean water, job aids, client education materials, supplies, and equipment)? If a service delivery site assessment has been conducted, summarize findings here.	
B. Reference Documents Available and Needed • Service policies, standards, procedures, guidelines • Job aids	
C. Supervision System • Who supervises the providers? On-site or visiting supervisors (off-site)? How often does supervision take place? • If there is no formal supervision system, how does the provider come to understand job expectations and receive feedback on performance? • What does the supervisor do when s/he meets with the providers (e.g., solve problems, provide feedback, ensure providers have tools and supplies, observe and evaluate, provide on-the-job training) • Are supervision guidelines and checklists available?	

continued

Appendix 5-2: Work Setting Characteristics Worksheet *(cont.)*

Work Setting Characteristics Worksheet	
D. Work Groups • Who are the co-workers? • How many co-workers are there and what cadres do they represent? • How do they work together? • What is their division of responsibilities?	
E. Potential to implement specific training and learning interventions at the work sites • What is the appropriateness of implementing any of the possible training approaches and methodologies (classroom, practicum, on-the-job, self-study) at the work site? • Would the site be convenient for participants and practical for trainers? • Is the client caseload adequate for practice, if needed? • How similar is the site to the actual settings where participants/providers work? • Does the site have an existing training mechanism (e.g., a teaching hospital, a continuing education program, training rooms, trained trainers/preceptors)?	

Adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

Appendix 5-3: Resources and Requirements for Training Worksheet

Resources and Requirements for Training	
Suggested use: Use this worksheet to record the resources and requirements that enable or constrain the training intervention. **Instructions:** Review and consider all available information that affects decisions about the training intervention and record it on this worksheet.	
Describe the policies, decisions, requirements, and resources that support or constrain training interventions.	
A. Requirements (policies, decisions already made by stakeholders, etc.) • Funding restrictions • Type of training time allowed for training • Location of training • Selection of trainers or facilitators and selection of participants • Existing curriculum and training materials that must be revised • Curriculum and training requirements (e.g., for certification, licensure, continuing education credit)	
Describe the policies, decisions, requirements, and resources that support or constrain training interventions.	
B. Available Resources • Funding • People (e.g., subject matter experts, training designers, trainers/facilitators, preceptors, managers, clients, or community groups) • Documentation (e.g., existing and up-to-date service policies and procedures, job aids/learning guides) • Clinical training equipment, supplies, commodities in working order • Facilities • Media and equipment (e.g., computers, Internet access, projectors) • Travel (e.g., transport, lodging, food, per diem, vehicles) • Communication (e.g., postage, courier, phone, Internet)	

Adapted from: Murphy, C., et al. 2007. *Learning for performance: A guide and toolkit for health worker training and education programs*. Chapel Hill, NC: IntraHealth International/The Capacity Project.

Appendix 5-4: Training Needs Assessment Data Gathering Methods

Method	Description	Tips
Interviews with: • Program Managers • Trainers • Providers	Interviews are conducted one-on-one or with a small group (the smaller the better, so that everyone has a chance to contribute fully). Interviews can be used throughout the data gathering process, but they are perhaps most useful during the performance analysis stage, when you are trying to determine what the real performance deficiency is. Although the process is time-consuming, it is useful because you can gather specific information and ask follow-up questions to get more detail on items of particular interest.	1. Write down your questions before the interview and give them to the person(s) being interviewed, if possible. 2. Decide beforehand how you want to document the information you gather. 3. Consider videotaping the interview so that you have a record to refer to later. 4. Put the persons being interviewed at ease by telling them the purpose of the interview and how you will use what they tell you. 5. When appropriate, assure them that what they say will be kept confidential.
Panels of Experts	Panels of experts are used to get the collective observations and opinions of the "best of the breed." They are particularly useful when there is not one correct solution or procedure (e.g., conducting a goal analysis).	1. Make sure that each participant is truly an expert. 2. Let participants know well in advance what you expect of them, and give them time to prepare. 3. Focus the discussion on the topic at hand, and keep the participants on track. 4. Document your panel just as well as you would document interviews.
Observations	Direct observation of work performance is an excellent means of gathering data. Observations are usually done in conjunction with another data gathering method that is used to fill in the gaps and answer questions.	1. Make sure to arrange your observations well in advance and get permission from management. 2. Let workers know why you are observing them. 3. If possible, have an expert with you who can tell you what to look for. 4. Videotaping observation sessions works well if it is permitted.

continued

Appendix 5-4: Training Needs Assessment Data Gathering Methods *(cont.)*

Method	Description	Tips
Surveys • Formal • Informal	Surveys are used when you want to gather data from a large number of people and when it is impractical to meet them all face to face. Surveys can be both formal (where the results are subject to statistical reliability and validity) and informal (where results are anecdotal). In the developing-world reproductive health context, there are relatively few commercially designed instruments. Generic survey instruments are of limited utility because of the unique situations within countries.	1. Decide up-front if you need to base your conclusions on statistically valid and reliable data. If so, consult an expert to help determine your sample group, your method of data collection, and how you will compute your results 2. It is best to use instruments designed by international organizations working in the specific field, if they are available (e.g., MEASURE Evaluation, WHO). They save development time, and they have been tested to ensure they are appropriate and useful. 3. If you must design your own survey, make sure you try it out on a sample group from the target population.
Review of service delivery records	Almost all organizations maintain records. These may include data about time and attendance, services rendered, and cost of services. A review of some of these records can provide valuable information to substantiate the performance deficiencies under consideration and lead to potential causes. It is important to focus on relevant data and whether the quality of the data is adequate.	1. Make sure that you understand how the data were collected and what the data mean. 2. Make sure that the data you have are current. Outdated data can be more harmful than no data at all. 3. It is important that you comply with any restrictions your client puts on your use of their data. Unauthorized use of confidential data can be illegal and harmful to the organization.

Adapted from: Prime II. No date. *Performance improvement: Stages, steps and tools—Data gathering methods*. Chapel Hill, NC: Intrahealth International. Accessed at www.intrahealth.org/sst/tool2-5.html.

Appendix 5-5: Sample—Service Delivery Site Assessment Questionnaire[1]

Interviewer	UPON ARRIVAL AT THIS FACILITY, ANSWER QUESTIONS 100 & 101, BASED ON YOUR OBSERVATIONS.				
Number	**Services**	**Yes**	**No**	**Not Determined**	**Skip To**
100	Are there clearly visible signs or posters advertising the availability of FP services? Availability is defined at minimum, as a signboard outside the facility that advertise FP services at the facility	1	2	9	
101	Are brochures/handouts on FP services available to take home?	1	2	9	
Interviewer	FIND THE PERSON PRESENT AT THE FACILITY WHO IS IN CHARGE. READ THAT PERSON THE MESSAGE SHOWN BELOW:				
	Hello, My name is ..... I am representing the ..... project. We are gathering information to improve the availability and quality of health services in your area. This interview is a part of this data gathering process and I would like to ask you some questions about this facility. There is no possible risk if you agree to participate in this study. Rather, it will benefit you by helping us to improve services in this facility. All the information that you give to me will be kept strictly confidential; your name will not be used and you will not be identified in any way. Your current and future position at this facility will not be affected in any way. This interview should take approximately one hour to complete. Your participation is absolutely voluntary, and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any question in the interview; and you may stop the interview at any point. Do you have any questions? Do I have your agreement to participate? If the respondent agrees, then you may begin the interview.				
	_____ Interviewer's Signature (indicates Respondent's willingness to participate) _____ Date				
102	May I begin the interview?	Yes . . . . . 1 No 2			→ **STOP**
	GENERAL INFORMATION				
103	Does this facility offer condoms?	Yes . . . . . 1 No . . . . . 2 Don't know. 9			
104	Does this facility offer pills?	Yes . . . . . 1 No . . . . . 2 Don't know. 9			

[1] *Adapted from:* The AMKENI Project Field Survey Tools. This comprehensive service delivery site evaluation form can and should be adapted/streamlined for more specific use.

Appendix 5-5

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*			
Number	**GENERAL INFORMATION *(cont.)***		**Skip To**
105	Does this facility offer injectables?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **107** → **107**
106	Routinely, how many days in a week is the facility open for injectable services?	Number of days . . . . . . Question skipped. . . . . 7 Don't know. 9	
107	Does this facility offer intrauterine devices (IUD)?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **109** → **109**
108	Routinely, how many days in a week is the facility open for IUD services?	Number of days . . . . . . Question skipped. . . . . 7 Don't know. 9	
109	Does this facility offer hormonal implants (Jadelle, Implanon)?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **111** → **111**
110	Routinely, how many days in a week is the facility open for implant services?	Number of days . . . . . . Question skipped. . . . . 7 Don't know. 9	
111	Does this facility offer tubectomy?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **113** → **113**
112	Routinely, how many days in a week is the facility open for tubectomy services?	Number of days . . . . . . Question skipped. . . . . 7 Don't know. 9	
113	Does this facility offer no-scalpel vasectomy (NSV)?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **115** → **115**
114	Routinely, how many days in a week is the facility open for NSV services?	Number of days . . . . . . Question skipped. . . . . 7 Don't know. 9	
115	Does this facility offer diagnosis for sexually transmitted infections (STIs)?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **117** → **117**
116	Does this facility offer treatment of STIs?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	

continued

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*			
Number	**GENERAL INFORMATION *(cont.)***		**Skip To**
117	How many beds for FP clients does this facility have?	Number of beds . . . . ☐☐☐ Don't know. 9	
118	Does this facility have electricity (from any source, including generator or solar panels)?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **122** → **122**
119	Does this facility have electricity today? **Interviewer:** VERIFY THAT POWER IS AVAILABLE.	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	
120	Is electricity *always* available during the times when the facility is providing services? Or is it sometimes interrupted?	Always available . . . . . 1 Sometimes interupted . . . . . 2 Question skipped. . . . . 7 Don't know. 9	→ **122** → **122**
121	How many days during the past week was the electricity *not* available for two or more hours?	Number of days . . . . . ☐ Question skipped. . . . . 7 Don't know. 9	
122	Is piped water available in the compound today? **Interviewer:** VERIFY THAT WATER IS AVAILABLE.	Yes . . . . . 1 No . . . . . 2 Don't know. 9	
123	Does this facility have a telephone? **Interviewer:** THIS DOES NOT INCLUDE STAFF CELL PHONES.	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **125** → **125**
124	Is the telephone working today?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	→ **127** → **127** → **127**
125	IF NO PHONE IS AVAILABLE ON-SITE: Is there a telephone (not including personal cell phones) that staff can reach and use within five minutes for an emergency?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	 → **127** → **127**
126	Is the off-site telephone available for use 24 hours a day?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	

continued

Appendix 5-5

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*

Number	GENERAL INFORMATION *(cont.)*		Skip To
127	Does this facility have an outreach program? (In an outreach program, facility staff visit unions on a regular basis to deliver services.)	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **129** → **129**
128	Which of the following services are included in your outreach program? **Interviewer:** READ OUT THE LIST AND CIRCLE EACH SERVICE MENTIONED BY THE RESPONDENT.		
	Condom. . . . . 1 Pill . . . . . 2 Injectable. . . . . 3 Referral for IUD . . . . . 4 Referral for implats . . . . . 5 Referral for tubectomy. 6	Referral for NSV . . . . . 7 Referral for diagnosis and treatment of STIs . . . . . 8 IUD services . . . . . 9 Question skipped. 77	
129	Have the service providers at this facility received training in the past three years on the following topics?		

