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MIDTERM EVALUATION  
PAC II TRAINING IN AFRICA AND ASIA  
(FAMILY PLANNING TRAINING FOR PARAMEDICAL/  
AUXILIARY/COMMUNITY PERSONNEL)  
PROGRAM FOR INTERNATIONAL TRAINING  
IN HEALTH (INTRAH)

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GLOSSARY

AHTIP	African Health Training Institution Program
AID	Agency for International Development
AMPPF	Malian Family Planning Association
AMREF	African Medical and Research Foundation
ASBEF	Association Senegalaise pour Bien-etre Familiale
AVSC	Association for Voluntary Surgical Contraception
AZBEF	Association Zairoise pour le Bien-etre Familiale
BARS	Behavioral Anchored Rating Scale
CA	Cooperating Agency
CAFS	Center for African Family Studies
CBD	Community-based distribution
CRS	Contraceptive Retail Sales
CTO	Cognizant Technical Officer
DFH	Division of Family Health
DON	Division of Nursing
FHTC	Family Health Training Center
FMOH	Federal Ministry of Health
FPASL	Family Planning Association of Sri Lanka
FPIA	Family Planning International Assistance
FP/MCH	Family Planning/Maternal and Child Health
IEC	Information, education and communication
IHP	International Health Programs of the University of California, San Francisco
IMCCSDI	Integrated Maternal Child Care Services and Development, Inc.

IMCH	Institute of Maternal and Child Health
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
ISTI	International Science and Technology Institute, Inc.
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LDC	Less developed country
MCH	Maternal and child health
MFPA	Mauritius Family Planning Association
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOPH/SA	Ministry of Public Health and Social Affairs
MOSA	Ministry of Social Affairs
MSH	Management Sciences for Health
NPC	National Population Council
ONAPO	National Office for Family Planning
PAC	Paramedical, auxiliary and community (personnel)
PCF	Population Center Foundation
PCS	Population Communication Services Project
PDA	Population and Community Development Association
PHC	Primary health care
PSND	Projet des Services des Naissances Desirables
REDSO	Regional Economic Development Support Office
RTC	Regional Training Center
RTSA/A	Regional Training Service Agency/Asia
SDC	Social Development Center, Chicago, Illinois
STD	Sexually transmitted disease

TA	Technical assistance
TAC	Technical Advisory Committee
TBA	Traditional birth attendant
TNA	Training needs assessment
TOT	Training of trainers
TRG	Training Resources Group, Inc.
UMATI	Tanzanian Family Planning Association
UNC	University of North Carolina
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development (overseas mission)
WCA	West and Central Africa
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council

## EXECUTIVE SUMMARY

This is one of three evaluations undertaken at midpoint to assess progress in the efforts of three Agency for International Development (AID) contractors to provide training in family planning to paramedical, auxiliary and community (PAC) personnel worldwide. This report assesses the work of the Program for International Training in Health (INTRAH), University of North Carolina, in implementing the PAC II contract in Africa and Asia. INTRAH was also the contractor in Africa for PAC I, the predecessor contract. PAC I was aimed primarily at training large numbers of workers while in PAC II, the focus has shifted to strengthening the capacity of host country institutions, both in-country and regional, to provide training.

The contract called for allocation of 80 percent of INTRAH's resources to Africa and the remaining 20 percent to Asia. In light of the tremendous growth in demand for family planning services in Africa compared with the relatively well-developed family planning infrastructure in Asia, this was appropriate. Moreover, it is recommended that INTRAH intensify its efforts in Africa and limit its efforts in Asia during the remainder of the contract.

Developing in-country institutional capacity in the fourteen African countries where INTRAH has conducted training is proving to be a long-term process. INTRAH's strategy has been to create groups of core trainers from within the institutions it has targeted for assistance. INTRAH has succeeded in introducing these trainees to experiential teaching methods and often, imbuing them with considerable self-confidence. Even this task, however, has been difficult, and little time has been left to train trainers in the wide range of other skills necessary to design, implement and evaluate training programs. Efforts have been made to include curriculum development as part of training of trainers (TOT), but trainees have not had time to master this skills. Several recommendations are made in this report to bring training goals more in line with the reality of the African setting: 1) to concentrate on improving teaching skills and to initiate special training workshops for curriculum developers; 2) to provide more follow-up for host country trainers, particularly as they begin to conduct workshops on their own, and 3) where the need for family planning services is urgent, to accelerate TOT training to create more core trainers.

In Asia, INTRAH's efforts cannot be credited with having led to institutional self-sufficiency: three of the five institutions with which INTRAH has been involved were at or near technical self-sufficiency before INTRAH's assistance, and the other two will continue to need additional strengthening.

INTRAH's efforts in evaluation were particularly problematic. Its initial approach, to develop a core of in-country evaluators to assess the training, essentially defeated the purpose of evaluation, which was to give trainers the ability to assess weaknesses in training they had conducted and to revise courses accordingly. Recently, INTRAH has improved this aspect of evaluation, but it still has not addressed another deficiency: how to ensure objective standards by which trainers should judge competence at the end of training. These standards should enable trainers to differentiate between people who have acquired the minimal knowledge and skills needed for their jobs and those who have not.

Regional training was designated as a major focus of INTRAH's work in Asia with considerably less emphasis planned for Africa. The two regional institutions with which INTRAH has worked in Asia have served as excellent resources, one for community-based distribution (CBD) and the other for clinical skills training, with the CBD site serving also as a site for observational tours for Africans. In Africa, where five potential regional institutions have been identified, the conclusion was reached that none were sufficiently developed to be targets for institutional development.

Other efforts for sharing regional expertise, however, such as development of a core group of master trainers and regional technical advisory committees, were deemed useful and well worth pursuing.

Overall, management of the contract has been competent, as witnessed by the quantitative accomplishments to date: at midpoint, the project had met or exceeded end-of-project goals in both regions in five out of six categories, including having initiated projects in nineteen countries, worked with seven regional institutions, and trained over 19,000 first generation trainees. Another strength is the existence of two regional headquarters in Africa, although efforts should be made to augment their staffing and to delegate more authority to the field. While INTRAH and its two subcontractors have provided high quality technical assistance in most areas, project training staff skills need upgrading in supervision, management and CBD, and evaluation staff need to adapt their skills for developing countries.

INTRAH has not yet undertaken any major efforts to compare different approaches to training, primarily because its approach does not differ substantially from place to place. Opportunities to collaborate in operations research (OR) should be pursued, particularly to test some of its innovative approaches to CBD training in Asia. Any new approaches to TOT that might be implemented in line with the recommendations in

this evaluation should also be tested through comparative studies.

Major and minor recommendations were made and are summarized in Chapter VII.

## I. INTRODUCTION

### I.1. The Evaluation

#### I.1.1 Project Summary

This report is a midpoint external evaluation of the work of the Program for International Training in Health (INTRAH), University of North Carolina (UNC) under its five-year contract DPE-3031-C-00-4077 (September 1984 to September 1989) with the Agency for International Development (AID) to provide family planning training and assistance in institutional development. This contract is a part of AID's worldwide project, the Family Planning Training Project for Paramedical/Auxiliary/Community Personnel (PAC), Project 936-3031.

The purpose of this project is to strengthen or develop the capacity of less developed country (LDC) institutions and agencies to design, implement and evaluate training programs so that various PAC workers will be able to provide family planning services. The project is a follow-on to PAC I, whose prime purpose was also to provide training in family planning, but whose strategy was primarily to produce large numbers of workers rather than to assist host country institutions to develop the capability to carry on effective, self-sustaining training for PAC workers.

The project is being implemented on a worldwide basis by three contractors--INTRAH of the University of North Carolina in Africa and Asia, Development Associates, Inc. in Latin America and Ronco Consulting Corporation in North Africa and the Middle East. The worldwide project is authorized for ten years and each of the first set of five-year contracts is just beyond its midpoint.

#### I.1.2 Evaluation Methodology

This report covers the work of INTRAH in Africa and Asia, which was evaluated by three separate teams. The first team spent two weeks in Kenya and Uganda (July 1987), and consisted of Fred Abbatt, Patricia Baldi and Robert Blomberg. The second team spent one month in Ivory Coast, Burkina Faso, Nigeria and Zaire (July-August 1987), and consisted of Carolyn Long and Sheila Ward, plus Patricia Baldi for the Nigeria portion. The third team visited INTRAH-assisted projects in Asia--Sri Lanka, Nepal and Thailand (September 1987)--and consisted of John McWilliam and Judith Rooks. In addition to initial briefing at AID in Washington, D.C., and at INTRAH's main offices in Chapel Hill, North Carolina, the Africa teams visited

the respective INTRAH regional office (Nairobi, Kenya in East Africa and Abidjan, Ivory Coast in West Africa) for briefings on country programs and interviews with key personnel.

In each country, the teams met with officials of the Ministry of Health (MOH) and of other relevant government and private sector agencies, and with USAID mission personnel. They interviewed members of the national or state training teams that have been developed through the INTRAH program; interviewed evaluators trained by INTRAH; observed ongoing training sessions where possible; interviewed trainees; and visited family planning clinics and community service programs to observe service provision. INTRAH, AID and host institutions made available to the teams numerous documents and materials for their review.

The East Africa team was accompanied on its field visits by Pauline Muhuhu, INTRAH's East Africa Regional Director. The West and Central Africa (WCA) team was accompanied on its visit to Ivory Coast and Zaire by Pape Gaye, INTRAH's West Africa Regional Director, and in Nigeria by Teresa Mirabito, an INTRAH Program Officer. The Asia team was accompanied by Maureen Brown, an INTRAH Program Officer.

In addition to their field visits, the teams drew on cabled responses from USAID missions regarding the effectiveness of INTRAH in assessing its overall performance (see Appendix A).

The teams used a scope of work developed by AID's Office of Population, which was reviewed and amended during a team planning meeting held for evaluators of all three contractors at the International Science and Technology Institute, Inc. (ISTI) in Washington, D.C. in early June 1987. This scope of work directed the evaluators to focus on

- the progress being made by each contractor toward the achievement of PAC II project objectives;
- the effectiveness of the contractor's strategies and activities planned to meet contract objectives and produce specific outputs;
- the accomplishments of each contractor in the development of regional training resources;
- the effect of project management on the implementation of the contractor's activities; and
- whether or not there is a continuing need for PAC training assistance, and if so, what kinds of assistance are needed.

A copy of the Scope of Work is included as Appendix B.

The evaluation teams benefited greatly from the comprehensive briefings held at the INTRAH headquarters at UNC, Chapel Hill; briefings with INTRAH's two U.S.-based subcontractors, International Health Programs of the University of California at San Francisco (IHP), a part of the Institute for Health Policy Studies, and Training Resources Group, Inc. (TRG); the extensive project materials provided by INTRAH including numerous summaries of activities especially produced for the evaluation; and, most important, the assistance provided to each team by accompanying INTRAH officers. These officers, besides helping to plan the country visits, provided invaluable background information on the projects and their national context.

In addition to INTRAH's assistance, the host country institutions visited were very cooperative, providing information and facilitating field visits. The national and regional institutions visited by the teams are provided as Appendix C.

### I.1.3 Constraints

All three teams experienced some difficulty in reviewing INTRAH and host country institution activities in the time allocated for the country visits. In one country, AID had not made the necessary appointments before the team arrived, thus putting further time pressure on the team. In another country, holidays were declared just before the team's arrival. Although plans had been made to observe a regional training site in the Philippines, circumstances arose that made this trip inadvisable.

It was not always possible for the teams to observe training or to see service provision. Some training materials, particularly in the Asia Region, were in the national languages and English translations were not always available.