Training Provided	Yes	No	Don't Know
a. IUD	1	2	9
b. Infection prevention	1	2	9
c. FP counseling	1	2	9
d. Tubectomy	1	2	9
e. Vasectomy (NSV or traditional)	1	2	9
f. Implants (Jadelle, Implanon)	1	2	9
g. Postpartum IUD	1	2	9

	Does this facility have a formal system for reviewing management or administrative issues through formal meetings and discussions?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **133** → **133**
130	How often are formal meetings and discussions held to discuss the facility's management or administrative issues?	Monthly . . . . . 1 Quarterly . . . . . 2 Semiannually. . . . . 3 Other (specify)_____4 Question skipped. . . . . 7 Don't know. 9	
131	Do community members routinely participate in these formal meetings?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	

continued

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*			
Number	**GENERAL INFORMATION *(cont.)***		**Skip To**
132	Does this facility hold formal meetings to discuss the quality of services it delivers?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 **→ 136** **→ 136**
133	When was the last such meeting held?	Within the past three months. . . 1 Between three and six months . . 2 More than six months ago . . . . . 3 Question skipped. . . . . 7 Don't know. 9	
134	Do community members routinely take part in these formal meetings about the quality of services?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	
135	Does this facility have a system for determining client opinion about the health facility or services?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 **→ 138** **→ 138**
136	What system is used? Interviewer: DO NOT PROMPT; CIRCLE EACH ANSWER MENTIONED. (MORE THAN ONE IS POSSIBLE)	Suggestion box . . . . . 1 Client survey form . . . . . 2 Client interview . . . . . 3 Other (specify)_____4 Question skipped. . . . . 7 Don't know. 9	
137	Is there a functioning Community Management Committee (CMC) associated with this facility?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 **→ 140** **→ 140**
138	How often would you say that the CMC meets with the community?	Never. . . . . 1 Once a year. . . . . 2 Twice a year . . . . . 3 Three time a year . . . . . 4 Every othe month . . . . . 5 Once a month (or more frequently). . . . . 6 Other (specify)_____7 Question skipped. . . . . 7 Don't know. 9	

continued

Appendix 5-5

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*			
FACILITY CENSUS AUDIT QUESTIONNAIRE			
Number	**PERSONNEL**		**Skip To**
139	How many of each type of staff are permanently assigned to client services? Interviewer: COUNT ALL STAFF TYPES LISTED. IF NO STAFF ARE ASSIGNED FOR SERVICE, CODE 00. IF DON'T KNOW, CODE 99.		
	a. Medical officers. . . . . ☐☐	e. Laboratory staff . . . . ☐☐	
	b. Nurses/midwives . . . . ☐☐	f. Pharmacists. . . . . ☐☐	
	c. Community health care visitors . . . ☐☐	g. Senior community health care visitor . . . ☐☐	
	d. Medical assistant . . . . ☐☐		
INFECTION PREVENTION			
140	Do you have a special puncture-resistant container for sharps?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	
141	Do you have leak-proof, lidded waste containers for medical waste disposal?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	→ **144** → **142**
142	What disposal device do you have for medical waste disposal?	Specify_____ Question skipped. . . . . 7 Don't know. 9	
143	Do you use a plastic bucket with a lid for chlorine solution?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	
144	How does this facility dispose of items such as syringes and bandages, which may be contaminated? **Interviewer:** PROBE IF NECESSARY; CIRCLE ONE ONLY.	Collected and disposed of externally . . . . . 1 Burned in incinerator . . . . . 2 Burned in open pit . . . . . 3 Burned and buried. . . . . 4 Put in trash/open pit . . . . . 5 Put in pit latrine . . . . . 6 Other (specify)_____7 Don't know. 9	
145	Has anyone at this facility attended trainings on infection prevention?	Yes . . . . . 1 No 2	

continued

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*

Number	STORAGE CONDITIONS		Skip To
146	Are drugs, FP methods, and other clinic supplies (e.g., gloves) all stored in the same room together? **Interviewer:** IF DRUGS AND FP SUPPLIES ARE STORED SEPARATELY, COMPLETE COLUMNS B & C FOR EACH CATEGORY.	Yes . . . . . 1 No . . . . . 2 Don't know. 9	→ **Col. A Below** → **Col. B & C Below** → **Col. B & C Below**

Interviewer: ASK RESPONDENT IF YOU CAN SEE THE STORAGE AREA(S). ANSWER QUESTIONS 147–152 BASED ON YOUR OBSERVATIONS. (ND=NOT DETERMINED)		**Col. A.** Single storage area			**Col. B.** Drug supply			**Col. C.** FP method		
		Yes	**No**	**ND**	**Yes**	**No**	**ND**	**Yes**	**No**	**ND**
147	Is the storage area floor swept clean?	1	2	9	1	2	9	1	2	9
148	Do walls show evidence of water leakage?	1	2	9	1	2	9	1	2	9
149	Are supplies stored away from direct sunlight?	1	2	9	1	2	9	1	2	9
150	Is storage area very hot or without ventilation?	1	2	9	1	2	9	1	2	9
151	Are any supplies stored on the floor?	1	2	9	1	2	9	1	2	9

152	Is there a working refrigerator?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **154** → **154**
153	Does refrigerator have a working thermometer inside?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	
	LABORATORY CAPABILITY		
154	Does this facility have a blood bank?	Yes . . . . . 1 No . . . . . 2 Don't know. 9	 → **157** → **157**
155	Is the blood stored in a refrigerator?	Yes . . . . . 1 No . . . . . 2 Question skipped. . . . . 7 Don't know. 9	

continued

Appendix 5-5

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*								
Number	**LABORATORY CAPABILITY *(cont.)***							**Skip To**
156	Do you screen all blood for transfusion for:		**Yes**	**No**	**Question Skipped**	**Don't Know**		
	a. Syphilis?		1	2	7	9		
	b. Hepatitis B?		1	2	7	9		
	c. Hepatitis C?		1	2	7	9		
	d. HIV?		1	2	7	9		
157	Do you have a diagnostic laboratory?		Yes . . . . . 1 No . . . . . 2 Don't know 9					→ **159** → **159**
158	Does this facility have the capacity to conduct the tests listed below? **Interviewer:** READ OUT LIST OF TESTS; IF RESPONDENT ANSWERS NO, ASK: • Do you collect the specimen and send it elsewhere for the test? • Do you refer the client elsewhere for the test?							
		Conduct test	Collect and send specimen	Refer client elsewhere	Test not used	Question skipped	Don't know	
	a. RPR or VDRL (for syphilis)	1	2	3	4	7	9	
	b. Gonorrhea	1	2	3	4	7	9	
	c. Hemoglobin/ hematocrit	1	2	3	4	7	9	
	d. Urinalysis	1	2	3	4	7	9	
Interviewer:	FOR QUESTIONS 159-163, ASK TO SEE THE FOLLOWING LABORATORY EQUIPMENT AND CHECK TO SEE IF IT IS WORKING. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE AND WHETHER IT IS IN WORKING ORDER. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE.							
		OBSERVED		**REPORTED**				
		Working	Not Working	Working	Not Working	Not Available	Not Determined	
159	Hemoglobinometer (for anemia)	1	2	3	4	5	9	
160	Urine analysis strips	1		3		5	9	
161	Gramstain (crystal violet, lugals iodine, acetone, neutron red)	1		3		5	9	
162	Microscope	1	2	3	4	5	9	
163	X-Ray	1	2	3	4	5	9	

continued

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*						
DRUG AND SUPPLY INVENTORY						
Medications	164. **Is this medication in stock today?**		165. **Have you been out of stock or unable to provide this medication at any time in the past six months?**		166. **Interviewer: DID YOU OBSERVE TWO UNEXPIRED UNITS?** **Interviewer:** UNITS REFERS TO THE CONTAINER OR BOX THAT IS SUPPLIED TO THE FACILITY.	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. Adrenaline (inj.)	1	2	1	2	1	2
b. Amoxycilline (capsule)	1	2	1	2	1	2
c. Atropine (inj.)	1	2	1	2	1	2
d. 5% dextrose in normal saline	1	2	1	2	1	2
e. Diazepam (inj.)	1	2	1	2	1	2
f. Diazepam (tablet)	1	2	1	2	1	2
g. Doxycycline (capsule)	1	2	1	2	1	2
h. Ferrous sulphate (tablet)	1	2	1	2	1	2
i. Hydrocortisone (inj.)	1	2	1	2	1	2
j. Ibuprofen (tablet)	1	2	1	2	1	2
k. Naloxone (inj.)	1	2	1	2	1	2
l. Paracetamol (tablet)	1	2	1	2	1	2
m. Pathidine (inj.)	1	2	1	2	1	2
n. Phenergan (inj.)	1	2	1	2	1	2
o. Sodi-bi-carb (inj.)	1	2	1	2	1	2
p. Vitamin B complex (tablet)	1	2	1	2	1	2
q. Xylocaine (inj.)	1	2	1	2	1	2

continued

Appendix 5-5

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*						
DRUG AND SUPPLY INVENTORY *(cont.)*						
Equipment	167. **Is this equip-ment available and operational?**		168. **Have you been without this equip-ment at any time in the past six months?**		169. **Interviewer: : DID YOU OBSERVE EQUIPMENT?**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. Adhesive tape	1	2	1	2	1	2
b. Airway tube	1	2	1	2	1	2
c. Ambu bag	1	2	1	2	1	2
d. Atraumatic catgut	1	2	1	2	1	2
e. Blood pressure machine	1	2	1	2	1	2
f. Foley catheter	1	2	1	2	1	2
g. IUD set	1	2	1	2	1	2
h. IUD sterilizer	1	2	1	2	1	2
i. IV infusion set	1	2	1	2	1	2
j. Laparoscopy set	1	2	1	2	1	2
k. Implant sets	1	2	1	2	1	2
l. NSV set	1	2	1	2	1	2
m. Oxygen cylinder	1	2	1	2	1	2
n. Ryle's tube	1	2	1	2	1	2
o. Stethoscope	1	2	1	2	1	2
p. Suction machine	1	2	1	2	1	2
q. Syringes with needle	1	2	1	2	1	2
r. Torch with batteries	1	2	1	2	1	2
s. Autoclave	1	2	1	2	1	2
t. High-level disinfection sterilizing	1	2	1	2	1	2
u. Burner	1	2	1	2	1	2

continued

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*

DRUG AND SUPPLY INVENTORY *(cont.)*

Supplies	170. **Is this supply in stock today?**		171. **Have you been without this supply at any time in the past six months?**		172. **Interviewer: DID YOU OBSERVE SUPPLY?**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. Bleaching powder	1	2	1	2	1	2
b. Chlorhexidine	1	2	1	2	1	2
c. Clean gloves	1	2	1	2	1	2
d. Disposable needles	1	2	1	2	1	2
e. Disposable syringes	1	2	1	2	1	2
f. Iodine	1	2	1	2	1	2
g. Sterile gloves (unused gloves)	1	2	1	2	1	2
h. Soap for hand-washing	1	2	1	2	1	2
i. Swab sticks	1	2	1	2	1	2
j. IUD	1	2	1	2	1	2
k. Injectables	1	2	1	2	1	2
l. Implants (Jadelle, Implanon)	1	2	1	2	1	2
m. Pills (progesterone-only and/or combined pills)	1	2	1	2	1	2
n. Condoms	1	2	1	2	1	2