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## II. CONTRACT PURPOSE, OBJECTIVES AND OUTPUTS

## II. CONTRACT PURPOSE, OBJECTIVES AND OUTPUTS

### II.1 Purpose

The project purposes are

- (1) to strengthen or develop the capacity of institutions and agencies in Africa and Asia to design, implement and evaluate a program of training activities so that various PAC workers will be able to provide family planning services, and
- (2) to demonstrate a new level of efficiency and coordination in the provision of international assistance for family planning personnel training and program enhancement through international and interregional exchange of capabilities and experiences and through applications of impact-oriented and cost-benefit-oriented comparative evaluations of training programs carried out in the regions.

Fulfillment of the first component of this goal would require creation of host institution capability not only to train PAC workers using a curriculum created with extensive INTRAH technical assistance, but also to identify and meet new and emerging PAC worker training needs without external aid. Three years into this five-year contract, INTRAH has made progress toward, but has not yet achieved, this long-term goal.

The secondary purpose of this contract has two parts. INTRAH has been very successful in exploiting international and interregional exchange to enhance PAC training.

On the other hand, although INTRAH is making serious efforts to build relatively long-term follow-up testing and performance appraisal into many of its projects, these are not impact evaluations and have not been designed in a way that can be expected to yield meaningful understanding regarding the comparative costs and benefits of various PAC training strategies and approaches. In addition, because most INTRAH training to date has followed the same basic approach, INTRAH has not been able to conduct evaluations to compare various approaches.

### II.2 Objectives and Outputs

The contract specifies four objectives and five outputs. Where there is substantial overlap between an objective and an output, the two are combined in the following discussion. Both objectives and outputs are paraphrased, with the full contract text provided in Appendix D.

## II.2.1 Objectives

**Objective 1: Creation or strengthening of in-country training and service capabilities through provision of appropriate technical and financial assistance.**

Overall, the technical assistance provided was appropriate and of high quality except in the area of evaluation. Assistance given in financial management was excellent. Many family planning national training institutions have been substantially strengthened. In order to institutionalize a high-quality, responsive training capability, however, in most cases much more technical assistance will be necessary. In order to institutionalize family planning service capability, it will be necessary to train considerably more people; in some countries, this may mean increasing the rate at which service providers are trained. In order to strengthen both training and service capabilities simultaneously, INTRAH may need to review and revise some aspects of its approach.

**Objective 2: Establishment of "credible and self-sustaining regional resources" for family planning clinical, non-clinical and management training and technical assistance.**

and

**Output 3: Regional training institutions should be established as "credible on-going entities," having demonstrated "requisite strengths of management, staff technical capability and organizational stability."**

### Africa

Under the terms of the contract, regional institutional development was not a high priority objective in Africa, and INTRAH's involvement with existing regional training centers has not substantially increased their self-sustainability. There has, however, been some use of African consultants regionally, who are being groomed to become well-trained, experienced master trainers who will represent an important regional resource.

### Asia

Under the terms of the contract, INTRAH was directed to put substantial effort into assisting regional institutions. INTRAH has provided technical and financial assistance to two regional institutions in Asia. One is the Asia Center, Population and Community Development Association (PDA) in Thailand, which primarily provides training to community-based workers. PDA is a world leader in its field and would have been a credible, self-sustaining regional resource with or without

INTRAH inputs. The other, Integrated Maternal Child Care Services and Development, Inc. (IMCCSDI) (formerly the Institute of Maternal and Child Health [IMCH]) in the Philippines, provides clinical training and has been substantially strengthened through assistance under this contract, building on earlier support to its predecessor organization under PAC I.

PDA was offering training and observation tours before INTRAH started to work in Asia. INTRAH's major effort has been to attempt to increase the use of experiential teaching methods in PDA's ongoing activities. PDA has been used successfully to provide community-based distribution (CBD) observation tours for African family planning leaders.

IMCH, to which INTRAH's contributions have been more critical, has filled a void for training of Africans who have no access to sites where clinical services are delivered by PAC workers. It has also proved useful to INTRAH in Asia in Papua New Guinea where there are no appropriate in-country resources for clinical family planning training.

**Objective 3: Adoption of "innovations" in training, deployment and support of all types of personnel.**

INTRAH has wisely not put a great emphasis on testing innovative approaches. In the face of the dimensions of the task before it, particularly in Africa, INTRAH has preferred to work with existing service providers and to develop a standardized training process that it can apply, with minor adjustments, in all its projects. Within this generally conservative approach, however, INTRAH's use of experiential methodology for its training cycles represents a new way of learning and teaching to the large majority of participants in Africa and Asia (see discussion in Output 1). Also innovative have been INTRAH's efforts to capitalize on the unique opportunity of dealing under its contract with two quite different regions. Its success in exposing African family planning personnel to examples of CBD and CBD training in Asia should ensure that as CBD services are introduced in Africa, the capability will exist to train people to manage and train workers to execute these services (see Output 3).

In Asia, INTRAH has been very responsive to opportunities to support innovative training and service delivery programs. The community-based workers trained represent a diverse and unusual range including, in separate projects, young village women, traditional birth attendants (TBA) and traditional medical practitioners.

Finally, INTRAH has developed some innovative materials; however, distribution has not been as wide as

desirable, and therefore their potential usefulness has been limited.

**Objective 4: Developing networks for exchange of information within each region.**

INTRAH has fostered exchange of ideas within each continent, primarily through the creation of regional Technical Advisory Committees (TAC) in both Africa and Asia, which include representatives from all the institutions where INTRAH training has been conducted. In addition, considerable exchange among country participants occurs during INTRAH-sponsored regional, interregional and U.S.-based courses. An added benefit has materialized during these interregional and U.S.-based courses--namely, exchange between Africans and Asians. While not called for in the contract, this international exchange has served to widen horizons for both groups.

## II.2.2 Outputs

### II.2.2.1 Qualitative outputs.

Output 1: Pre-service and in-service institutions will increase their "technical self-reliance" (and in some cases achieve technical autonomy) in planning, designing, implementing and evaluating training programs. The institutions should be capable of developing curricula, producing "simple but effective" training materials, providing training with "sound and appropriate" techniques and "accurate content" and undertaking evaluations.

#### Africa

In Africa, INTRAH's training strategy for each institution with which it is involved is to provide a heavy influx of technical assistance at the start of each project, with decreasing levels as the core trainers become increasingly skilled. Specifically, an in-country training team, after intensive core training courses, will conduct workshops, usually with some INTRAH consultant involvement, after which--except in special cases--they are expected to be on their own in terms of organizing and providing further training courses.

At this point in the projects, while much progress has been made in improving the teaching skills of core trainers, very few trainers or the institutions with which they work can be considered to have reached the stage of "technical self-reliance" envisioned in this training process.

Few trainers have assimilated the full range of skills necessary to plan, design, implement and evaluate training programs on their own. So little time has been allocated to curriculum development that host country trainers are unable either to revise existing curricula or to develop new curricula; almost no time or effort has gone into teaching trainers to develop materials; and much of the effort to teach evaluation skills has been misdirected or misguided, so core trainers do not have a good notion as to how to ascertain whether their training efforts have really been successful.

In sum, in Africa, INTRAH is still in the early phases of developing institutional self-reliance. Attempting to instill the full range of trainer skills over a few brief weeks would be a difficult proposition even in the most advanced societies. In Africa, the new experiential teaching methods are quite foreign to most trainees and clinical skills cannot be learned without considerable experience. Perhaps INTRAH underestimated the magnitude of the task when it included not only adult learning methods but also curriculum development in its short training courses. Most African countries are in the early stages of developing national policies for family planning, building up services, developing a clientele and generating capacities to deal with needs for child spacing and contraception. Training is only one of the necessary inputs. In this light, the expectation of achieving self-sufficiency within this limited time period may be unrealistic.

### Asia

Three of the five institutions with which INTRAH has worked in Asia (Ministry of Public Health in Thailand, Family Planning Association of Sri Lanka [FPASL], and the Contraceptive Retail Sales [CRS] project in Nepal) were at or near technical self-sufficiency before INTRAH became involved. INTRAH's input has made them stronger but was probably not necessary for technical self-reliance. While there has been some strengthening of the other two, neither is technically self-sufficient at this point.

Output 2: First and second generation trainees will acquire "new knowledge and skills," and self-confidence in those skills, in management, delivery and support to family planning programs.

### Africa

INTRAH has made significant progress in instilling both knowledge and self-confidence in its trainees, attributable largely to experiential training methods and the quality of

INTRAH training consultants. First generation graduates exhibited new optimism, enthusiasm and self-confidence. Some first generation trainers said they had applied their new training skills to courses they teach in pre-service nurse/midwifery schools and had taught new methods to other teachers. One man noted that the experiential methodology not only required him to master his subject and prepare more before class, but that in class the students worked harder and enjoyed it more.

Judging from the reaction of second generation trainees, the experience has also been beneficial for them. One community health educator from Lagos State who had worked for 15 years as a health educator without apparent success spoke in glowing terms of how INTRAH's community education course had revolutionized his approach. With new skills, he has been able to effectively communicate with various urban groups in markets, parking lots and bus stations. The demand for condoms in his catchment area shot up dramatically after he began to apply his new skills.

Of the three projects in which INTRAH has worked to train new types of community-based workers, two have been extremely successful. Most notable has been INTRAH's training for young village women involved in CBD through an FPASL project in Sri Lanka. As a result of INTRAH's training, some 14,000 educated, community-minded but unemployed young women have undertaken new responsibilities that have provided them with a recognized role in the community. Their supervisors are community leaders, and monthly meetings with these leaders add to their social status. The second successful group of INTRAH-trained community-level workers were traditional medical practitioners in Nepal. As in Sri Lanka, INTRAH's training has been effective, not only in enabling these villagers to distribute family planning methods in a knowledgeable way, but, through assumption of this new role, to increase their visibility in their communities and to earn some money.

**Output 4: Training of community-based workers will increase "substantially, leading to an equitable distribution of primary health services."**

In Africa, given the nascent state of family planning service delivery and infrastructure, INTRAH has concentrated on training the existing cadres of professional nurses and midwives to provide family planning. Efforts to introduce CBD have been limited to orientation and training for African family planning/maternal and child health (MCH) leaders and trainers in Asia.

Overall in Africa, INTRAH's strategy has succeeded in developing services where none existed before. While the quality

of these services varies, some are quite good. Problems in the quality of family planning services, however, are evident throughout the world. More attention needs to be given by INTRAH to addressing training to improve effectiveness of PAC-delivered services.

In Asia INTRAH's focus on training CBD workers has had an impact on availability of primary health services, particularly in Sri Lanka, where the bulk of trainees trained under PAC II have been located (see Table 1).

Output 5: Policy makers, decision makers and opinion leaders will demonstrate an "understanding and active support" of family planning service delivery.

### Africa

In the context of government services, in some ways family planning is leading the way in terms of upgrading clinics, upgrading in-service training of middle-level service providers and developing the capacity of training institutions.

Kwara, Benue and Lagos states in Nigeria are making progress in developing state family planning training plans. Kwara and Benue now have a training line item in their budgets (albeit a nominal sum), and Lagos will have one in next year's budget.

To the extent that INTRAH is able to guide countries to incorporate line items and training plans into family planning government budgets, their investment in training teams should produce long-lasting effects. Similarly, INTRAH is increasing its efforts to orient high level policy-makers and upper-middle level managers regarding family planning training and evaluation objectives. Orientation of the supervisors of the service providers to be trained is included in newer INTRAH projects, but should become a more regular part of their program.

Once training plans are formulated, INTRAH encourages its in-country partners to review the readiness of clinical facilities to accommodate improved family planning service delivery. Clinic upgrading has occurred in some places and trained program managers, such as those in Burkina Faso, are beginning to ask important questions about quality control, data collection methods and supervisory needs.

In Zaire, Zairians involved in INTRAH activities were very clear in articulating family planning goals, plans for training events, distribution of responsibility and the next steps required for good service. They knew the problems that were ahead of them, particularly regarding the need for inter-

agency coordination, and expressed their commitment to resolving existing problems.

### Asia

In the Asia region, there is wide recognition of the need for family planning and acceptance of community-based family planning programs. Thus this output did not have high priority in Asia. Nevertheless, the INTRAH project in Sri Lanka contributes to this objective by involving grassroots community leaders in organizing and implementing the FPASL's program in their villages.

II.2.2.2 Quantitative Outputs. INTRAH has done an excellent job in achieving the quantitative goals specified in the contract, i.e., numbers of institutions, both in-country and regional, and numbers of first generation trainees. At the three-year point, the project has met or exceeded end-of-project goals in both regions in all categories but one: number of first generation participants in Africa. Even here, the output is commensurate with the amount of time expended. Table 1 below provides a detailed summary.

Table 1

PAC II: INTRAH CONTRACT REQUIREMENTS  
AND OUTPUTS, TO AUGUST 31, 1987

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FRICA

<u>Contract (life of contract)</u>	<u>Actual 8/31/87</u>
. 24 <u>in-country</u> institutions in 12 countries	25 <u>in-country</u> institutions in 14 countries
	Botswana: MOH
	Burkina Faso: MOH
	Chad: MOH
	Cote d'Ivoire: MOSA MOPW
	Kenya DFH DON NPC
	Mali MOPH/SA AMPPF (completed)
	Niger: MOPH/SA
	Nigeria: Bauchi (completed) Benue Gongola Imo (completed) Kwara Lagos 5-day updates FMOH (completed)
	Rwanda: ONAPO
	Sierra Leone: MOH (completed)
	Somalia: MOH (completed)
	Togo: Under development with MOH
	Uganda: MOH
	Zaire: AZBEF PSND

Table 1 (continued)

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3. 4 <u>regional</u> institutions in 4 countries	5 <u>regional</u> institutions in 5 countries
	Kenya: CAFS (completed)
	Mauritius: MFPA (completed)
	Senegal: ASBEF
	Tanzania: UMATI (under develop- ment)
	Togo: FHTC (under develop- ment)

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10,310 first generation participants	6,563 first generation participants using 5-day formula
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ASIA

<u>Contract</u>	<u>Actual to 8/31/87</u>
1. 7 <u>in-country</u> institutions in 3 countries	7 <u>in-country</u> institutions in 5 countries
	Nepal: Division of Nursing/MOH
	FP/MCH Project
	CRS (completed)
	Papua New Guinea: MOH (under develop- ment)
	Philippines: IMCCSDI/IMCH
	Sri Lanka: FPASL
	Thailand: MOPH
4 <u>regional</u> institutions in 2 countries	3 <u>regional</u> institutions in 2 countries
	Philippines: IMCCSDI/IMCH
	PCF (under develop- ment)
	Thailand: Asia Center/PDA
4,464 first generation participants	12,686 first generation participants, using 5-day formula

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### III. COMPARISON OF INTRAH'S APPROACH IN AFRICA AND ASIA

### III. COMPARISON OF INTRAH'S APPROACH IN AFRICA AND ASIA

#### III.1 The Setting

INTRAH has developed different approaches for Africa and Asia to respond to the very different levels of development in the two regions. The prime differences are summarized below.

#### Africa

1. High infant, child and maternal mortality rates still prevail.
2. Availability of modern health care services is uneven; clean water supplies, sanitary sewage disposal and safe food supplies are still priority needs.
3. Many governments are in the early phases of developing national population policies; many countries still operate with pro-natalist policies and laws.
4. Most countries are in the early stages of building a clinical family planning service base; the approach is to depend on nurses and midwives to provide services. It is widely believed that clinical services should precede CBD programs in order to prepare the clinic-based professionals to handle referral problems.

#### Asia

1. Country vital rates vary. Thailand's infant and child mortality rates are similar to those of a developed country while Nepal's rates are similar to those of countries in Africa.
2. Modern health care is available to a large extent throughout the region, but distribution may be uneven in some countries.
3. Most governments have established family planning population policies and are serious about their implementation.
4. Clinical services are available, particularly in urban areas; extension of coverage to rural areas is provided in many countries through CBD and primary health care (PHC).

Africa

5. Contraceptive prevalence rates are low throughout the region, although they are beginning to increase.

6. Temporary methods are used primarily; there is very limited demand for and acceptance of voluntary surgical contraception.

Asia

5. In some countries, the contraceptive prevalence is relatively high; in others, it has leveled off in an intermediate range; and in others, it has remained low.

6. A wide variety of both permanent and temporary contraceptive methods is used; in some countries, the use of voluntary surgical contraception is very high.

III.2 The Background

III.2.1 Africa

INTRAH has now been working in Africa for eight years. Before that, UNC's African Health Training Institution Program (AHTIP) had a five-year AID/Population contract to assist African schools of nursing/midwifery and medicine to incorporate family planning concepts into their curricula. The AHTIP contract ended in 1977 and the PAC I contract started in 1979. Thus UNC has had long experience in training for family planning service delivery in Africa. Although its focus on medical schools ended with the AHTIP contract, INTRAH's involvement with the training of professional nurses and midwives has been consistent over approximately 13 years.

III.2.2 Asia

INTRAH's involvement in Asia began with the PAC II contract. It followed in the footsteps of the University of Hawaii's Regional Training Service Agency/Asia (RTSA/A) program, which had the Asia PAC I contract. INTRAH was relatively inexperienced in training for the kind of CBD programs that were most prevalent under PAC I. It inherited an ongoing program, however, whose momentum and existing plans including a 1984 RTSA/A follow-up study of the various training programs and accompanying recommendations, which helped it establish a course of action without delay.

III.2.3 INTRAH'S Approach

III.2.2.1 Africa. The PAC II contract anticipated that half of all PAC II resources would be used in Africa, and INTRAH's contract targeted 80 percent of its resources for Africa. INTRAH has worked with a total of 24 institutions in 18 East, Central and

West African countries to date, and currently has projects under way in 16 countries. Most of the "institutions" with which INTRAH is affiliated in Africa are ministries of health. It has focused primarily on increasing the ability of these in-country institutions to conduct training, with little emphasis on improvement of regional facilities.

Throughout Africa, INTRAH concentrates primarily on training of trainers to support the provision of clinical family planning services. Its training is designed to add family planning to the repertoire of skills and responsibilities of the nurses and midwives who directly provide and/or supervise preventive maternal and child health (MCH) services through the national (or, in some cases, state) MOHs. This has been an appropriate strategy because both professional- and auxiliary-level nurses/midwives play a strong role, not only in service delivery, but also in supervision, management and administration of MCH programs throughout the region. In WCA, INTRAH is also involved in training for community health education. In some West African countries, it also collaborates with organizations that focus on the dissemination of information, education and communication (IEC) for family planning. To summarize, in Africa INTRAH is attempting to achieve three principal objectives:

- Development of national or state training teams to provide in-service training for nurses/midwives currently working in MCH service delivery sites operated by the MOH;
- Efforts to incorporate strong family planning modules into the curricula of pre-service basic schools of nursing and midwifery; and
- Plans to develop three or four regional training centers with facilities and training expertise to enable them to meet needs for family planning training that cannot be handled through in-country efforts.

III.2.2.2 Asia. Only 20 percent of INTRAH's resources are directed to Asia. INTRAH has supported in-country training in only three countries (Thailand, Sri Lanka and Nepal). In addition, INTRAH is exploring the possibility of starting a project in Papua New Guinea, where family planning services are at a very low level.

In all but Thailand, where one INTRAH project is working with the Ministry of Public Health, INTRAH's in-country projects have aimed primarily at expanding and improving provision of services through community-based workers such as village volunteers and traditional medical practitioners and/or improving performance of district- and provincial-level administrators of community family planning programs. This focus is appropriate

because of the existence of CBD networks into which INTRAH can fit.

To summarize, INTRAH is attempting to achieve three principal objectives in Asia:

- to continue to develop and use selected regional PAC training institutions;
- to provide opportunities for leaders of PAC training institutions to meet and learn from one another; and
- to develop in-country capacity to train persons involved in providing services at the community-based level.

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IV. IMPLEMENTATION OF COUNTRY/INSTITUTIONAL PROGRAMS

#### IV. IMPLEMENTATION OF COUNTRY/INSTITUTIONAL PROGRAMS

##### IV.1 Needs Assessment, Project Planning

##### IV.1.1 Needs Assessments

IV.1.1.1 Summary. INTRAH's practice is to begin work in a country by conducting a project identification exercise, which it refers to as a needs assessment. This exercise involves one to three people, including an INTRAH officer, who visit a country for one to two weeks. The team collects information on government policies and priorities, the level of development in family planning/MCH service delivery, the infrastructure and support systems in place, AID priorities and the roles of other cooperating agencies (CA). The purpose is to assist INTRAH in identifying the institutions with which it can work to carry out its program.

The term "needs assessment" usually connotes a broader concept than the activity that INTRAH undertakes under this rubric. Missing in INTRAH's approach have been a systematic assessment of existing pre- and in-service public and private sector PAC training facilities and programs; the PAC personnel in place and produced per year; the adequacy of training, including an analysis of curriculum for all pre- and in-service PAC workers; and analysis of current roles of PAC workers in family planning services. INTRAH has also been lax in identifying major family planning service deficiencies; i.e., population subgroups whose particular needs are not being addressed, lack of access to specific methods, poor continuation rates and excessive complications. INTRAH is making progress in improving its needs assessment process, however, and more of these elements have been included in its most recent project identification exercise.

Finally, INTRAH has not always worked as closely with host governments as it should, relying instead on USAID inputs. In some cases, this has resulted in flawed projects. Moreover, it has also meant that INTRAH has lost an opportunity to train host country personnel in conducting needs assessment, which should be a vital part of the project development process.

IV.1.1.2 Africa. In Africa, for example, INTRAH'S main concern seems to be to identify an institution and members of a core training team with whom it can work to develop a training plan for that country. In some instances, the research leading to the choice of institution and plan has not been adequate. For example, INTRAH's needs assessment in Burkina Faso relied too heavily on a project paper that had been done for the USAID bilateral project, and which lacked some information relevant to training.

The informal needs assessments conducted by INTRAH project managers during program monitoring visits are often quite valuable. INTRAH's thorough trip reports help to ensure that important information is fed back to central planning levels, and INTRAH often attempts to respond to newly identified needs as programs evolve (see Section VI.4.2).

IV.1.1.3 Asia. In Asia, the project identification process has been influenced by two external factors:

- needs identified by USAID missions, either to support their bilateral programs or to meet emerging needs; and
- the work begun by RTSA.

INTRAH has limited its efforts largely to filling gaps identified by AID and continuing RTSA's efforts, an appropriate course of action given its limited resources for in-country training. Many of these efforts, moreover, have been successful, characterized particularly by appropriate and innovative selection of groups to be trained at the grassroots level. In the FPASL project in Sri Lanka, for example, the target trainees are educated, community-minded but unemployed young women, and the training approach used was successful in motivating them. In Nepal the focus on traditional medical practitioners, a fairly ubiquitous group, was shown to be successful in spreading sales of condoms and pills to people in communities who previously had had no access to these methods. In another Nepal project, INTRAH provided training to traditional birth attendants (TBA) who are available in most Nepali communities and whom women trust and look to for advice in matters related to childbearing. By relying on these women, the project has succeeded both in improving childbirth practices and increasing referrals for family planning and high risk maternity care.