Number	**DRUG AND SUPPLY INVENTORY *(cont.)***		**Skip To**
173	Do you have inventory records for drugs and supplies?	Yes . . . . . 1 No . . . . . 2 Don't know 9	 → **175** → **175**
174	When was the last time you updated the inventory records?	Within the last six months . . . . . 1 More than six months ago . . . . . 2 Question skipped . . . . . 7 Don't know 9	

continued

Appendix 5-5

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*			
WAITING, COUNSELING, AND EXAMINATION AREAS			
Interviewer:	FOR QUESTIONS 175-176, RECORD THE INFORMATION ABOUT THE MAIN SERVICE AREAS FOR FP PATIENTS OR CLIENTS.		
175	Where do most clients wait until they are served? **Interviewer:** CIRCLE ONE RESPONSE	Sheltered area with seats outdoors . . . . . 1 Seats in room separate from treatment/ examination area . . . . . 2 Curtained off, seats shared with treatment/ examination area . . . . . 3 No sheltered waiting area with seats . . . . . 4 Not shown area 9	
176	Where are most clients counseled? **Interviewer:** CIRCLE ONE RESPONSE	Separate room with door . . . . . 1 Curtained area, no door . . . . . 2 Other private area where clients cannot be seen or heard . . . . . 3 Same area as where others are waiting, no privacy . . . . . 4 Not shown area 9	
177	Where are most clients examined? **Interviewer:** CIRCLE ONE RESPONSE	Separate room with door . . . . . 1 Curtained area, no door . . . . . 2 Other private area where clients cannot be seen or heard . . . . . 3 Same area as the one used for waiting/counseling . . 4 Not shown area 9	
Interviewer:	ASSESS THE SOURCE OF LIGHT IN THE EXAMINATION AREA.		
178	WHAT IS THE LIGHT SOURCE IN THE EXAMINATION ROOM?	Overhead light only, no other light . . . . . 1 Light coming in only from window, no other light . . . . 2 Working exam lamp that can be positioned . . . . . 3 No examination lamp or lamp not working . . . . . 4 Not observed 9	
179	Does this facility have a lamp or torch that can be positioned for pelvic examinations? **Interviewer:** IF NOT OBSERVED, THEN ASK IF LAMP OR TORCH EXISTS.	Yes . . . . . 1 No . . . . . 2 Not determined 9	
180	Is there an examination bed or table in the exam room?	Yes . . . . . 1 No . . . . . 2 Not determined 9	

continued

Sample—Service Delivery Site Assessment Questionnaire *(cont.)*					
Interviewer:	ASK TO SEE ALL PROTOCOLS/GUIDELINES.				
181	Does this facility have written protocols/guidelines for:				
	a. Family planning guidelines				
	b. Infection prevention standards and guidelines				
182	TIME INTERVIEW ENDED	Hour . . . . . ☐☐ Minute . . . . . ☐☐			
183	INTERVIEWER COMMENTS:				

Note to observer: Not all of the questions may be appropriate for all of the service delivery sites assessed. However, the interviewer should still circle a response for each question.

Appendix 5-6: Sample Provider Interview Guide[2]

Number	Question	Coding	Skip To
Interviewer	CHOOSE THE APPROPRIATE GREETING AND READ IT OUT BEFORE BEGINNING THE INTERVIEW.		
	1. Hello, my name is _____ I am representing the _____ project (give name of project). We are conducting a training needs assessment to improve the availability and quality of health services in your area. This interview is a part of this needs assessment. There is no possible risk if you agree to participate in this study. Rather, it will benefit you by helping us to improve services in this site. All of the information that you provide will be kept strictly confidential; your name will not be used, and you will not be identified in any way. Your current and future position at this service site will not be affected in any way. Your participation is absolutely voluntary and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any question in the interview; and you may stop the interview at any point. Do you have any questions? _____ Do I have your agreement to participate? _____		
	_____ Interviewer's Signature (Indicates Respondent's willingness to participate) Date: _____		
	May I begin the interview?		
	What is your main qualification?		

continued

[2] Adapted from: The AMKENI Project Field Survey Tools

Sample Provider Interview Guide *(cont.)*

Number	Question	Coding	Skip To
304	Do you personally provide any family planning (FP) services?	Yes. . . . . 1 No 2	→ **STOP**
305	For how long have you been providing these services? **Interviewer:** IF LESS THAN ONE YEAR, RECORD '00'.	Yes . . . . . ☐☐ No = 98	
306	Do you personally provide injectable services?	Yes. . . . . 1 No 2	
307	Do you personally provide IUD services?	Yes. . . . . 1 No 2	
308	Do you personally provide implant services?	Yes. . . . . 1 No 2	
309	Do you personally provide vasectomy services?	Yes. . . . . 1 No 2	
310	Do you personally provide tubectomy services?	Yes. . . . . 1 No 2	
311	Have you received any in-service training in the last three years in: **Interviewer:** CIRCLE ALL TRAININGS THAT THE PROVIDER HAS RECEIVED, UNDER **RECEIVED** COLUMN.	**RECEIVED** / **SPONSORED** FP counseling ..... A ..... SA IUD insertion/removal ..... B ..... SB Implant insertion/removal ..... C ..... SC No-scalpel vasectomy ..... D ..... SD Tubectomy ..... E ..... SE Infection prevention..... F ..... SF Complications management ..... G ..... SG No training _____ 2	

continued

Sample Provider Interview Guide *(cont.)*

Interviewer	READ THE FOLLOWING STATEMENT AND THEN GO TO THE TABLE AND ASK THE QUESTIONS FOR EACH METHOD LISTED. MOVE ACROSS THE TABLE ANSWERING EACH QUESTION FOR A METHOD BEFORE MOVING ON TO THE NEXT METHOD. Now I would like to ask you some questions about your beliefs concerning prescribing some of the different FP methods.									
Method	312. Is there a minimum age below which you will not offer METHOD?		313. What is that age?	314. Is there a maximum age above which you will not offer METHOD?		315. What is that age?	316. Is there a minimum number of children a woman must have before you will offer METHOD?		317. What is that minimum number of children?	318. Do you require a partner's consent before you will provide METHOD?
a. Pill	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2
b. Injectable	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2
c. Condoms	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2
d. IUD	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2
e. Implant	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2
f. Vasectomy (NSV)	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2
g. Tubectomy	Yes .....1 No 2	→ 314		Yes .....1 No 2	→ 316		Yes .....1 No 2	→ 318		Yes .....1 No 2

continued

Sample Provider Interview Guide *(cont.)*

Number	Question	Coding	Skip To
319	What do you usually check before you prescribe the pill? **Interviewer:** DO NOT READ OUT ANSWERS. CIRCLE ALL MENTIONED.	Ask about breastfeeding.....A Check/ask about pregnancy.....B Check blood pressure .....C Ask about smoking.....D Check/ask about lump in breast .....E Check/ask about jaundice.....F Ask about spotting after intercourse.....G Ask about weight (more than 70 kg).....H *Other (specify)* _____ _____I	
320	What do you usually check before you insert an IUD? **Interviewer:** DO NOT READ OUT ANSWERS. CIRCLE ALL MENTIONED.	Check/ask about pregnancy.....A Ask about number of children.....B Ask about excessive bleeding during menstruation.....C Ask about bleeding in between menstruation.....D Ask about bleeding after intercourse.....E Ask about painful menstruation .....F Check for infections.....G Check for uterine prolapse .....H *Other (specify)* _____ _____I	
321	What do you usually check before you give an injectable? **Interviewer:** DO NOT READ OUT ANSWERS. CIRCLE ALL MENTIONED.	Ask about number of children.....A Check/ask about pregnancy.....B Check blood pressure .....C Ask about smoking.....D Check/ask about lump in breast .....E Check/ask about jaundice.....F Ask about spotting after intercourse.....G Ask about weight (more than 70 kg).....H *Other (specify)* _____ _____I	

continued

Sample Provider Interview Guide *(cont.)*

Number	Question	Coding	Skip To
322	What do you usually check before you insert Norplant? **Interviewer:** DO NOT READ OUT ANSWERS. CIRCLE ALL MENTIONED.	Ask about number of children.....A Check/ask about pregnancy.....B Check blood pressure .....C Ask about smoking.....D Check/ask about lump in breast .....E Check/ask about jaundice.....F Ask about spotting after intercourse.....G Ask about weight (more than 70kg).....H *Other (specify)* _____ _____I	
323	What do you usually check before you perform a vasectomy? **Interviewer:** DO NOT READ OUT ANSWERS. CIRCLE ALL MENTIONED.	Ask about number of children.....A Ask about age of last child.....B Ask about marital status .....C Check/ask about medical status.....D *Other (specify)* _____ _____E	
324	What do you usually check before you perform a tubectomy? **Interviewer:** DO NOT READ OUT ANSWERS. CIRCLE ALL MENTIONED.	Ask about number of children.....A Ask about age of last child.....B Ask about marital status .....C Check/ask about medical status.....D Check for infection.....E Ask about pregnancy .....F *Other (specify)* _____ _____G	

continued

Sample Provider Interview Guide *(cont.)*

Number	Question	Coding	Skip To
	INTEGRATION OF FP & STI/HIV/AIDS SERVICES		
325	Do you routinely discuss anything about sexually transmitted infections (STIs) with your FP clients?	Yes ..... 1 No ..... 2 Don't know 9	 → **328** → **328**
326	Do you routinely discuss anything about HIV and AIDS with your FP clients?	Yes ..... 1 No ..... 2 Question skipped ..... 7 Don't know 9	 → **328** → **328**
327	Please tell me the things you routinely discuss about HIV, AIDS, and STIs: IF NECESSARY PROBE: Do you...		
	a. Discuss the risk of STIs?	Yes (spontaneous) ..... 1 Yes (probed) ..... 2 No ..... 3 Question skipped 7	
	b. Discuss HIV and AIDS and ways to reduce the risk of infection?	Yes (spontaneous) ..... 1 Yes (probed) ..... 2 No ..... 3 Question skipped 7	
	c. Ask the FP client about the presence of STI symptoms (such as genital discharge or ulcers)?	Yes (spontaneous) ..... 1 Yes (probed) ..... 2 No ..... 3 Question skipped 7	
	d. Explain the role of condoms in reducing transmission risk of STIs and HIV?	Yes (spontaneous) ..... 1 Yes (probed) ..... 2 No ..... 3 Question skipped 7	
328	*If STI symptoms are reported or noticed during an FP exam, what do you usually do?* **Interviewer:** DO NOT READ OUT ANSWERS. *CIRCLE ALL RESPONSES.*	Treat the client ..... 1 Refer the client to another provider in the same facility ..... 2 Refer the client to a specific clinic for treatment ..... 3 Advise the client to seek treatment (without a specific referral) ..... 4 Do nothing ..... 5 *Other (specify)* _____ 6 Don't know 9	

continued

Sample Provider Interview Guide *(cont.)*

Number	Question	Coding	Skip To
	INTEGRATION OF FP & STI/HIV/AIDS SERVICES		
329	Do you provide postabortion care?	Yes ..... 1 No ..... 2 Don't know 9	
330	Do you provide menstrual regulation?	Yes ..... 1 No ..... 2 Don't know 9	 → **332** → **332**
331	Do you routinely include FP counseling as a part of management of menstrual regulation?	Yes ..... 1 No ..... 2 Question skipped ..... 7 Don't know 9	
332	TIME INTERVIEW ENDED	Hour . . . . . ☐☐ Minute. . . . . ☐☐	
333	INTERVIEWER COMMENTS:		

Appendix 5-7: Sample Supervisor Interview Guide (from Bangladesh)[3]

Supervisor's Work Station: _____ **District:** _____

Districts/subdistricts supervised _____

TYPE OF SUPERVISOR INTERVIEWED (CIRCLE CORRESPONDING CODE)

Divisional Director 1

Deputy Director Family Planning (DDFP) 2

Assistant Director Clinical Contraception (ADCC)/ADFP/MOCC 3

FP Clinical Supervision Team/QA Team (FPCST/QAT) 4

MO-MCH/FP/MO-Clinic 5

Upazilla Family Planning Officer (UFPO) 6

Family Planning Inspectors (FPI) 7

AUFPO/Sr. FWV 8

Other _____ 9

_____ **Interviewer's Name**	**Day** ☐☐ **Month** ☐☐ **Year** ☐☐☐☐

Interview	**READ OUT THE FOLLOWING GREETING BEFORE BEGINNING THE INTERVIEW WITH THE SUPERVISOR.**

Hello, my name is _____. I am representing the _____ project. We are working with the _____ (public sector name) to improve supervision. As part of this, I would like to ask you some questions about the supervision you provide. This interview should take approximately 30 minutes. There is no possible risk to you if you agree to participate in this study. Rather, it will benefit you and other supervisors by helping us to improve supervision. All of the information you give me will be kept strictly confidential; your name will not be used, and you will not be identified in any way. Your current and future position will not be affected in any way.

Please understand that your participation is entirely voluntary, and there is no penalty to you if you decide not to participate. You are free to ask any questions. You only need to respond to those questions that you wish to answer.

Do you have any questions?

Do you agree to participate in the interview?

_____ _____
Interviewer's Signature (indicates Respondent's willingness to participate) Date

continued

[3] Adapted from tool used in 2007 in Bangladesh *Performance Improvement Needs Assessment (PINA-2) to Strengthen the Supervision System*.

Sample Supervisor Interview Guide *(cont.)*

Number	Question	Coding	Skip To
100	For how long have you been a supervisor?	_____ Years _____ Months	
101	Did you receive training in supervision or management when you were appointed or promoted to supervisor?	Yes ..... 1 No ..... 0 Don't know 88	 → **103** → **103**
102	What training did you receive? **INTERVIEWER: DO NOT READ THE LIST. MULTIPLE RESPONSES ALLOWED.**	Communication skills ..... 1 Technical areas to supervise (e.g., FP, MCH, counseling) ..... 2 Facilitative supervision ..... 3 Reporting forms/recordkeeping ..... 4 Providing feedback skills ..... 5 Conflict resolution ..... 6 Managerial skills ..... 7 Using data for decision making ..... 8 Other (specify) _____ 9	
103	Do you feel that you have all the knowledge and skills you need to be a supervisor?	Yes ..... 1 No .....0 Don't Know 88	→ **105**
104	What knowledge and skills do you feel you still need to make you a better supervisor? **INTERVIEWER: DO NOT READ THE LIST. MULTIPLE RESPONSES ARE ALLOWED.**	Communication skills ..... 1 Technical areas to supervise (e.g., FP, MCH) ..... 2 Facilitative supervision ..... 3 Reporting forms/recordkeeping ..... 4 Feedback skills ..... 5 Other (specify) _____ 6	
105	Do you have a job description specifically describing your supervisory duties?	Yes ..... 1 No ..... 0 Don't know 88	 → **107** → **107**
106	Can you please show me a copy of the job description?	Observed .....1 Not observed .....0 **INTERVIEWER:** If observed, does it specify supervisory job duties? ____Yes ____No	
107	What levels in the health system do you supervise? **INTERVIEWER: MULTIPLE RESPONSES ARE ALLOWED.**	Division ..... 1 District ..... 2 Upazilla (UHC) ..... .3 Union (FWC) ..... 4 Other (specify) _____ 5	

continued

Sample Supervisor Interview Guide *(cont.)*

Number	Question	Coding	Skip To
108	How often are you ***expected*** to supervise each level? **INTERVIEWER: ASK FOR EACH LEVEL MENTIONED IN Q105.**	Specify how often for each mentioned in Q107: Division: ..... 1 District: ..... 2 Upazilla (UHC): ..... 3 Union (FWC): ..... 4 Other (_____): _____ 5	
109	How often are you ***actually*** able to supervise each of the levels you mentioned? **INTERVIEWER: ASK FOR EACH LEVEL MENTIONED IN Q107.**	Specify how often for each mentioned in Q107: Division: _____ 1 District: _____ 2 Upazilla health complex: _____ 3 Family welfare center: _____ 4 Field workers: _____ 5 Other (_____): _____ 6	
110	Do you have a schedule or plan for conducting your supervisory visits each quarter or at other specified time periods?	Yes ..... 1 No ..... 0 Don't know 88	 → **112** → **112**
111	Can you please show me a copy of the supervision schedule or plan?	Observed ..... 1 Not observed 0	
112	What do you do to prepare for a supervisory visit? **INTERVIEWER: DO NOT READ THE LIST. MULTIPLE RESPONSES ALLOWED.**	Review results from the previous visit ..... 1 Review my own plan developed after a previous visit ..... 2 Develop a visit plan ..... 3 Contact site's supervisors to discuss scope of work and logistics ..... 4 Prepare materials needed during a visit .. 5 Prepare checklist to use during a visit ..... 6 Other _____ 7 I do not prepare/I just go 8	

continued

Sample Supervisor Interview Guide *(cont.)*

Number	Question	Coding	Skip To
113	What do you do when you supervise? **INTERVIEWER: DO NOT READ THE LIST. MULTIPLE RESPONSES ARE ALLOWED.**	Check supplies/equipment/inventory system ..... 1 Check staffing and staff utilization ..... 2 Check infection prevention practices ..... 3 Review client records, facility service statistics ..... 4 Discuss service statistics data with staff ..... 5 Discuss work expectations/roles and responsibilities ..... 6 Observe client consultations or procedures performed ..... 7 Check what client educational materials available..... 8 Provide updates on service delivery standards/guideline..... 9 Check what job aids are available ..... 10 Give feedback on performance..... 11 Update provider knowledge/skills ..... 12 Recognize/praise performance/ motivate ..... 13 Discuss with staff results of a supervisory visit ..... 14 Discuss problems/solutions ..... 15 Other (specify) _____ 16 Don't know 88	
114	What do you do to improve quality of services and performance of staff?		
115	How do you monitor and evaluate staff performance?		
116	Do you feel that supervision is a priority within the Directorate General of Family Planning and that it is given the necessary resources?	Yes ..... 1 No ..... 0 Don't know 88	→ **118**
117	Why do you think supervision is not a priority or given the necessary resources?		

continued

Sample Supervisor Interview Guide *(cont.)*

Number	Question	Coding	Skip To
118	What do you suggest could be done to make supervision more of a priority within the Directorate General of Family Planning so that it has the resources it needs?		
119	What helps you do your job as a supervisor?		
120	What makes it difficult for you to do your job as a supervisor?		
121	Do you feel you have all the resources you need to fulfill your supervisory duties?	Yes ..... 1 No ..... 0 Don't know 88	→ **123**
122	What additional resources do you need to fulfill your job as a supervisor? **INTERVIEWER: DO NOT READ THE LIST. MULTIPLE RESPONSES ARE ALLOWED.**	Transportation/vehicle ..... 1 Per diem costs ..... 2 Supervisory guidelines or checklist ..... 3 Training in supervision/management ..... 4 Review supervisors' job description ..... 5 Establish supervision monitoring/ evaluation system ..... 6 More time ..... 7 Other (specify) _____ _____ 8	
123	What suggestions do you have for improving the supervision system in the district?		→ **Thank you for your time and frank responses**

Appendix 6-1: Sample Training Timeline

<table>
<tr><th colspan="5">Planning Timeline I</th></tr>
<tr><th colspan="5">Time in months before training event</th></tr>
<tr><th>6 months</th><th>5 months</th><th>4 months</th><th>3 months</th><th>2 months</th></tr>
<tr><td>Involve/orient Ministry of Health (MOH) and other stakeholders for buy-in and support.</td><td>Reach agreement on training site location and identify trainers and/or consultants to plan for and conduct training.</td><td colspan="3">Ensure ongoing communication to maintain continued support to training event.</td></tr>
<tr><td></td><td colspan="2">Visit clinical training site(s) and meet with staff to discuss training event(s). Ensure availability of classroom(s) for lecture and group sessions.</td><td colspan="2">Select and notify participants in collaboration with training and service delivery unit. Reconfirm availability of trainer and co-trainer for event.</td></tr>
<tr><td></td><td colspan="4">Review trainer skills, if needed, and continue communication with trainers for training event.</td></tr>
<tr><td></td><td colspan="4">Upgrade clinical training site according to national training site selection criteria, if needed. This includes physical infrastructure and clinical practice standards and ensuring adequate client load for training.</td></tr>
<tr><td></td><td></td><td></td><td>Identify hotel for trainee accommodation, if needed. Arrange to meet participants.</td><td>Confirm hotel accommodation for participants and trainers.</td></tr>
<tr><td></td><td></td><td></td><td>Ensure supply of training and learning materials.</td><td>Review training materials by trainers and co-trainers.</td></tr>
</table>

continued

Appendix 6-1: Sample Training Timeline *(cont.)*

Planning Timeline II			
Time in Weeks before Training Event			
4 weeks	**3 weeks**	**2 weeks**	**1 week**
Check availability of all learning materials. Prepare session plans and assign sessions. Assist co-trainer, if needed. Prepare audiovisual aids, flipcharts, and training exercises; visit classroom facility; and make seating and other arrangements. Make photocopies of handouts and other training materials, as needed.		Confirm arrival date of participants/trainees and inform hotel.	
		Review final list of participants/trainees. Ensure availability of clients at clinic facility. Get training materials ready. Review training materials with co-trainer.	Check final arrangement of classroom. Check audiovisual aids and other logistics required for training. Meet with co-trainer for final discussions.

Appendix 6-2: Sample Training Materials Checklist

Checklist for materials needed for an IUD training course[4]

Supplies and Equipment	Quantity	√ when supplies secured for training	Comments
Flipchart easels	2		
Flipchart pads	5-6		
Flipchart pens	3 boxes		
Masking tape	3 rolls		
Name tents	1 for each participant, clinical trainers, observer, etc.		
Transparency films	3 boxes of 100 of either the film used in the copy machine or boxes plain acetate sheets		
Transparency pens	4 sets of nonpermanent pens		
Overhead projector with an extra bulb	1		
Projection screen	1		
Videotape player and monitor	1 of each		
Power extension cords	2		

continued

[4] Adapted from JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

Sample Training Materials Checklist *(cont.)*

Learning Materials	Quantity	√ when supplies secured for training	Comments
Reference manual	1 for each participant and trainer		
Participant course handbook	1 for each participant		
Trainer's manual	1 for each trainer		
Copies of any other relevant reference materials	1 for each participant and trainer		
Course certificates	1 for each participant		
Videos	1 of each technical area covered in training, if available		
Anatomic models			
• Zoë pelvic model	1 for every 3 participants		
• Hand-held uterine model	1 for each participant, if possible		
IUD insertion and removal kits	1 for each Zoë pelvic model		
IUDs in sterile packages	2 for each participants		
Supplies			
• Bleach			
• Buckets			
• Exam gloves			
• Drapes for models			
• Cotton or gauze			

Appendix 6-3: Sample Planning for Training Checklist

Key Preparation Steps	√ when complete	Comments
Participant selection and management		
Review participant selection criteria.		
Communicate with participants' supervisor(s) for support of the training and to confirm release letter for participation.		
Communicate with the participants about the arrangements made for transportation to and from the training site, when needed.		
Communicate with the participants regarding their housing arrangements.		
Review official full names and personal information of the participants for their diplomas or certificates and make corrections, if necessary.		
Designate a person to prepare the training completion certificates for distribution at the end of the training.		
Provide the participants with the phone and fax numbers of the training site and/or the persons making arrangements, when appropriate.		
Classroom Logistics		
Ensure that the classroom is close to the clinical training site.		
Ensure that the classroom is sufficiently large and has good light and ventilation.		
Ensure that required audiovisual equipment is available.		
Arrange for breakout rooms, if needed.		
Arrange for breaks and meals.		
Arrange to set up the class room the day before the training begins.		
Make sure that the furniture is arranged appropriately.		
Clinic Logistics		
Ensure that an adequate number of clients are 'booked' for services, when appropriate.		
Ensure that adequate supplies are available.		

continued

Appendix 6-3: Sample Planning for Training Checklist *(cont.)*

Key Preparation Steps	√ when complete	Comments
Ensure that appropriate service provision practices are being followed.		
Ensure that sites are equipped and prepared to handle emergencies.		
Ensure that clinic staff are aware that individuals in training will be working in the clinic and that staff are aware of the training objectives.		
Classroom Session Preparation		
Review the training schedule.		
Review the training methodology.		
Review learning guides and checklists.		
Review pretest and posttest questionnaires.		
Review the reference manual.		
Prepare presentation notes/session plan.		
Prepare supporting audiovisuals (flipcharts, video, exercises, etc.).		
Check all audiovisual equipment.		
Prepare anatomic models, instruments, and other equipment.		
Practice clinical procedure with anatomic models using learning guides, when appropriate.		
Follow-Up and Evaluation		
Prepare template for participant action plan, when appropriate.		
Communicate with participants' supervisors for follow-up plan for participants.		
Update supervisors/facility managers on need for special instrument or equipment to start services after training.		
Ensure availability of copies of pretest and posttest questionnaires for training event.		