On the other hand, particularly in Nepal, INTRAH should have undertaken additional research beyond the groundwork laid by RTSA before embarking on training efforts. While the TBA project, for example, represents an appropriate activity, a field needs assessment was needed to make realistic plans for solving problems related to supervision. The project envisions that one auxiliary nurse-midwife will supervise 20 newly trained TBAs through visits to their home villages. This is an unrealistic idea, given the distances and dependence on pedestrian transportation in Nepal. Had INTRAH been more aware of the problem, it might have developed a different plan. A second example of inadequate preparation is INTRAH's course for family planning/MCH district storekeepers in Nepal. This was developed without any site visits to district stores, and training for the storekeepers' supervisors focused only on the chief storekeepers. Without participation by the District Family Planning Officers, who exercise real control over

local storekeepers, however, training of storekeepers and their immediate supervisors may be of little avail.

These two experiences suggest that INTRAH should not stint in its efforts to conduct thorough field needs assessments. When projects fail, the costs in terms of wasted worker energy and time, as well as of overall credibility of the strategy itself, can be high. In every case, therefore, INTRAH needs to weigh the potential costs of the risk of failure against the cost that would be involved in conducting a thorough needs assessment.

#### Recommendation

o INTRAH should conduct thorough training needs assessments, including field observations, prior to the development of any new projects, and as part of future TOT courses. It should work with host country nationals in this process to increase their skills in needs assessment and to ensure that projects meet host country needs (#16).<sup>1</sup>

#### IV.1.2 Project Planning

Plans for each INTRAH training activity are laid out in an overall project subcontract/design which is drawn up by INTRAH staff in cooperation with representatives from the institutions through which the project will be implemented. The training plan is very detailed, including the subcontract dates, total dollar amount, goals, objectives, and delineation of each party's responsibilities in a clear-cut work plan with due dates and definite quantities for expected outcomes.

Other INTRAH training inputs may be added later to strengthen the service delivery infrastructure. The core training team is usually involved in any subsequent training, unless it requires specialized expertise. Examples of additional types of training might include training of the PAC workers' supervisors; training to improve the record/reporting system; management training (usually accomplished by sending one or more people away for a special course); IEC training; training in community health education; training for clinical preceptors; and advanced TOT for selected trainers.

#### IV.2 Training Process

##### IV.2.1 Summary

##### IV.2.1.1 Africa and Asia Prototypes. I N T R A H h a s

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<sup>1</sup>Numbers after recommendations identify their position in the full list of recommendations in Chapter VII.

developed two prototypical training project designs--one to provide training of trainers (TOT) and family planning clinical skills to professional and auxiliary nurses and midwives in Africa, and the other to prepare and support Asian village volunteers or traditional health workers who provide family planning advice and either referral or commodities. The Africa training involves two steps and the Asia training, three. In Africa, INTRAH prepares a core training team which is in turn directly responsible for training nurse-midwives and other health-related personnel. The Asia programs involve an additional step: INTRAH trains centrally based core trainers who train the provincial or district level supervisors of the village workers, who in their turn train the community-based workers who are the ultimate targets of the training. While these patterns are repeated in projects in various countries, no two projects are identical; the model is adapted to the local situation.

A strength of the Asian approach is that the people who are expected to be delivering services--the workers--are being trained by their supervisors. While a project can falter seriously if the wrong supervisors are chosen (see Section IV.1.1.3), in most cases, the Asia model, with its built-in continual reinforcement, works well. In Africa, by contrast, they are trained by outsiders who have no continuing involvement with them once training is finished. Moreover, INTRAH has not always involved supervisors in the training process. Where it has, the reception has been extremely positive. In Nigeria, for example, where a two-day orientation in Lagos State was held for supervisors of nurses, the principal reaction was a request for at least a three-day session in the future. In Uganda, a week-long orientation for supervisors has enhanced integration of family planning with MCH. On the other hand, in Kenya, in cases where orientation has not been held for supervisors of enrolled community nurses trained by INTRAH, the nurses have found it difficult to apply their new skills on the job.

IV.2.1.2 Selection of Trainers. In Africa, the focus is on identification of core trainers, and here INTRAH's host country partner agency selects the individual team members, using three criteria developed by INTRAH: that trainees be nurses, midwives or physicians; have prior training experience; and can devote at least 20 percent of their future work time to training. The core teams usually include several nurses and midwives involved in supervision of family planning/MCH services, faculty members of the basic schools of nursing, one or two key physicians, individuals responsible for in-service family planning/MCH training within the MOH or other agency charged with providing family planning services, and sometimes a health educator.

INTRAH and its host country colleagues have become increasingly successful in identifying appropriate leaders to be

trained as trainers. At this point, INTRAH can generally influence the selection process. Most people now selected for INTRAH's TOT sequence hold positions in which they can influence pre-service and in-service training of nurses, midwives and family planning managers and are thus able to develop training programs that incorporate family planning training into both basic and in-service curricula. While core trainers usually are the key people in clinical services, they may not, however, always represent those with the best clinical skills.

#### IV.2.1.3 Detailed Description of Training Process.

Over time, learning from its experience under PAC II, INTRAH has developed several standardized components in its training process. One is geared to orienting host country institution leaders, while four others constitute a series of training events to produce a core training team. A summary description follows.

##### o Orientation for leaders

An orientation for leaders (about three days) is conducted by representatives from the host institution with whom INTRAH designed the project and subcontract. INTRAH staff help their host country counterparts to plan the meeting and facilitate the orientation session. The people invited are those whose cooperation and participation will be needed to support the work of the end-point trainees. During the orientation session, participants are told about INTRAH and about the project objectives, work plan, anticipated outcomes, and roles and responsibilities of meeting participants.

##### o Training of core training team

The first "Core Training Team Building" activities are usually scheduled 2-4 weeks after the orientation for leaders. In Africa, where the training team will most likely be teaching clinical family planning skills, the first part of the training covers clinical skills. In both Africa and Asia, there are three additional components. The methodology throughout is experiential; i.e., it includes exercises that put trainees through the task to be done and provides time to reflect on that experience and to draw conclusions. The four activities are summarized below.

- (1) A 4-6 week clinical family planning skills course which usually includes content on sexually transmitted diseases (STD) as well as a wide range of family planning methods; a clinical practicum is always included.
- (2) A 2-3 week training of trainers (TOT) course. The first week is primarily theoretical, with focus on principles of training needs assessment (TNA), how

adults learn, group process, use of active learning methods, and how to write learning goals and objectives. During the second and third weeks, the participants plan and develop the curriculum they will use to train the target trainees. They write or revise the trainees' job description and conduct task analysis to determine necessary knowledge, skills and attitudes. They then develop training goals and objectives; write lesson plans; identify resource people and training materials to be used; make plans for a clinical practicum, if needed; and develop the pre- and post-test.

- (3) About a month later the core training team, ideally with the INTRAH co-trainers, use the newly developed curriculum to train the first group (in some cases, two groups) of target trainees. Working side by side with experienced INTRAH trainers, the participants have an opportunity to practice the experiential methods taught during the TOT course. At the end of each day the core training team and INTRAH co-trainers discuss the day's events, problems and progress. At the end of the course, they administer the post-test and analyze the pre- and post-test differences. Not all workshops, however, include an INTRAH staff member; in these cases, an important opportunity is lost to reinforce good teaching habits and to correct mistakes as the trainers learn.
- (4) INTRAH's efforts to provide training in evaluation of training have evolved over time. While evaluation skills are still taught in special workshops that are not integrated into the TOT sequence, participants are now core trainers and the workshops are being held in the region. Moreover, the content has been simplified to help ensure that evaluation can be an integral part of the training process.

#### IV.2.2 Training of Trainers

IV.2.2.1 Summary. The TOT course is very short (2-3 weeks), considering the amount of material to be covered. A full week at the outset is spent on establishing general principles. This leaves only 1-2 weeks to develop the curriculum upon which the rest of the project will be based.

IV.2.2.2 Teaching Skills. One of the ingredients sacrificed to lack of time in the TOT courses is the opportunity for trainees to do sufficient practice teaching. Although these

first generation trainers are expected to conduct workshops using the experiential training methods they have experienced as trainees, they have little opportunity to try out these new methods. The intention is that they will have coaching and technical assistance from an INTRAH trainer during the first workshop they conduct, but when there is no INTRAH consultant available to co-train, this needed reinforcement is lost (see Section IV.2.1.3). The methods, moreover, are being introduced into a hierarchical tradition of learning where didactic teaching methods, memorization, and passivity on the part of students are long-held practices. Nevertheless, some trainers observed during the evaluation visits were surprisingly competent in view of their limited training experience; particularly in East Africa, however, more training was clearly needed. The experiential training method appears to have been well accepted by most trainees and is beginning to take root in the workshops for second generation trainees. Moreover, the trainers show the potential to perform at significantly higher levels with comparatively small exposure to further TOT (see Appendix E for additional details on training).

IV.2.2.3 Curriculum Development. Since the TOT course cannot realistically be lengthened, the solution to providing more time for practice teaching might be to reduce the focus on other areas--specifically on TNA and/or curriculum development.

As it is, however, little time is devoted to TNA curriculum development. Participants are told during week one how to conduct a complete TNA, but they are given no time to go to the field to conduct the necessary observations, interviews and data gathering that this activity would comprise. Rather, they base the revision or writing of a new job description (and thus their curriculum) on the ideas and experience of a few supervisors and project leaders, plus those of INTRAH training staff. This means that specific project curricula may not be optimally focused to address unique local needs (see Section IV.1). The writing of the curriculum is done under the supervision of INTRAH trainers in the short time allocated to that purpose, and the quality of the resulting curriculum is often marginal.

While the curriculum developed in Zaire was found to be excellent,<sup>2</sup> in another instance the curriculum was no more than a

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<sup>2</sup>The pre-service curriculum developed in Zaire is based on experiential TOT and includes sections on clinical family planning, IEC, management, research and statistics, legislation and politics. The only component that seemed to be missing was training for clinic facility and equipment maintenance. Developed through INTRAH workshops, the curriculum has been tested for use in 100 basic nursing schools. The next step planned is to train nurse tutors in the experiential methods called for in the curriculum. While the need for this training was not originally

compendium of handouts and notes from sessions, arranged in no meaningful order.

In addition, while host country trainers may be able to undertake some curriculum development under the supervision of INTRAH trainers, most are not capable of revising that curriculum later without further technical assistance (TA). Although that TA could be provided, the conclusion remains that the skills of curriculum development have not been institutionalized at this point.

Based on this situation, INTRAH argues that what is needed is an increase, not a decrease, of emphasis on TNA and curriculum development training. It argues not only that curricula developed during training would be specific to the needs of the INTRAH-sponsored workshop that follow but also that the process of developing the curricula helps trainees to assimilate the materials and to understand what they will need to accomplish in the course. In short, the argument is that the ability to develop curriculum is intrinsic to the skill base of a trainer.

While this argument has merit, the process of curriculum development requires a great deal of work, group discussion, development of consensus, testing and revision. It is not possible to develop a full-fledged curriculum during a 2-3 week TOT. Rather, INTRAH can only orient trainers to the process and to accept and use the curriculum developed regardless of its quality.

An alternative approach would be to leave curriculum development to a select group of INTRAH-trained trainers. This suggestion was made specifically for Nigeria, where it will be necessary to develop a training team for each of 19 separate states. The approach might also be applicable elsewhere and deserves serious consideration.