Appendix 7-1: Sample Presentation Skills Self-Assessment Guide

Use the self-assessment guide to assess your presentation skills by identifying the different steps you followed in making a good presentation.

Presentation Skill	Yes	Sometimes	No
1. I present an effective presentation.			
2. I state the objectives of the presentation as part of the introduction.			
3. I ask questions of the entire group.			
4. I target questions to individuals.			
5. I ask questions at a variety of levels.			
6. I use participants' names.			
7. I provide positive feedback.			
8. I respond to participants' questions.			
9. I use a session plan and trainers' notes.			
10. I maintain eye contact with the participants during the presentation.			
11. I project my voice so that all participants can hear.			
12. I move about the room.			
13. I use audiovisuals effectively.			
14. I display a positive use of humor.			
15. I present an effective summary.			
16. I provide opportunities to apply or practice the presentation content.			

I feel competent in using the following presentations skills:

I would like to improve in the use of following presentation skills:

Appendix 7-2: Group Process: Behavior and Interventions

Aspect of Group Process	Desired Behavior	Examples of Undesirable Behaviors	Possible Interventions
Communication	When participants speak, other group members listen and respond appropriately. Participants are aware of how communication is happening in the group.	Participants interrupt one another or the trainer. Group members do not listen to one another. Participants look at the floor when they talk. Participants carry on side conversation.	The trainer asks group members what they notice about how they are communicating: "Do you see any patterns or themes in the way people are communicating?" When there are side conversations, the trainer moves toward the people who are involved in it or asks the participant who is trying to speak to the group: "What does it feel like when you are speaking and others are talking at the same time?"
Participation	Discussion is structured so that everyone can participate.	Some participants dominate discussion. A few participants are uncomfortable talking in a group. The trainer talks too much.	When dominant members want to contribute, the trainer says, "Let's hear from some other people." The trainer is sensitive in drawing out the participants. The trainer monitors the amount of time he or she is speaking; self-awareness is the key.
Group Cohesion	Members accept group goals and are willing to work toward them.	There is competition between individuals or subgroups working on a task.	The trainer calls the group's attention to the effects of competition, and explains to them that some degree of competitiveness can be helpful to the group interaction. The trainer tells the group, "There are enough rewards for everyone and enough time for all to complete the tasks."
Environment	Group members are friendly with one another and feel free to express themselves and share personal feelings.	Group members are formal in their interactions. The learning environment is tense.	The trainer asks the group, "What is the learning environment in the group right now?" If the group is silent, the trainer describes the group environment and asks for comments from participants. If the learning environment is tense, the trainer starts a discussion about the effect of tension on the group. If tension is the result of unresolved conflict, discuss the issue and resolve it, or agree to disagree.
Group Norms	The group has developed a consensus about how to work together.	Participants arrive late. Participants talk at the same time. Sessions do not end on time. Feedback is insincere.	Discuss norms on the first morning. When norms are not honored, the trainer must discuss this issue with the group. The trainer can bring to the front of the room the flipchart page about norms that was created on the first day, and ask the group members whether they are still committed to following the norms or if they want to change them.
Leadership	The trainer respects the participants and speaks to them as colleagues, and the participants respect the trainer.	The trainer speaks to the participants in a condescending way. The trainer is not comfortable in a leadership role. The trainer discourages discussion that disagrees with her/his opinion.	The trainer has to take responsibility for her/his own behavior. When there are two or more trainers, they need to give one another feedback. If training alone, the trainer arranges to be observed by a more experienced trainer who will provide feedback. In either case, the trainer being observed will have to make clear to the observer in what areas he or she believes feedback is needed.

Source: JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

Appendix 7-3: Interactive Training Techniques

TRAINING TECHNIQUES	ADVANTAGES	DISADVANTAGES	REMINDERS
Illustrated Lecture: Used to transfer information (knowledge) to all of the participants.	• Is good for large groups of participants. • Is useful when you want to introduce new topics, disseminate facts, or define policies or procedures. • Requires only a few teaching aids; is relatively inexpensive.	• Often requires a substantial amount of preparation by the trainer. • Is relatively passive in comparison with other methods. • Is only effective for about 45 to 60 minute sessions at a time.	• Should only be used to introduce factual information; does not build skills and is not very effective at shaping attitudes. • Must be followed by or interspersed with discussion or question-and-answer time. • Trainer must have complete command of the materials, because assistance from the participants is not available.
Small-Group Work: Used to get input from all of the participants.	• Is good for creating a sense of teamwork. • Provides an opportunity to learn from one another. • Is used to save time by dividing large tasks into subtasks. • Is good for discussing a case study or acting out a role play.	• Requires additional rooms/space to accommodate multiple groups. • Trainers need to keep moving from one group to another to supervise and provide guidance. • May need more trainers to supervise all groups equally.	• Should provide **written instructions** for the group work. • Should allocate **time for presentation** or discussion at the end. • Must **check in with groups** intermittently to ensure timely progress. • Should allow all groups to express their viewpoints.
Case Study: Relies on real-life situations and problems for analysis or resolution by the participants. The objective is to have the participants apply diagnostic, analytic, and problem-solving skills	• Requires participant involvement. • Promotes a variety of methods for solving a problem. • Can be used as an out-of-classroom assignment.	• Trainer must be able to deal with varying ideas and responses. • Requires sufficient time for participants to complete the case study. • Assumes that all participants can read and can communicate at, or at about, the same level.	• Do not use cases for which there are predictable responses. • Cases that are not well-prepared can cause more harm than good. • Participants may become too interested in the case content and may miss the point of discussion.

continued

Appendix 7-3: Interactive Training Techniques *(cont.)*

TRAINING TECHNIQUES	ADVANTAGES	DISADVANTAGES	REMINDERS
Role Play: An educational technique in which a situation is presented and acted out. The enactment is usually followed by a discussion and analysis of what happened, why it happened, and how the situation could be handled differently.	• Allows the participant to apply what was learned. • Helps the participant appreciate another point of view (e.g., the client's perspective). • The participant can become sensitive to the way his/her behavior affects others.	• May be difficult for shy learners. • Requires sufficient time and space to conduct role play where all participants can see it and engage in a discussion after the role play. • If participating in the role play is dependent on past knowledge, the trainer must ensure that the participants possess that knowledge.	• Creates a learning environment that is safe and where there is mutual respect between the participants and the trainer. • Requires follow-up discussion: ◦ What did you see? ◦ What went well? ◦ What would you have done? ◦ How might this situation have been improved? • Roles need structure, but, at the same time, they must be flexible to allow for adaptation by the trainees. • Successful role plays need clear objectives.
Brainstorming: Used when you are trying to generate a wide variety of ideas, opinions or possibilities. There are no incorrect answers.	• Gets all participants involved. • Values everyone's contribution.	• Participants must have prior knowledge of the subject. • Can be time-consuming when used for larger groups because, to be effective, everyone must respond.	• Because there are no incorrect answers, brainstorming should not be used to elicit factual information. • Should not be used to select the best idea or right answer.
Group Discussion: Used when the trainer wants to give the participants the opportunity to exchange their thoughts and ideas in a conversational style with others.	• Everyone has equal rights and access to the discussion. • Trainers can ensure that participants stay on the topic. • Keeps participants interested and involved. • Information can be discovered and shared.	• Requires a trainer with skills in managing discussion dynamics (what to do if no one talks, or someone dominates a discussion). • If poorly facilitated, training content may become confusing or lost. • Staying on time may be difficult.	• The trainer should prepare discussion questions or points ahead of time so as to guide the discussion. • Do not try to discuss more than one subject or topic at a time.
Demonstration/Practice: The trainer shows the participants the expected behaviors/tasks step-by-step, and then asks them to exhibit or perform those same behaviors/tasks.	• Has high learner participation. • Participants learn by doing. • Is good for teaching routine processes, such as a clinical procedure or filling out forms.	• Only teaches skills; is not appropriate for teaching ideas, theories, or attitudes. • May require a high trainer-to-participant ratio.	• Never allow a participant to practice a skill or task incorrectly. • Never allow a participant to perform a clinical procedure unsupervised. • Clear performance standards must be set, which the participant must understand before practicing the skills.

Appendix 7-4: Demonstration Skills Self-Assessment Guide[5]

Trainers should use this self-assessment guide to assess their demonstration skills by identifying the different steps they followed or should follow in conducting a good demonstration.

Demonstration Skill	Yes	Sometimes	No
1. I assembled the models, equipment, and supplies ahead of time for the clinical demonstration.			
2. I used trainer's note or learning guides for the demonstration.			
3. I stated the objective(s) as part of the introduction.			
4. I presented an effective introduction.			
5. I arranged the demonstration area so that participants were able to see each step in the procedure clearly.			
6. I did not demonstrate an incorrect procedure or short cuts in a procedure.			
7. I communicated with the model (in a simulation) or client during the demonstration of the activity/skill.			
8. I asked questions and encouraged the participants to ask questions.			
9. I demonstrated or simulated appropriate infection prevention practices.			
10. When using a model, I positioned the model as if it were an actual client.			
11. I maintained eye contact with the participants as much as possible.			
12. I projected my voice so that all participants could hear clearly.			
13. I provided opportunities for the participants to practice the activity/skill under direct supervision.			

I feel confident using the following demonstration skills: *(list the skills that you felt confident using)*.

I would like to improve the following demonstration skills:

[5] *Source:* JHPIEGO. 1998. *Clinical training skills for reproductive health providers, 2nd edition*. Baltimore.

Appendix 7-5: Sample Training Report Outline

1. Executive Summary

2. Background and context

3. Training Workshop

A. Workshop Purpose and Objectives
B. Workshop Content
C. Workshop preparation and methodology
D. Highlights of the workshop
E. Key workshop outcomes, e.g.
   1. LAPM expansion next steps (action points)
   2. Participants skills assessment
F. Workshop Evaluation

4. Next Steps

A. Participants' action plans
B. Follow-up

5. Attachments

A. List of participants
B. Agenda

Appendix 8-1: Sample Action Plan for Linking Training to Performance

Action Plan				
Learner:		Course:		Date:
My Support Team:	Supervisor: Trainer: Co-worker(s):			
Specific areas to improve: (Write down distinct accomplishments and activities to achieve)				
Issues to address: (Describe the barriers that must be eliminated or reduced and how this will be done)				
Detailed specific actions (in sequence)–include regular progress reviews with support team as part of the specific actions	Responsible person(s)	Resources	Date/time*	Changes to look for
Step 1				
Step 2				
Step 3				
Step 4				
Step 5				
Step 6				
Step 7				
**Establish set day and time for ongoing activities*				
Commitment of support team: I support the action plan described above and will complete the actions assigned to me. If I am unable to complete an activity, I will help make arrangements to modify the plan accordingly.	Signature of learner: _____ Date: _____ Signature of supervisor: _____ Signature of trainer: _____ Signature of co-worker: _____			

Adapted from: IntraHealth International. 2007. *Learning for performance: a guide and toolkit for health worker training and education programs*. Chapel Hill, NC.

Appendix 8-2: Training Follow-Up Form

Follow the instructions given below to use this follow-up of training form for providers.[6]

The purpose of this form is to document:

1. The number of participants who apply their new skills on the job
2. The number of participants who retain their skills competency posttraining
3. The existence of factors limiting the use of participants' skills on the job

At least one follow-up visit should be conducted, ideally within six months of training, to as many newly trained RH/FP providers as possible. All participants who were rated qualified at the end of the training should be considered candidates for follow-up visit. Facility managers and providers should be notified of a visit in advance, so that the provider (or his or her supervisor) can schedule one or more cases for observation. The evaluator should use the same skills checklist used during the RH/FP training when assessing the provider's skills at the end of training.

A. General Information

1. Provider's name: _____

2. Training event dates: From _____ to _____

3. Date of visit: _____

4. Facility name: _____

5. The provider:
   ___ Is in the same facility as she/he was when trained
   ___ Is in a different facility from when she/he was trained

6. Service procedure being assessed: (check only one per form)
   ___ Counseling ___ Injectables ___ IUD
   ___ Implants ___ No-scalpel vasectomy ___ Minilaparotomy
   ___ Postabortion care ___ Other (specify) _____

7. Was this service offered in this facility before the provider was trained?
   ___ Yes ___ No

8. Approximately how many times has the provider performed this service since training?
   ("0" if none) _____

9. Is the provider currently providing the service?
   ___ Yes ___ No

continued

[6] Form adapted from "follow up site visit form" from JHPIEGO. 1997. *Instructional design skills for reproductive health professionals*. Baltimore.

Appendix 8-2: Training Follow-Up Form *(cont.)*

10. If no, check the difficulties that prevented service provision. (Check all that apply).
    ___ Provider lacks confidence in skills.
    ___ Service procedure in which training was received is not provided at the facility.
    ___ Provider is not in a job position to provide the service procedure.
    ___ There is a lack of demand/clients.
    ___ There is a lack of supplies/equipment/instruments.
    ___ There are other service system barriers (e.g., lack of operating room time, lack of support staff).
    ___ Other (specify) _____

11. If yes, is the provider experiencing any difficulties provider in regular service provision. (Check all that apply)
    ___ Low demand/low client caseload
    ___ Periodic stockout of supplies/equipment/instruments
    ___ Other service system barriers (e.g., insufficient operating room time or support staff)
    ___ Other (specify) _____

B. Assessment of Clinical Skills

Please rate the service provider's performance in the clinical procedure noted in No. 6 above by placing a check in the appropriate box for each skill/activity listed. Use the clinical skills checklist from the training course as the basis for making your assessment. If no procedure or skill/activity was observed, please check "Not Observed."

DEFINITIONS

Satisfactory: Performs the skill or activity according to the procedure or guidelines.

Unsatisfactory: Is unable to perform the skill or activity according to the standard procedure or guidelines.

Not Observed: The skill or activity was not performed by the participant during evaluation.

Skill/Activity	Satisfactory	Not Satisfactory	Not Observed
Preprocedure counseling			
Client assessment			
Clinical procedure			
Postprocedure counseling			
Infection prevention practices			
Overall Performance			

continued

Appendix 8-2: Training Follow-Up Form *(cont.)*

If the performance was not satisfactory in any area, please list in the comments section below, those steps/tasks needing improvement, and indicate the action required to correct deficiencies.

Comments: _____

_____

_____

Recommended Action: _____

_____

_____

Site Visit Evaluator: _____ Date: _____

Facility Manager: _____ Date: _____

Appendix 8-3: Sample Skills Observation Checklist

IUD Counseling and Clinical Skills

*(To be completed by **Trainer/Supervisor**)*

Place a check mark (√) in the case box if the step/task is performed satisfactorily, a cross mark **(X)** if the step/task is not performed satisfactorily, or N/O if the step/task was not observed.

Satisfactory: Performs the step/task according to the standard procedure or guidelines.

Unsatisfactory: Is unable to perform the step/task according to the standard procedure or guidelines.

Not Observed: The step/task/skill was not performed by the participant during evaluation.

Participant _____ **Date of follow-up** _____

Sample Checklist for IUD Counseling and Clinical Skills (Copper T-380 A)			
Step/Task	**Cases**		
Method-Specific Counseling			
1. Once the woman has chosen to use the IUD, assess her knowledge of the method.			
2. Ensure that she knows that menstrual changes are a common side effect among IUD users and that the IUD does not protect against sexually transmitted infections (STIs).			
3. Describe the medical assessment required before IUD insertion, as well as the procedures for IUD insertion and removal.			
4. Encourage her to ask questions. Provide additional information and reassurance as needed.			
Skill/Activity Performed Satisfactorily			
IUD Insertion			
Client Assessment (confirm that the woman is eligible for IUD use)			
1. Review the client's medical and reproductive history.			
2. Ensure that equipment and supplies are available and ready to use.			
3. Have the client empty her bladder and wash her perineal area.			
4. Help the client onto the examination table.			
5. Tell the client what is going to be done, and ask her if she has any questions.			
6. Wash hands thoroughly and dry them.			
7. Palpate the **abdomen**.			
8. Wash hands thoroughly and dry them again.			
9. Put clean or high-level disinfected (HLD) gloves on both hands.			
10. Inspect the external genitalia.			
Note: • **If findings are normal, perform the bimanual exam first** and the speculum exam second. • **If there are potential problems, perform the speculum exam first** and a bimanual exam second.			

Sample Checklist for IUD Counseling and Clinical Skills (Copper T-380 A)			
Step/Task	**Cases**		
11a. Perform a bimanual exam.			
11b. Perform rectovaginal exam only if indicated.			
11c. If a rectovaginal exam is performed, change gloves before continuing.			
12. Perform a speculum exam. (*Note:* If laboratory testing is indicated and available, take samples now.)			
Skill/Activity Performed Satisfactorily			
Preinsertion and Insertion Steps (using aseptic or no-touch technique)			
1. Provide an overview of the insertion procedure. Remind her to let you know if she feels any pain.			
2. Gently insert the HLD (or sterile) speculum to visualize the cervix (if not already done), and cleanse the cervical os and vaginal wall with antiseptic.			
3. Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.			
4. Insert the HLD (or sterile) uterine sound using the no-touch technique.			
5. Load the IUD in its sterile package.			
6. Set the blue depth-gauge to the measurement of the uterus.			
7. Carefully insert the loaded IUD and release it into the uterus, using the "withdrawal" technique.			
8. Gently push the insertion tube upward again until you feel a slight resistance.			
9. Withdraw the plunger rod and partially withdraw the insertion tube until the IUD strings can be seen.			
10. Use HLD (or sterile) sharp Mayo scissors to cut the IUD strings to 3–4 cm length from the cervical os.			
11. Gently remove the tenaculum and speculum and place them in 0.5% chlorine solution for 10 minutes for decontamination.			
12. Examine the cervix for bleeding.			
13. Ask how the client is feeling and begin performing the postinsertion steps.			
Skill/Activity Performed Satisfactorily			
Postinsertion Steps			
1. Before removing gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.			
2. Properly dispose of waste materials.			
3. Process gloves according to recommended infection prevention practices.			
4. Wash hands thoroughly and dry them.			

continued

Appendix 8-3

Sample Checklist for IUD Counseling and Clinical Skills (Copper T-380 A)			
Step/Task	**Cases**		
5. Provide postinsertion instructions (key messages for IUD users): • Basic facts about her IUD (e.g., type, how long it is effective, when to replace/remove it) • That the IUD affords no protection against STIs, and that she needs to use condoms if she is at risk • Possible side effects • Warning signs • Checking for possible IUD expulsion • When to return to the clinic			
Skill/Activity Performed Satisfactorily			
IUD Removal			
Preremoval Steps			
1. Ask woman her reason for wanting to have the IUD removed.			
2. Determine whether she will have another IUD inserted immediately, start a different method, or neither.			
3. Review the client's reproductive goals and need for protection against sexually transmitted infections (STIs), and counsel as appropriate.			
4. Ensure that equipment and supplies are available and ready for use.			
5. Have the client empty her bladder and wash her perineal area.			
6. Help the client onto the examination table.			
7. Wash hands thoroughly and dry them.			
8. Put new or high-level disinfected (HLD) gloves on both hands.			
Skill/Activity Performed Satisfactorily			
Removing the IUD			
1. Provide an overview of the insertion procedure. Remind her to let you know if she feels any pain.			
2. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic.			
3. Alert the client immediately before you remove the IUD.			
4. Grasp the IUD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.			
5. Apply steady but gentle traction, pulling the strings toward you, to remove the IUD. Do not use excessive force.			
6. Show the IUD to the client.			
7. Place the IUD in 0.5% chlorine solution for 10 minutes for decontamination.			
8. If the woman is having a new IUD inserted, insert it now, if appropriate. (If she is not having a new IUD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.)			
9. Ask the client how she is feeling and begin performing the postremoval steps.			
Skill/Activity Performed Satisfactorily			

continued

Sample Checklist for IUD Counseling and Clinical Skills (Copper T-380 A)			
Step/Task	**Cases**		
Postremoval Steps			
1. Before removing gloves, place all used instruments and the IUD in 0.5% chlorine solution for 10 minutes for decontamination.			
2. Properly dispose of waste materials.			
3. Process gloves according to recommended infection prevention practices.			
4. Wash hands thoroughly and dry them.			
5. If the woman has received a new IUD, review the key messages for IUD users. (If the woman is starting a different method, provide the information she needs to use it safely and effectively [and a back-up method, if needed.])			
Skill/Activity Performed Satisfactorily			

___ Participant is **qualified and performing to standard**.

___ Participant **needs further support and improvement** to provide services according to standard.

Recommended **next steps** to strengthen services with regard to the **provider** being followed up:

1.

2.

3.

Trainer/Supervisor's Signature _____ Date: _____

Appendix 8-4: Follow-Up Facility Observation Form

Follow the instructions given below to use this follow-up facility observation form.

The purpose of this form is to document:
1. Adequacy of the functional space and its physical condition supporting service delivery
2. Availability of contraceptive supplies, instruments, and equipment for service delivery

At least one follow-up visit should be conducted, ideally within six months of training, to as many newly trained providers as possible. All participants who were rated qualified at the end of the training should be considered candidates for a follow-up visit. Facility managers and providers should be notified of the visit well in advance, so the provider (or his/her supervisor) can schedule one or more cases for observation. The evaluator should use the same skills checklist used during training when assessing the provider's skills at the end of training.