### Recommendations

o INTRAH should address the problem that its TOT sequence, particularly in Africa, is attempting to cover too much ground and as a result is failing to teach any one aspect adequately. To improve the quality of training, INTRAH should experiment with new approaches that would increase the time allotted to teaching trainers how to use experiential training methods in the classroom. For example, one approach would be to reduce or eliminate the time now given to curriculum development or other

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anticipated in the training plan, INTRAH and its colleagues in Zaire are discussing ways to implement the training. If successful, 100 schools would have not only a family planning curriculum but also 100 nurse tutors trained in adult learning methodology -- with potential positive spin-off in other subject areas.

subjects that may not be critical to the trainers. In conjunction with this change, INTRAH should initiate special training workshops for curriculum developers, who would be drawn from existing INTRAH-trained trainers and who would become country experts on curriculum development (#3).

o INTRAH should also experiment with various ways to accelerate its TOT training in order to create more core training teams to train PAC workers. This approach should be used in those countries where demand for family planning is creating a need for large numbers of trained family planning workers. These experiments would focus on how to shorten the length of training without lessening the essential elements required of the core trainers to carry out PAC worker training (#4).

o In all cases, INTRAH should ensure that adequate follow-up TA is provided to INTRAH-trained trainers. It should make sure that the consultant or staff member who assisted in the TOT workshop course participates in the graduates' initial workshop, be alert to subsequent trainer needs, and continue to provide TA on a routine basis until it is satisfied that trainers have achieved a satisfactory level of competence. Follow-up should also be provided for those trained in special skills such as curriculum development and materials design (see Recommendations 3,4, and 7 [#5]).

#### IV.2.3 Clinical Skills Training

In general, the objectives for practical clinical skills training were adequately spelled out, substantial time was allocated to practicing skills, and the skills had been learned sufficiently for nurses to provide services properly and to share their knowledge with colleagues who had not attended the course.

Some weaknesses were observed, however. There were insufficient opportunities for field practice on insertion of IUDs, especially in countries where demand for this method of family planning was low. Moreover, too little stress was put on the importance of disinfection, aseptic techniques and adequate instrument and equipment maintenance in IUD insertions. These are critical issues in Africa, where environmental sanitation is often poor. Another problem was lack of enough emphasis on communication skills. The focus on IUD insertion may be detracting from important training in other skills in some instances.

Because of these and other considerations, there is a question as to whether IUD insertion should be routinely included as part of the curriculum for nurses and nurse-midwives. Although these groups are eager to learn to insert IUDs (a technique that carries status and may provide opportunities for some to earn additional income through after-duty private practice), there is a

real question whether the demand for IUDs is great enough to justify the time and effort needed to train people to perform this service (see section IV.1).

Moreover, the question of risk should not be overlooked. The issue is not just that unsanitary clinic conditions may lead to infection. There is also the danger of infertility: clinics in Africa do not have the routine testing facilities that would identify cases of STD which are common in Africa and may lead in many cases to infertility in women who use IUDs.

INTRAH has made substantial efforts to teach all methods of family planning, including the advantages and disadvantages of each method, and to instruct the trainees on where the various methods can be obtained. Workshop content as well as overall project design, however, must also recognize the host agency's and host country's policies on family planning service delivery. In Kenya, for example, government policy dictates that each family planning service delivery point must offer all methods except voluntary surgical contraception, which is provided only in specially designated clinics.

### Recommendation

- o The need for IUD insertion training in the initial family planning skills training courses for nurses and midwives in Africa should be evaluated on a country-by-country basis. In some cases, IUD clinical training may need to be offered later to nurses who have already demonstrated competence in the other aspects of family planning practice and who are working in sites at which there is demand for IUDs (#17).

### Suggestions

- o To the extent feasible within budget constraints, additional simulation models should be provided so that each course has access to sufficient numbers. This would enable several students to practice simultaneously rather than waiting for 19 other students to practice. Teaching equipment such as overhead projectors could allow teachers to increase their effectiveness. If appropriate to country circumstances, consideration should be given to providing video recorders and to preparing within countries videotapes of clinical procedures carried out in typical field conditions. Another vital area where videotapes would be useful is in demonstrating communication techniques.
- o Because of general problems in some African countries with environmental sanitation and insufficient provider attention to concepts of disinfection, aseptic technique and adequate instrument and equipment maintenance, more training emphasis needs to be given to basic theory and

practice of these concepts.

- o Because of the absence of routine laboratory testing of family planning clients to rule out STDs, INTRAH should look for ways of promoting linkages with clinical research related to quality care in family planning services in Africa. Research relevant to family planning services might include such studies as method suitability for selected subgroups of the population, follow-up of IUD experience, and attitudes of providers in relation to method accepted. UNC's potential for conducting research (without funding from the INTRAH budget) or "twinning" with host country researchers should be explored.

#### IV.2.4 Evaluation

IV.2.4.1 Summary. Under its contract, INTRAH is required to undertake two types of evaluation activities: 1) to train host country evaluators to assess the quality of the training activities conducted by INTRAH-trained trainers; and 2) to evaluate the achievement of project objectives in each country and in the overall INTRAH contract. Both activities are the responsibility of INTRAH's Evaluation Unit in Chapel Hill and are in theory closely linked. Unit staff (or sometimes consultants) conduct training workshops whose participants are expected to collect baseline information on family planning, participate in analysis of pre- and post-tests of trainees and trainee reaction forms after each workshop, and to do a final performance appraisal on a sample of trainees. The Evaluation Unit is supposed to collaborate with host country evaluators in analyzing the final performance appraisal at the end of each project and to draw heavily on information gathered by host country evaluators in carrying out its final evaluations.

Although there is a close link between the gathering and analysis of data, the Unit's functions of training and evaluation are treated separately in this report, with the focus here on the Unit as trainers and the discussion of its work in evaluation in Section VI.4.3.

INTRAH's training in evaluation reflects misunderstanding of the prime purposes of developing evaluative skills in trainers. These skills should serve two purposes: 1) to enable trainers to identify weaknesses in the training and revise the curriculum accordingly; and 2) to differentiate between people who have acquired the minimal knowledge and skills, including decision-making skills, to undertake their jobs in the field, and those who have not.

Seen in this light, the training that INTRAH should be providing should prepare trainers to assess trainee performance,

which in turn reflects on the quality of training, not to carry out formal evaluations focused directly on the quality and impact of training.

INTRAH, however, seems to have confused the two types, providing training in sophisticated, complicated techniques appropriate for evaluation but inappropriate for producing immediate feedback needed by trainers to assess trainee performance and revise their activities accordingly. This confusion was caused in part by a misdirected strategy for evaluation implemented by INTRAH for the first two years of its contract, and following from this strategy, inappropriate technical assistance for the trainees.

IV.2.4.2 Strategy. INTRAH's evaluation training strategy, as stated in its original PAC II proposal, was ill suited to meet the needs for training evaluation as its program in training developed. INTRAH identified the "critical shortage of trained specialists in family planning program evaluation" as the main problem for training evaluation to be rectified. As stated in its proposal

INTRAH will provide for the practical training of a core group of specialists in program evaluation and evaluation training. Four regional institutions will nominate three professionals each - two from the permanent staff and one from a closely affiliated organization - for training in a two-course series. In the summer of the first year of the contract period, the twelve will participate in a three-month intensive course at UNC-CH [Chapel Hill]. They will return to their work sites with basic evaluation skills and instruments and plans for participating in various phases of evaluating INTRAH-supported host country projects. After one year of this practical "laboratory" experience, they will return to UNC-CH for a second summer's intensive training in training methods, data analysis and applications of evaluation findings. At the completion of this course, the twelve program evaluators will rejoin their organizations which will then assume full subcontracted responsibilities (with access to INTRAH technical assistance if required) for the evaluation of INTRAH-assisted projects and the provision of training and technical assistance in family planning program evaluation for countries of the region.

To sum up, the strategy had three main components, all of which turned out to be problematic:

- (1) At the start, INTRAH provided training in evaluation to people who were not members of the core training team. The original basic intent of INTRAH's evaluation training was not to train trainers in training evaluation, but rather to begin to build a cadre of evaluation specialists who could serve as evaluation resources in their respective regions.
- (2) Also in the early days, training was offered in regional, interregional and U.S workshops, which contained few if any elements of regional, let alone country specificity.
- (3) INTRAH did not always look to INTRAH-trained trainers to assess the quality of their own training efforts.

Each of these deficiencies in the strategy is discussed below.

(1) Choice of Trainees

Training evaluators who were not part of the core training team meant not only that core trainers were not responsible for assessing their own efforts and finding ways to improve them; it may also have threatened the core trainers since it effectively meant that external evaluators would be looking at their work, rather than they themselves using evaluation as one of their own tools in providing good training. In addition, the evaluation training went sometimes to individuals whose other works assignments and priorities kept them from being actively involved in INTRAH training.

(2) Interregional Workshops

The training of evaluators in distant locations in workshops designed for a wide range of participants added to the evaluators' isolation from the core trainers. During the project's first years, specialized interregional workshops took place at INTRAH headquarters in Chapel Hill, Nairobi and Bangkok, and included participants from both the Africa and Asia regions. Little preliminary research was undertaken to ensure that the content of the workshops would be suitable for all participants. Few assessment visits were made to Africa. In Asia, more assessment visits were made, but they were fairly cursory: generally, the purpose for these trips seemed to have been to identify candidates to attend the workshops rather than to identify evaluation needs. In fact, the needs in Africa and Asia were different. In Africa, little work has been done in evaluation of training at the formative level, and almost none at the level of impact. In Asia, by contrast, there is some experience in formative evaluations, and impact evaluation is

familiar since there has been considerable work in evaluation of service statistics in measurement of program success.

(3) Confusion Regarding Who Should Learn What Kind of Evaluation

While the INTRAH evaluation staff is knowledgeable about the uses of formative and impact evaluation, there has been little understanding of who should learn what types of evaluation. Formative evaluation (biodata, pre- and post-test, participant reaction, etc.) should be used by the trainer to improve the training program. In both Sri Lanka and Nepal, however, the tabulation and interpretation of results of formative evaluation are the responsibility of the evaluation unit. The individual trainers do not take this responsibility.

The role of summative evaluation is a much more appropriate role for an evaluation unit. Instead, however, in the case of Sri Lanka much of the attention of the unit is on formative evaluation, and the summative evaluation has been contracted out to an officer who was previously employed by the evaluation unit.

Recently, INTRAH has made improvements in relation to the first two problems discussed above: 1) Members of core training teams are now given training in evaluation, and 2) workshops are being given on a regional basis exclusively for either Asia or Africa participants. There is, however, still confusion regarding how much responsibility should be given trainers in carrying out evaluations.

INTRAH evaluation training efforts have become increasingly mindful of the contexts in which evaluators work; there is more awareness of the need for practical and technologically appropriate training. However, since these efforts are fairly recent, the evaluation teams were not able to see the results at the field level of this new emphasis; rather, the results of the misdirected evaluation strategy enunciated in INTRAH's PAC II proposals were the only visible results that could be recorded.

IV.2.4.3 Content. If training in evaluation is to be useful to the trainer, it should be an activity that fits into his or her ongoing responsibilities. The evaluation methods taught by INTRAH should enable core trainers or evaluators to assess their training efforts from the following standpoints:

- (1) Whether the curriculum was appropriate for the level of trainees enrolled in the course (biodata forms);
- (2) Whether trainees were achieving the goals of the course (instruments to assess trainee performance, including

pre- and post-tests and level of practical skills);

- (3) Whether trainees perceived the training as useful (trainees' reaction forms); and
- (4) How trained service providers were performing in the field (follow-up evaluations and service delivery data).