A. General Information

1. Facility name: _____

2. Provider's name: _____

3. Course dates: From _____ to _____

4. Date of visit: _____

5. What is the average number of family planning clients receiving services at facility per day/week/month? _____ (check as appropriate)

6. What is the average number of clients for the service for which the provider received recent training? _____ per day/week/month (check as appropriate)

7. Does the facility provide long-acting and permanent methods or other surgical procedures?

___ Minilaparotomy (tubal ligation) ___ Vasectomy (no-scalpel or traditional)

___ IUD ___ Implants (Jadelle or Implanon)

___ Other surgical procedure (mention by name) _____

Follow-Up Facility Observation Form *(cont.)*

B. Functional Space

Counseling	Yes	No	Comments
Reception/registration area			
Waiting area			
Counseling area (private)			
Audiovisual aids			
Toilet			
Storage area			
Other			

Record an overall comment on the adequacy, physical condition, and allocation of functional space for RH/FP counseling activities.

_____

_____

C. Contraceptive Supplies

Contraceptive Method Availability	Yes	No	Comments
Oral contraceptives			
Condoms			
Injectables (DMPA, others)			
IUD (CuT-380A, others)			
Implants (Jadelle, Implanon)			

D. Exam Room

Equipment	Yes	No	Comments
Exam room			
Exam table			
Weight scale			
Adequate lighting			
Blood pressure instrument			
Stethoscope			
Thermometer			
Pelvic exam instruments			
Chair or stool			

continued

Follow-Up Facility Observation Form *(cont.)*

D. Exam Room

Equipment	Yes	No	Comments
IUD insertion kit			
IUD removal instruments			
Implant insertion instruments			
Implant removal instruments			
Sharps disposal containers			
Decontamination buckets			
Garbage buckets			
Bleach			
Expendable supplies			
Other			

E. Laboratory

Laboratory	Yes	No	Comments
Lab test area			
Laboratory equipment			
Laboratory supplies			

F. Operating Room (if providing surgical sterilization and other surgical procedures)

Operating Room	Yes	No	Comments
Adequacy and functioning of operating table and operating light			
Adequacy and completeness of surgical kits			
Adequacy of surgical supplies			
Adequacy of surgical supplies storage facility			
Expiration date on drugs			
Availability of emergency preparedness equipment			
Functionality of emergency preparedness equipment			
Accessibility of emergency preparedness equipment			

continued

Appendix 9-1: Daily Participant Feedback (Reflection) Form

Instructions: Write down in a few sentences your reaction to today's sessions.

1) The *one* thing that I learned today and that I want to remember and share with others is:

2) The information (or exercise or activity) that I found *most* interesting and useful today was:

3) The one suggestion I have for how today's session could be improved is:

ADDITIONAL COMMENTS:

Appendix 9-2: Sample End-of-Session Evaluation

Session Title: _____ Trainer: _____

Instruction: Please circle the number that best reflects your opinion about the session, using the following rating scale:

5—Excellent	4—Very Good	3—Average	2—Poor	1—Unacceptable

1. The trainer clearly stated instructional objectives.	5	4	3	2	1
2. The trainer communicated effectively.	5	4	3	2	1
3. The information presented was new to me.	5	4	3	2	1
4. The trainer used a variety of audiovisuals.	5	4	3	2	1
5. The trainer was enthusiastic about the subject.	5	4	3	2	1
6. The session content was practical and not too theoretical.	5	4	3	2	1
7. The session was well-organized.	5	4	3	2	1
8. The trainer asked questions and involved me in the session.	5	4	3	2	1
9. The content was relevant to my work.	5	4	3	2	1
10. The session made me feel more competent in my work.	5	4	3	2	1

Which aspects of the session were **not** clear?

Comments:

Appendix 9-3: Sample End-of-Training Evaluation

Training Name: _____ Training Dates: From _____ To _____

Instruction: Please answer the questions, as directed, to best reflect your assessment of the training course. Your response will assist in determining what modifications should be made to strengthen the course.

A. Please circle the number that best reflects your assessment of the training course, using the rating scale given below.

5—Excellent	4—Very Good	3—Average	2—Poor	1—Unacceptable

1. Achievement of course objectives	5	4	3	2	1
2. Achievement of personal expectations	5	4	3	2	1
3. Relevance of course to your work	5	4	3	2	1
4. Usefulness of training materials	5	4	3	2	1
5. Organization of the course	5	4	3	2	1
6. Training facilities	5	4	3	2	1
7. Administrative support	5	4	3	2	1
8. Travel arrangements	5	4	3	2	1
9. Financial arrangements	5	4	3	2	1
10. Hotel accommodations	5	4	3	2	1

B. Course length: _____ Too long _____ Too short _____ Just right

C. What topics covered in this course do you think will be most useful to you in your work?

D. On which topics would you have liked more information or have preferred to spend more time?

E. On which topics would you have liked less information or have preferred to spend less time?

Additional Comments

Appendix 9-4: Sample Trainer Evaluation

(To be completed by **Participants**)

Name of Trainer: _____ Training Event: _____

Instructions: Please circle the rating scale that best reflects your opinion about the trainer's performance of each task/activity (N/O=not applicable; N/A= not applicable).

The Trainer:	**RATING**			
1. Made me feel welcome.	Yes	No	N/O	N/A
2. Clearly stated the learning objectives.	Yes	No	N/O	N/A
3. Outlined clearly the standard of performance expected of me by the end of the training event.	Yes	No	N/O	N/A
4. Demonstrated the skills through role play or by using learning models before demonstrating with clients.	Yes	No	N/O	N/A
5. Used a skills checklist to give me feedback on my performance.	Yes	No	N/O	N/A
6. Gave constructive feedback on my performance, offering suggestions for improvement.	Yes	No	N/O	N/A
7. Provided me with adequate opportunity to practice and achieve competency in the new skills.	Yes	No	N/O	N/A
8. Assessed my skills on learning models (or in simulated settings) before initiating the skills training with clients.	Yes	No	N/O	N/A
9. Encouraged interaction among the participants.	Yes	No	N/O	N/A
10. Was sensitive to any feelings or anxiety I may have exhibited when learning new skills.	Yes	No	N/O	N/A
11. Made it easy for me to ask questions or express my concerns.	Yes	No	N/O	N/A
12. Met with me to discuss my performance following each practice session with a client.	Yes	No	N/O	N/A

Comments:

Appendix 9-5: Sample Pretest Questionnaire

No-Scalpel Vasectomy Knowledge Assessment Test[7]

Note: This test will not be graded. It will be used by the trainer in order to adapt this course to best suit your needs.

Instruction: Decide whether each of the following statements is T (true) or F (false). Write your answer in the space provided for each statement.

Anatomy and Physiology

1. ____ During vasectomy an opening is made along the median raphe midway between the base of the penis and the top of the testes.

2. ____ Following a vasectomy, the flow of semen is blocked.

3. ____ The vas deferens is located just outside of and parallel to the spermatic cord.

Counseling and Informed Consent

4. ____ A trained counselor or a doctor is the best person to choose an appropriate contraceptive method for a couple.

5. ____ Vasectomists should verify a client's informed consent by talking with him before the procedure.

6. ____ During vasectomy counseling the client should be assured that he can change his mind at any time before the procedure without losing the right to other medical services.

Prevasectomy Evaluation

7. ____ A man with diabetes cannot have a vasectomy.

8. ____ A prevasectomy evaluation includes a medical history, a complete physical, and a hemoglobin count or hematocrit.

9. ____ A client with syphilis should be treated before having a vasectomy.

10. ____ A client whose vasectomy needs to be postponed should be counseled about alternative methods of contraception.

11. ____ Prophylactic antibiotics should always be given before vasectomy.

continued

[7] EngenderHealth. 2007. *No-scalpel vasectomy curriculum: A training course for vasectomy providers and assistants: Trainer's manual*. New York.

Sample Pretest Questionnaire *(cont.)*

Infection Prevention

12. ____ An iodophor is an appropriate antiseptic to use on the scrotal area before no-scalpel vasectomy (NSV).

13. ____ Instruments that have been boiled for 20 minutes can be used in NSV.

14. ____ Instruments can be high-level disinfected by soaking them in alcohol or an iodophor for 20 minutes.

15. ____ Instruments and gloves can be decontaminated by soaking them in a 0.5% chlorine solution for 10 minutes.

16. ____ Handwashing is indicated before putting on and after removing sterile or high-level disinfected gloves to perform a vasectomy.

17. ____ Used hypodermic needles should be recapped, bent, or broken, then disposed of in a puncture-resistant container.

Surgical Knowledge

18. ____ The three-finger technique is used to identify the vas.

19. ____ Before performing a vasectomy, you should inject 20 cc of lidocaine without epinephrine.

20. ____ The ringed clamp is used to puncture the vas.

21. ____ The occlusion techniques used in NSV differ from those used in standard vasectomy.

22. ____ After the right vas has been occluded, the left vas is isolated, anesthetized, and occluded.

Postvasectomy Care

23. ____ After vasectomy, a man should use an alternative contraceptive for three weeks.

24. ____ A man who has bruising and/or passes a blood clot during ejaculation should immediately return to his NSV provider.

25. ____ Following a vasectomy, a man should avoid strenuous activity and wear a snug undergarment for 48 hours.

26. ____ Vasectomy provides protection against pregnancy and STIs.

continued

Sample Pretest Questionnaire *(cont.)*

Management of Complications

27. ____ If a client becomes nauseated and weak and has a low blood pressure during a vasectomy, you would suspect a vasovagal reaction.

28. ____ Providing clients with clear postvasectomy instructions is an important way to prevent complications.

29. ____ Fascial interposition does not reduce the vasectomy failure rate.

30. ____ Nonsteroidal pain relievers can be used for pain related to sperm granulomas.

Appendix 10-1: Sample Instructional Planning Worksheet

Sample Instructional Planning Worksheet

Training Objective: By the end of the training, the participants will be able to provide no-scalpel vasectomy services according to national standards.

Major Job Task: *Use different planning worksheet for each major job task.*

• Counsel clients on advantages of and precautions for NSV

Skills or Knowledge	Session Objective	Assessment Method	Training Activity	Training Materials	Training Methods
Counseling skills	In a simulated counseling session, demonstrate four interpersonal communication techniques while counseling a potential NSV client	Observation during role play, observation during client counseling	Illustrated lecture, role play	Counseling video, counseling job aid	Group-based training
Knowledge of advantages and precautions for NSV	In a written test, list three advantages and three precautions for NSV procedure, based on national standards.	Written test	Illustrated lecture, group discussion		Group-based training
Knowledge about other temporary FP methods available to NSV client/couple	In a question-and-answer session, mention at least two other temporary family planning methods suitable for NSV client or couple.	Oral test or participant interview	Illustrated lecture, group discussion	Samples of actual temporary FP methods	Group-based training
Add as appropriate					
Add as appropriate					

Blank Instructional Planning Worksheet

Instructional Planning Worksheet

Training Objective:

Major Job Task: *Use different planning worksheet for each major job task.*

Skills or Knowledge	Session Objective	Assessment Method	Training Activity	Training Materials	Training Methods

Appendix 10-2: Job Tasks Worksheet

Major Job Tasks Worksheet

Suggested use: Use this worksheet to identify the major job tasks that help to achieve the training objective.

Instructions: List the Training Objective in the box labeled **A**. Identify the major job tasks required to accomplish the training objective in Column B, and fill in Column C to note which participants will perform the major job task (especially where two or more providers are needed to perform the job—e.g., surgeon and assistant).

A. Training Objective: Write down the training objective.

B. Major Job Tasks List the major job tasks for this training objective. Review the list and remove any job tasks that: • Are not necessary to do the job • Providers already know how to do Check (√) the remaining job tasks. These are the tasks for which a training is needed.		**C. Participants/providers**
	Check	

Adapted from: IntraHealth International. 2007. *Learning for performance: a guide and toolkit for health worker training and education programs*. Chapel Hill, NC.

Appendix 10-3: Essential Skills and Knowledge Worksheet

Essential Skills and Knowledge Worksheet	
Suggested Use: Use this worksheet to specify the essential **skills and knowledge** required to perform each major job task (to achieve training objective). **Instructions:** Use a separate sheet for each major job task you are analyzing. Write the major job task in the box labeled A. In columns B and C, list the skills and knowledge the provider would need to complete the job task. Review each item in the skills and knowledge lists and ask yourself "Could the provider still perform the task if he or she did not have that skill or knowledge?" **Eliminate skills and knowledge that are not essential for these particular cadres of providers.**	
A. Major Job Task	
B. Skills Required What does the provider need to be able to do to perform this job task? Is this skill REQUIRED to perform to standard?	**C. Knowledge Required** What does the provider need to know to perform this job task? Is this knowledge REQUIRED to perform to standard?

Adapted from: IntraHealth International. 2007. *Learning for performance: a guide and toolkit for health worker training and education programs*. Chapel Hill, NC.

Appendix 10-4: Sample IUD Training Schedule/Agenda[8]

Day 1	Day 2	Day 3
08:30–12:00 **Opening** • Welcome and introduction • Participant expectations **Overview of training event** • Goals and objectives • Review of course materials and schedule **Precourse Questionnaire (Pretest)** **Lecture/Discussion**—Introduction to copper bearing IUDs **Lecture/Discussion**—Family planning education and counseling	**08:30–12:00** **Overview** of day's scheduled activities **Tour of clinic facilities and observation** **Presentation**—Infection prevention (IP) **Discussion**—Counseling, IP practices, and method provision observed **Demonstration**—From abdominal exam through IUD insertion and removal	**08:30–12:00** **Overview** of day's scheduled activities **Discussion and Presentation**—Client assessment **Clinic Practice**—Provide counseling, IP, or IUD services in clinic with supervision or in classroom practice
Lunch	**Lunch**	**Lunch**
13:00–16:30 **Assessment**—Assess current skills **Discussion**—Use and care of anatomic models **Review** of day's activities	**13:00–16:30** **Demonstration and Practice**—Loading the IUD in its sterile package **Activity and Discussion**—Review IP practices and discuss **Classroom Practice**—Divide into two groups to practice: • Counseling a client • Doing pelvic exam and inserting/removing IUD on pelvic models **Review** of day's activities	**13:00–16:30** **Clinical Conference** **Exercise/Discussion**—Client assessment and screening **Exercise and discussion**—Insertion of IUD **Discussion**—Assessing individual risk of STIs **Review** progress so far
Reading Assignment: Chapters 1–5 and FHI's "Quick Reference Chart"	**Reading Assignment:** Chapter 6 and Appendices A–D	**Reading Assignment:** As needed

[8] *Adapted from:* The Capacity Project and JHPIEGO. 2006. *IUD guidelines for family planning service programs: Course notebook for trainers*. Baltimore.

Appendix 10-4: Sample IUD Training Schedule/Agenda *(cont.)*

Day 4	Day 5	Day 6
08:30–12:00 **Overview** of day's schedule activities and warm-up **Clinic Practice**—Provide counseling, IP, or IUD services in clinic with supervision or in classroom practice (**Note:** Participants assess each other's performance using learning guides or practice checklist. Over the next few days, those who wish to be assessed in certain skills should let the trainer know, and trainers will assess their performance using the checklist.)	**08:30–12:00** **Overview** of day's scheduled activities **Clinical Practice/Assessment**—Provide counseling, IP, or IUD services in the clinic with supervision or in classroom practice	**08:30–12:00** **Overview** of day's scheduled activities **Posttest** **Clinic Practice/Assessment**—Provide counseling, IP, or IUD services in clinic with supervision or in classroom practice
Lunch	**Lunch**	**Lunch**
13:00–16:30 **Clinical Conference**—Assess current skills in stations **Demonstration/Discussion**—Review IP guidelines **Demonstration and Practice**—In a simulated clinical area, demonstrate and practice insertion or IUD **Review** of day's activities	**13:00–16:30** **Clinical Conference** **Classroom practice**—In a simulated clinical area, demonstrate and practice pelvic exam and insertion of IUD **Discussion/Activity**—Quality assurance for IUD services **Review** of day's activities	**13:00–16:30** **Clinical Conference** **Demonstration/Discussion**—Managing lost strings **End-of-Training Evaluation** **Closing**
Reading Assignment: As needed to prepare for the posttest	**Reading Assignment:** As needed	

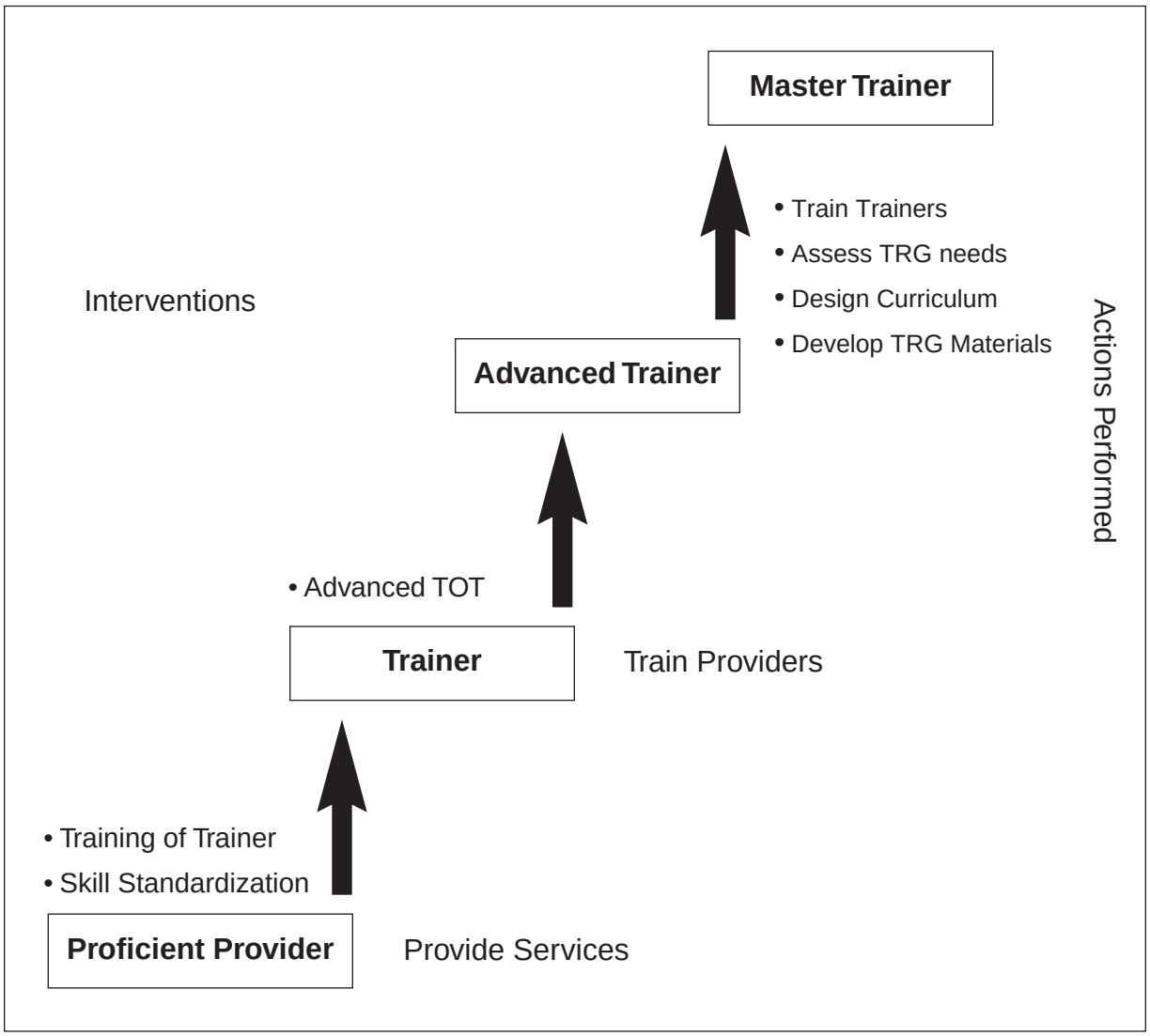
Appendix 10-5: Sample Session Plan

Appendix 10-5: Sample Session Plan	
Session Objective	*At the end of the session, the participants will be able to…* *(These are the session objectives written for each major job task.)*
Time	*Allocated time for completing the session*
Resources and materials	*List of training materials and resources required for completing the session*
Advance preparation	*Activities that need to be completed before the training session to conduct the training session smoothly*
Description of methods and activities	*This will describe the activities that the trainer and participants should do in order to achieve the session objectives.*
Assessment/evaluation	*Assessment strategy for measuring objective*

Alternative Session Plan Format

Alternative Session Plan Format				
Time	**Session objectives**	**Methods/activities**	**Resources and materials**	**Assessment**

Appendix 11-1: Trainer Development Pathway



Appendix 11-2: Sample Training Event Information Form

Trainers may use this form to gather information regarding the training event, as well as information for each participant attending the training event.

Appendix 11-1: TRAINING EVENT INFORMATION FORM	
Part I: Training Event Information **Instruction:** Trainers should fill out parts I and II of this form. Part III should be filled out by the participants for each training event.	
1. Name of training event	Family Name MI Given Name
2. Name of training site (venue)	
3. Name of lead trainer	
4. Name(s) of co-trainer(s), when applicable	
5. Start date of training event	dd/mm/year
6. End date of training event	dd/mm/year
7. Duration of training event (total number of training/working days)	Number of days _____
8. Number of participants who attended training	
9. Number of participants who successfully completed training and received certification	
10. Name of organization/institution managing the training event	__ Ministry of Health __ National Health Training Center/Institute __ Others (name in full) _____ _____
11. Name of organization/institution funding the training event	__ Ministry of Health __ National Health Training Center/Institute __ Others (name in full) _____ _____

continued

Sample Training Event Information Form *(cont.)*

Part II: Participants' Summary Information

Name of Training _____ Training Venue/Site _____

Trainer _____ Start Date _____ End Date _____ Total No of. Training Days _____

Name of Participants Family Name/Given Name	Knowledge Test		Skills Test			Certification		Attendance X/Y days	Comments
	Pre-test	Post-test	Skilled	Skilled But Needs Assistance	Not Skilled	Yes	No		
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									

continued

Sample Training Event Information Form *(cont.)*

Part III: Participant's Individual Information **Instructions:** Each participant should competently fill out this part of the form	
1. Name of participant (full name)	
2. Designation of participant (official designation of participant)	
3. Date of birth – dd/mm/year	
4. Sex	__ Male __ Female
5. Job Category	__ Doctor __ Clinical Officer __ Nurse __ Midwife __ Health Assistant __ Medical Technologist __ Others (mention name) _____
6. Present Place of Work	Service Delivery Center: _____ _____ District: _____ Subdistrict _____ Phone # _____
7. Previous Trainings Taken by Participant	__ FP Counseling __ IUD __ Implants __ Vasectomy (NSV or Traditional) __ Minilaparotomy __ Postabortion Care __ Others (name in full) _____ _____
8. Current Contact Information	Street Address, If Applicable _____ _____ _____ Primary Phone # _____ Alternative Phone # _____ E-mail: _____

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