While examples of all these methods were observed, INTRAH's evaluation training efforts most noticeably have stressed those implemented during the project's beginning stage-- theoretical and sophisticated approaches rather than ones that can be easily used by trainers. For example, evaluators at the Chapel Hill workshop were being taught how to use such sophisticated tools as F-tests, T-tests, regressions and sampling. These tools are not suitable for evaluating the kinds of workshops INTRAH-trained evaluators are assessing. Moreover, even the suitable and simple approaches listed above were often being used inappropriately. Use of these approaches is reviewed below. Again, INTRAH has revised its strategy for evaluation training, and many of the questionable practices described below have been changed or discontinued.

- 1) Biodata Forms

A close look at the biodata forms of training participants can help trainers evaluate whether the curriculum they have devised is suitable given the previous training and experience of their trainees. In Nepal, for example, these forms have been used for 10 years by national trainers as the basis of the curriculum used in a continuing education system in the training unit. When INTRAH began its training efforts, however, it substituted its own forms, because they better suited its purposes of reporting to AID on numbers of participants trained. Thus, a good opportunity was lost to evaluate the match between trainee skills and course content and approach.

- 2) Assessment of Trainee Performance

- o Pre- and post-tests

INTRAH has put considerable emphasis on this evaluation instrument, which normally involves a pre-test, followed by a mid-course written exam and a final written exam (which in some instances is a repeat of the pre-test). Combined with assessment of practical work on a continuous basis, this is a superficially reasonable approach.

The problem has been that the pre-test questions have often focused on obscure, technical parts of the training rather than testing the main areas of the learner's competence that will be most vital to his/her performance. If the pre-tests were being used correctly, they would point up the areas of weakness,

providing guidance as to where the curriculum should concentrate. As it is, they often do not. There are a few cases where results of the pre-tests have been used to alter the course design, e.g., in Lagos and Benue states of Nigeria. There are instances, however, in which the tests seemed to be conducted in a perfunctory way, with the findings not used to make indicated course revisions. The final written exams showed examples of some good problem-based questions which closely reflected the kinds of situations with which the learners would have to deal in their jobs. There were, however, also a number of matching questions and even some essay questions of the "write brief notes" type; these are inappropriate because they give no indication of the kind of job the trainee will be able to do in a field setting. Appropriately, the written assessment did not appear to feature prominently in decisions concerning pass or fail. If it had, however, the very low pass mark of 50 percent would not have ensured competence.

INTRAH is aware of many of these problems and is making efforts to improve the pre- and post-test methodology. Its revised approach is expected to be introduced at the next scheduled evaluation workshop.

o Assessment of practical skills

The assessment of practical skills to be learned during training was loosely defined. None of the usual techniques for improving reliability were adopted, and there seemed to be no agreed or accepted criteria for acceptable performance. Because of the absence of documentation, it is difficult to be definite about the importance of decision-making and communication skills in the assessment process (see Appendix E).

INTRAH evaluation staff and consultants have more recently attempted to support trainers and in-country evaluators by addressing performance evaluation in their evaluation workshops. INTRAH evaluation staff have also collaborated with program staff and consultants in the development of performance evaluation tools for clinical trainees. These tools have been used and revised in Nigeria, Uganda and Nepal. In addition, INTRAH is providing day-to-day feedback to students on the quality of their practical work.

3) Participant Reaction Forms

INTRAH may overemphasize the value of participant reaction forms in evaluating training workshops. While useful for certain aspects of workshop structure (amount of material covered, pacing, intensity, future directions), they do not evaluate some dimensions of the quality of training. On the whole, trainees tend to be agreeable and provide neutral to positive feedback which they believe trainers want to hear. Moreover, when these forms are used on a daily basis, they tend to generate less

thoughtful feedback but nonetheless require time-consuming analysis.

4) Field Follow-up

o Field performance

The performance appraisal of trainees, at a point subsequent to completion of training, is one of the areas where INTRAH's evaluation of training should legitimately be focused. It should be noted that INTRAH did begin to address this issue with the introduction of the Behavioral Anchored Rating Scale (BARS) at three international evaluation workshops (see Section IV.2.4.2). INTRAH now considers that this emphasis was "misguided" and believes that "less sophisticated methods of performance appraisal" would have been "better suited to the constraints of evaluation."

The performance appraisals of trainees in Francophone Africa countries are now scheduled for the end of INTRAH's project activities in a country. There was concern that the results of these appraisals would not be done in time to permit suitable revisions in training activities. However, with evaluation training for Francophone trainers scheduled for Lome in June 1988, there is some hope that more widely distributed host country evaluation skills will increase the likelihood of more frequent in-country trainee follow-ups. INTRAH's attention to the provision of earlier follow-up is needed. Such follow-up and the lessons learned from evaluation activities elsewhere can and has been applied to revising INTRAH training programs in-country.

o Service statistics

Where service statistics are routinely gathered, they offer one effective way to judge the success of training; i.e., statistics that show higher contraceptive rates, referrals, etc., often reflect more effective performance by workers, which ultimately often reflects on the quality of their training. In both Sri Lanka and Nepal, however, too little attention was being directed to these statistics. They were being tabulated by a central evaluation unit, or even in the case of Sri Lanka, contracted out, with little feedback to supervisors. Part of the fault lies with INTRAH staff who tend to ignore these data, thereby failing to teach their colleagues management by objective.

On the other hand, these statistics must not be given too much weight. In Africa, for example, the December 1984 consulting team visit report to Uganda was oriented almost exclusively to family planning service data systems and how they might be used to assess the impact of training on numbers of acceptors and on "defaulters." Given the number of variables that affect prevalence, and the difficulties involved in determining the net effect of training on family planning service delivery,

this orientation was misguided.

### Recommendation

o INTRAH should simplify its approach to training host country nationals in evaluation (assessment) of in-country training efforts, keeping in mind two goals: (1) that assessment should be undertaken primarily to enable trainers to identify weaknesses in training so as to revise the curriculum accordingly; and (2) that it should differentiate between people who have acquired the minimal knowledge and skills, including decision-making skills, to undertake their jobs in the field, and those who have not (#6).

### Secondary Recommendations

o Where data for impact evaluation (i.e., service delivery statistics) are readily available from existing service delivery organizations, these data should be routinely used by INTRAH staff to evaluate programs (#19).

o INTRAH should select a few key programs for operations research and should ask appropriate CAS or host country research institutions to conduct these more sophisticated studies to assess selected INTRAH programs. INTRAH has made an effort in this direction and this should be encouraged by AID. In Asia, for example, where INTRAH has been very responsive to opportunities to support innovative training and service delivery programs, some of these deserve further evaluation at the level of operations research (see Recommendation 22). Likewise, experimental approaches to TOT should be evaluated (see Training Process, Recommendations 3 and 4 [#18]).

### IV.3 Training Materials

The INTRAH component for training materials has four stated purposes:

- 1) Collecting materials: forming a library at INTRAH's offices in Chapel Hill;
- 2) Providing materials for INTRAH-sponsored workshops;
- 3) Developing needed new materials; and
- 4) Training Africans and Asians in how to develop and use their own materials.

Currently, most of INTRAH's efforts go into the three Chapel Hill-based activities--(purposes 1, 2 and 3)--rather than into assistance given to local development capabilities.

#### IV.3.1 Materials Collected and Developed at Chapel Hill

While materials collected and created at INTRAH headquarters are of high quality, they have not been widely distributed to host country trainers, and few books or other learning materials were available to students in the courses visited. This may be due in part to the lack of provision of resources in the PAC II contract for more production and distribution of printed materials. There are, therefore, real limits on the resources that INTRAH can justifiably devote to mass dissemination of materials. Concepts and Issues in Family Planning and Teaching and Learning with Visual Aids (TLVA), for example, are excellent resources, but are used infrequently. INTRAH TIPS, while regarded favorably by those who had them, were not always available. The Glossary of Family Planning Terms had not reached all host countries at the time of the evaluation, although it seems to be an item with high potential value because nothing comparable is currently in use.

INTRAH has taken the lead in negotiating a publishing agreement with Macmillan and Company, London, to ensure the wide and low-cost availability of TLVA.

In some cases there is also a question regarding the relevance of the materials developed. For example, detailed protocols have been developed in Chapel Hill in areas such as breastfeeding and STDs. They are designed to establish a standard that can be adapted to individual country settings and are impressive in their coverage. In one instance, however, these protocols were not needed. A trainer for the Benue State, Nigeria workshop found that a draft protocol on contraceptives did not contain any more information on depo provera than the information she had had in training. The question of relevance is particularly pertinent in Francophone Africa, since almost all available materials were originally written for use in Western or Anglophone African countries and translations of English materials are not always easily understood.

Finally, on several subjects there are no materials available from any source. For example, there are no materials on how to equip and operate a family planning clinic, including information on care and maintenance of equipment and basic management concepts useful in running a clinic. Also lacking are manuals on the types of family planning activities that could be done by nurses, and information on criteria for clinical service evaluation that would serve as a tool for managing and controlling quality of care.

INTRAH, however, has taken steps to provide materials that are available from other CAS and donor organizations, e.g., from the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO); from Management Sciences for Health (MSH) (INTRAH management and supervision training materials); from Population Communication Services (PCS) (IEC

training materials); and from Pathfinder (teaching models and equipment). INTRAH coordinates and shares with the materials development/distribution programs of the International Planned Parenthood Federation (IPPF) and the United Nations Fund for Population Activities (UNFPA) and has recommended in several countries that requests be made to the Johns Hopkins University Population Information Program for computer searches for existing materials on specific topics.

#### IV.3.2 Locally Developed Materials

In view of the issues of relevance and distribution of materials produced in Chapel Hill, the solution may be to shift the emphasis to increasing the production of materials in a host country setting. The approach should probably be to capitalize on INTRAH regional office capabilities (see Section VI.2), rather than to utilize individual core trainers either during or after their training programs. Most of the trainers interviewed reported difficulty in gaining access to typewriters, duplicating equipment and teaching supplies. Many trainers had little access to books or articles for their own professional use.

An example of the effectiveness of using INTRAH's Africa headquarters expertise is the assistance provided by the INTRAH East Africa staff to the Zimbabwe National Family Planning Council (ZNFPC) in the production of clinical procedures and CBD manuals. These manuals have been useful both locally and in other countries. For instance, in Benue State, Nigeria, the accelerated TOT workshop had insufficient time to prepare protocols for their manual and so used the Zimbabwe manual, which they adapted to their own circumstances. These manuals are successful in part because they were developed through the combined skills of INTRAH's regional office and a consultant who worked with local practitioners to produce materials appropriate to their needs. The same process could be used to respond to other requests for assistance in developing materials. Another option might be to capitalize on existing regional training resources. The Strengthening Health Delivery System Project (a 10-year primary health care program run jointly by AID and the World Health Organization [WHO]), has made a substantial investment in developing the materials and production capacity of the WHO Regional Training Center (RTC) in Lome, Togo. This investment included the purchase of computers and printing equipment. If INTRAH proceeds with its plan to develop the Family Health Center in Lome (which is housed in the same building as the RTC) into a regional training center, it would be worthwhile to investigate the possibility of using this equipment for the production of locally developed materials. Finally, the African Medical Research Foundation in Nairobi has a complete printing and distribution capability which could be of assistance to INTRAH.

### Recommendation

o Efforts in training materials development should be reoriented from materials produced at and/or distributed from Chapel Hill, and toward training and other support to assist host country trainers to create simple materials for their own use. This may require a reduction in the number of training materials staff at Chapel Hill and an increase of human resources (staff or consultant time) at INTRAH's two African regional offices. INTRAH should continue to seek ways to produce and distribute larger quantities of the most valuable materials it develops.

For Africa, the approach might be to produce regional prototypes which could be adapted for specific countries. Subject areas that should receive priority are the equipping and managing of family planning clinics, the role of nurses in family planning, and criteria for clinical service evaluation (#7).

#### IV.4 Assessment of Training Programs

INTRAH's approach to developing an in-country training capacity is based on considerable experience and uses appropriate training techniques. It has also been generally successful from a quantitative standpoint (see Section II.2.2.2), with core training teams continuing to train additional groups at least up to, and sometimes beyond, the numbers in the original INTRAH/host institution subcontract/project plan.

The self-confidence and enthusiasm expressed by training team members was impressive. The training has obviously been an empowering force for the participants and has energized them in their work and inspired or reinforced their commitment to family planning training. Some first generation trainers said they had applied their new training skills to courses they teach in nursing/midwifery schools, and had taught the new methods to other teachers. One man noted that the experiential methodology not only required him to master his subject and prepare more before class, but that in class, the students worked more and enjoyed it more too.

The failure to institutionalize skills of curriculum development and evaluation, however, puts into question the success of the project in regard to its overriding objective of enabling institutions to continue INTRAH-type training without INTRAH inputs.

While INTRAH's initial TOT sequence has many good points, the curriculum development training it contains is too dilute, and INTRAH-trained trainers are not yet using evaluation techniques routinely to improve their training activities. Furthermore, there is no consensus as to how to provide all the skills necessary to achieve technical self-sufficiency, i.e., how to create self-sufficient teams capable of meeting the country's

future PAC training needs without additional assistance. This is not because INTRAH's process is ineffective; it is not. Rather it reflects the difficulty and magnitude of the task, particularly in Africa. Here, most countries are in the early stages of setting up national policies and delivery services for family planning, and most family planning services are being delivered through MOHs which, given their lack of autonomy, do not lend themselves easily to institutional development efforts.

#### IV.5 Overall Recommendations Re: Revised Country/ Institutional Programs

##### Africa

o INTRAH requires full funding in order to continue its ambitious program in Africa. The demand for family planning services in Africa has increased rapidly in just the past several years. Now is a critical period for developing the service capacity to meet the growing needs (#1).

o INTRAH needs to continue its current efforts to develop training teams capable of providing family planning service skills, primarily to the nurses and midwives who run government maternal and child health services (#13).

o INTRAH needs to increase its efforts to introduce the concept of CBD of family planning services to African family planning policy makers, program managers and PAC trainers through special observation/study tours. INTRAH should also be prepared to support nascent CBD programs with individually planned internships, technical assistance provided by Asian experts, and new training programs (see Recommendation 23 [#14]).

o INTRAH should give increased attention to supervisors of the PAC workers being trained through INTRAH projects. Supervisors should always be oriented to the proposes of the training and the desired new PAC worker behaviors (#15).

##### Asia

o The recommendations above call for an intensification of effort in Africa, which will need to be balanced by a reduction of resources for Asia. Specifically, while INTRAH should continue to support Asian regional training institutions (see Chapter V), it should not start any new in-country training activities in Asia, with the exception perhaps of continuing TBA training in Nepal after the current subproject ends. It should also continue to support and participate in meetings of its Asia TAC, whose membership should be expanded and whose purpose should be broadened (#2).

**V. REGIONAL, INTERREGIONAL AND U.S.-BASED TRAINING**

## V. REGIONAL, INTERREGIONAL AND U.S.-BASED TRAINING

To supplement the training that can be provided through in-country workshops, INTRAH has used three types of outside training resources: regional, interregional and U.S.-based. The choice of which is most appropriate is governed by issues of cost-effectiveness and need as well as by INTRAH's contractual obligation to strengthen regional institutions.

### V.1 Regional

Three activities are taking place at the regional level: 1) development of regional institutions; 2) some training in one country for individuals from another country; and 3) in Africa, the beginning of an effort to develop a corps of master trainers. To reinforce these efforts, in both Africa and Asia INTRAH has established Technical Advisory Committees (TAC) made up of the chief training persons in each of the major institutions to which INTRAH provides assistance. TAC meetings make possible intra-regional exchange of information about PAC training programs, and assist INTRAH in setting the future direction of its program in each region.

#### V.1.1 Regional Institutions

INTRAH's contract specifies that 20 percent of its training resources in Africa and 70 percent of its resources in Asia will be used to develop regional family planning training programs.

VI.1.1.1 Africa. In the Africa Region, five institutions have been identified as possible regional training centers: the Center for African Family Studies (CAFS) in Nairobi, Kenya; the Family Health Training Center (FHTC) in Lome, Togo; the Association Senegalaise pour le Bien-etre Familiale (ASBEF) in Dakar, Senegal; UMATI (Tanzanian Family Planning Association) in Tanzania; and the Mauritius Family Planning Association (MFPA) (see Table 1).

None of these fulfill all of INTRAH's criteria for a regional training site, which are

1. the presence of qualified family planning staff;
2. self-sustainability as an institution;
3. credibility in other countries;
4. the availability of a series of programs;
5. appeal to both the public and private sectors; and

6. a hospitable political environment within the country.

Three of them, however, meet several of these criteria. CAFS, in East Africa, is already conducting regional training courses with assistance from IPPF and USAID/Regional Economic Development Support Office (REDSO). It has a small clinical skills training staff, although this has not been in place for very long. CAFS, however, does not have regular access to facilities for clinical practicum. In addition, its approach to training is very rigid, it lacks a participant-oriented focus, and the schedule of training activities is extremely compressed with no follow-up of trainees.

In West Africa, ASBEF is a functioning national family planning training center, with sufficient staff and client loads to allow for ample practical training in IUD insertions. At the present time, INTRAH is planning a small clinical family planning training course at ASBEF for Chadians. Depending on the success of this pilot project, INTRAH may want to have further discussions about expanding the role of ASBEF in regional training.

The FHTC of Lome is underused at the moment. It is a well-equipped, spacious facility which would be suitable for TOT courses.

Given the level of development of these centers, coupled with the current focus of INTRAH training on developing basic clinical skills, there is currently very little justification for putting resources into creating regional training institutions. Institutionalization of regional training implies a high cost undertaken over the long term, with little prospect even at the end for real self-sufficiency. This is not to say that INTRAH should not use the capabilities that exist either regionally or in another country for specialized training in management, logistics, CBD or other areas. Regional training, however, is not seen as appropriate for basic clinical training, which constitutes the bulk of INTRAH's efforts in Africa. At INTRAH's Africa Regional TAC meeting in late 1987, the case for regional training needs to be thoroughly thought through and documented. If the costs appear to outweigh benefits, consideration should be given to decreasing the contractual requirement to develop and strengthen regional training institutions in Africa.

V.1.1.2 Asia. In the Asia region, INTRAH is strengthening two regional institutions: the Asia Center, the Population and Community Development Association (PDA) in Thailand, and the Integrated Maternal Child Care Services and Development, Inc. (IMCCSDI) in the Philippines (previously known as the Institute of Maternal and Child Health [IMCH]).

PDA has been an established regional training institute for some time, concentrating primarily on community-based family planning. INTRAH has worked with PDA both to increase its use of participatory training methods and to organize and provide a venue for Africans to observe and study a successful CBD program.

INTRAH has not taken a long-term approach to training PDA staff in active adult learning methods; instead, it has provided only one exposure to this method--a special INTRAH-supported TOT conducted at IMCH. On their initiative PDA staff who attended the workshop followed up by organizing two in-house workshops to share what they had learned with their colleagues. Since then, however, several of those who attended the original special course have left PDA, and others without the training have come. This minimal emphasis on training in active adult learning methods is appropriate. PDA's prime purpose is to offer observational tours in CBD. These tours are not training per se; they are inherently active and can be successfully conducted even by people who are not skilled in participatory methods.

On the other hand, clinical skills training requires accomplished, confident PAC clinicians skilled in participatory methods to serve as trainers and role models, as well as a large volume of family planning clients. IMCCSDI provides access to both these ingredients, and thus represents an excellent training site for INTRAH activities.

#### V.1.2 Training in One Country for Other-Country Participants

In addition to use of established regional centers, INTRAH has organized special one-time workshops or observation tours to meet country-specific needs. For example, participants from several African countries attended family planning clinical skills workshops in Zimbabwe; the national training team and important officials from Chad toured family planning/MCH projects in Senegal; and one trainer from Fiji attended an adolescent information and counseling course in the Philippines.

A wider use of this approach might be advantageous. In Nepal, for example, individuals responsible for establishing a CBD program expressed a desire for individualized assistance to supplement the exposure to CBD they gained at PDA in Thailand. This would be relatively easy to organize and should serve to reinforce the grounding in general principles gained during group courses.

#### V.1.3 Master Trainers

The plan to establish a core group of master trainers in Africa has grown out of the need to develop a cost-effective mechanism to provide appropriate training within Africa as well as to capitalize on the skills of the best trainers who have been

trained over the project life. This network would involve trainers from both public and private sector agencies who would represent various skill areas--task analysis, curriculum design, training methodology, evaluation, etc. A few tentative beginnings have been made to implement the plan. In a few cases, the best training team members have been asked to participate as trainers in INTRAH workshops in other areas; e.g., two Kwara State trainers acted as trainers in Lagos State workshops in Nigeria. In late 1987, INTRAH plans to hold a regional workshop to provide selected members of the national training teams from East Africa with consulting skills so that they can begin to function as training consultants in their own and other countries.

Training people to become master trainers, however, will require long-term, consistent intervention, not simply one or two training cycles supplemented with brief and occasional TA. INTRAH's plans on how to develop this core group are still embryonic, but the idea is good and should be pursued.

## V.2 Interregional Training

INTRAH has used interregional training exclusively to send Africans to Asia, with JMCH serving as the locale for clinical training, and PDA for CBD. Six major interregional training events have been supported by INTRAH since 1984, all quite successful. In the case of CBD, INTRAH did a good job in supporting the African trainees. INTRAH staff helped the Asian trainers set up the training, and also facilitated group discussions during the event to help the Africans apply concepts from field visits and lectures to situations in their own countries. The involvement of INTRAH also benefited PDA, because INTRAH Africa staff, acting to facilitate group discussions, exposed PDA trainers to good examples of active training methods. The group of trainees from each country was large enough to guarantee that members would carry some weight when, upon returning home, they tried to bring about institutional changes. The strategy of involving physicians and nurse-midwives from the same institutions was also good because participants should work together and reinforce one another after returning to their institutions.

Finally, INTRAH plans for PDA staff to visit Africa to follow up its African trainees. This is a good idea, as follow-up will be necessary to reinforce the concepts of CBD training.

In addition to PDA, there are other options for CBD training which INTRAH could use to show alternate models for CBD of family planning to Africans. The village volunteer program of FPASL and the traditional medical practitioner training program in Nepal are two examples of additional programs that would be of benefit to African trainers and family planning program managers.

On the minus side, a number of INTRAH regional and interregional courses held in Nairobi, Mauritius and Bangkok have not taken advantage of these countries for field observation experience and thus have the drawbacks of the U.S.-based courses described below (see Section V.3).

### V.3 U.S.-based Training

The contract calls for 200 Africans and 20 Asians to receive training in United States. Whereas the regional and interregional courses use sites that are particularly suited to the needs of training, the rationale for U.S.-based training is not clear. Except for the cytology course attended by one person, none of the sites for U.S.-based training has the unique characteristics needed for the training. In fact, it appears that the trainees are simply being brought to the trainers rather than the trainers going to the trainees. Two types of U.S.-based courses have been used:

- (1) Courses regularly scheduled by American institutions, including
  - skills for managing effective training organizations, at Management Sciences for Health (MSH);
  - Family Planning Management Training Workshop, at the International Health Programs (IHP);
  - Training of Trainers, at the University of Connecticut; and
  - Training in Population Communication and Research, at The Social Development Center, Chicago, Illinois (SDC).
- (2) Courses that are developed by INTRAH or its major subcontractor to meet project needs, including
  - the Evaluation and Management Course sequence at INTRAH, Chapel Hill; and
  - Training of Trainers Refresher Training Skills Update at IHP.

Courses from the first category have been used successfully for many years, and it is presumed that their curricula have been developed and revised based on the training needs of developing country participants. That these courses have been mounted on a continuing basis, and, in most cases, must pay for themselves, is some evidence of their usefulness. The main drawback is that often only one or two persons from an institution can attend, with the result that institutional impact may be limited.

Courses at INTRAH and IHP, on the other hand, while they may not accommodate large numbers of people from any one institution, are designed specifically for those involved in PAC training and thus offer a good opportunity for participants from different countries to share information. INTRAH can also design the curricula to fit country needs. Over the long run, relationships forged between the participants and the staff of the training institutions may become important sources of support for later INTRAH or IHP in-country training programs.

Both categories of U.S.-based courses run the risk of training in technologies that are not always appropriate to the needs of the trainees. An example was training in the use of computers during the first training evaluation course held at Chapel Hill. While computers may be very useful in evaluation of training, some participants from the Asia Region did not have access to the type of computer necessary for the software that was taught. Moreover, training in computer technology for the types of data being generated by the INTRAH evaluation system, namely the pre- and post-test data and BARS, does not require computerization. Indeed, computerized analysis may detract from the value of the evaluation exercise. It is usually undertaken by someone other than the trainer; the printout may not be available for some time; and, most important, the trainer loses the opportunity to ponder the meaning of the results as he/she analyzes them (see Section IV.2.4.2).

## Recommendations

### Regional Training

#### General

o In Africa, given the experience so far in regional institutional development, INTRAH should continue to explore other means for regional training but deemphasize the priority given to regional institutional development in the contract. This may mean contract modification (#8).

o In Asia, INTRAH should continue to work with the two regional institutions with which it already has relationships, and should continue to support and participate in meetings of its Asia TAC, whose membership should be expanded and purpose broadened (see Recommendation 22).

#### Master Trainers

o Efforts should be continued to develop master trainers who are capable of serving as consultants to provide TA to PAC training programs in their respective regions. Representatives of these national groups should become part of a regional trainers network.

The master trainers should be drawn from the proposed group of curriculum development and materials specialists (see Recommendations 3 and 7) as well as from existing core training teams. INTRAH should work with these individuals to ensure that each master training network includes all training skills (task analysis, curriculum design, training methodology, evaluation, etc.). It should promote experience-sharing and problem-solving among master trainers. Participants in the regional network should be expected to impart their skills to national core training teams with INTRAH support. The INTRAH master trainer network should be available to other CAS working in family planning in the region (#21).

### TAC

o Consideration should be given in Asia to widening the purpose and membership of the TAC. It might be refashioned as a regionwide PAC Training Leadership Group, including representatives from countries with which INTRAH has not been able to work so far. India, for example, which is the largest and most influential country in the region and which provides much of the foreign-based training for nurses from other Asian countries, could then be included in the Asia TAC. Broadening TAC membership might lead to identification of specific needs in new countries, which INTRAH or other CAS could fill. A reconstructed TAC could also examine operations research findings relevant to improving the performance of family planning service workers (see Recommendation 18 [#22]).

### Interregional Training

INTRAH should continue to use PDA and IMCCSDI to meet selected needs for training of Africans. It should also consider sending groups of Africans to observe and study other successful Asian family planning service programs: i.e., the village volunteer program run by the FPASL and the Nepali CRS program (see Recommendation 14 [#23]).

### U.S.-based Training

Unless there is a compelling reason for U.S. training, efforts should be made by INTRAH and its subcontractors to hold training events either in-country or regionally where there are field practice sites (#24).

9

**VI. INTRAH MANAGEMENT**

## VI. INTRAH MANAGEMENT

### VI.1 Headquarters and Regional Offices

#### VI.1.1 Headquarters

VI.1.1.1 Organization. As of September 1987, headquarters staff consisted of 12 management professionals and 11 support staff. Eight of the professionals and six of the support staff were part-time employees. Overall, the number is adequate, except in respect to project managers, who were few in relation to the large number of projects to be supervised. The most acute staff needs currently are in WCA, where the posts of project officer and two project assistants have been vacant for eight months. Funds for these positions have been reallocated to the regional offices, allowing the hiring of local consultants. As the number of activities has increased dramatically in Africa, this is an appropriate use of these resources. It does, however, place an additional burden on Chapel Hill-based staff.

The organization of headquarters staff results in considerable overlap, an arrangement with both advantages and pitfalls (see Organization Chart below). Two divisions are involved with programs: Program Management and Technical Services. Program officers are responsible for overseeing country activities but also provide some TA. Program management staff have some responsibility for a large number of discrete projects in many countries on two continents, requiring an inordinate amount of travel, interaction with technical resource staff, and writing and reviewing large numbers of reports. Despite every effort, it is difficult for any one person to be fully cognizant of all aspects of any one project. The Technical Services staff are not given country assignments; their job is to provide TA to particular projects.

Much of the project's TA, particularly for Francophone Africa, is provided either through consultants or by two major subcontractors. The two subcontractors are International Health Programs (IHP) of the University of California at San Francisco, a part of the Institute for Health Policy Studies in Santa Cruz, California; and the Training Resources Group, Inc. (TRG) in Alexandria, Virginia. In addition to providing TA, these subcontractors run most of the direct training courses. IHP has participated in the area of needs assessment and project planning. Management of country projects is carried out by an already overextended INTRAH staff.

The major advantage of the project's organization is that countries may receive TA from a variety of INTRAH staff and consultants, many of whom have highly specialized technical

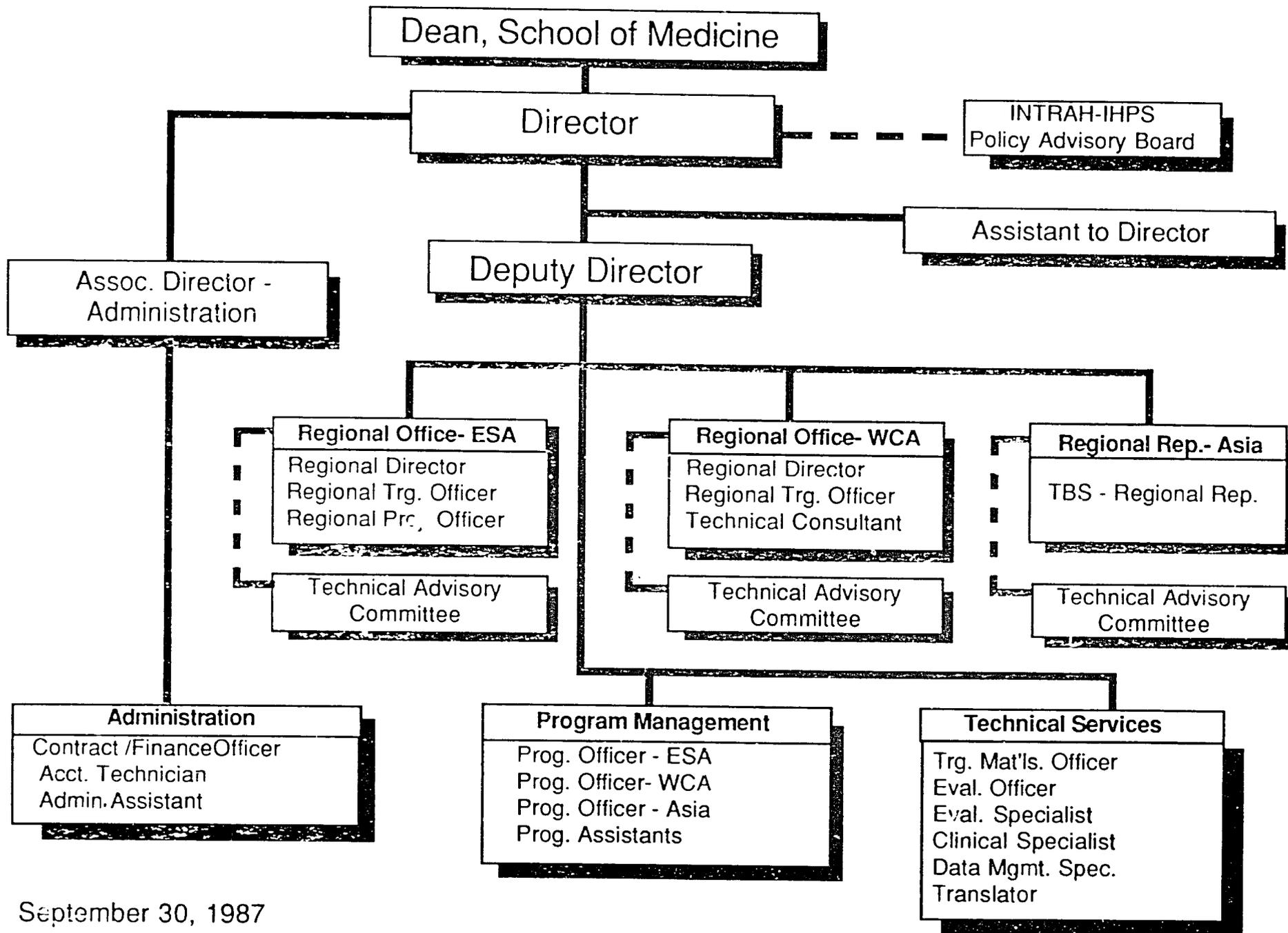


Figure 1. INTRAH Organization Chart

September 30, 1987

skills. No country is necessarily limited to getting TA from only one or two persons.

On the other hand, with so many people involved in each project, it is sometimes unclear where ultimate responsibility lies. While this approach may foster creativity and initiative, it is equally likely to be frustrating and exhausting. The high level of stress may pose a danger of staff erosion.

VI.1.1.2. Performance. That the INTRAH project has met its quantitative goals is strong evidence of the excellence of INTRAH staff. A wide range of courses has taken place and substantial numbers of people have been trained more or less according to schedule despite a number of serious constraints; this achievement has required strong administrative skills ranging from coordination with governments to monitoring the training process.

The quality of TA provided by INTRAH core staff, major U.S. subcontractors and consultants has also been very good. Personnel representing and working for INTRAH in both Africa and Asia are almost universally highly regarded. Their skills in training, in fiscal management and in project design are all greatly respected. Even experienced leaders of successful Asian training institutions commented that they had benefited from working with INTRAH core staff in designing training projects and developing money management procedures.

TA routinely provided by INTRAH includes (a) very frequent contact, including curriculum review and training management assistance, between INTRAH technical staff and local trainers in preparation for each workshop; (b) TA provided during project monitoring visits; and (c) ad hoc TA provided to individual core training team members and family planning program supervisors during study tours, project reviews, TAC meetings and by telephone and correspondence. INTRAH's reputation for responsiveness and practical involvement in training development is due in significant measure to the continuous supportive TA which it provides both formally and informally.

Most trainers used by INTRAH are up-to-date and experienced in designing curricula based on job descriptions and task analysis; they are skilled in and committed to the use of adult learning methods; they build evaluation into their courses, create good rapport with both co-trainers and trainees, and create an energetic, positive learning environment.

In addition to some of INTRAH's core staff, IHP and TRG provide strong experiential training skills and related technical

assistance. TRG is additionally appreciated for its roster of French-speaking trainers, whereas IHP's special contribution is trainers with family planning clinical skills.

The major weaknesses of training staff are that some consultants hired for management/supervision training lack adequate management/supervision experience and skills, that there is a lack of French language capability at INTRAH's headquarters, that no one on the INTRAH staff has in-depth knowledge and experience in CBD, and that the evaluation unit is not as strong as it should be in adapting evaluation concepts and methodology for use in LDCs.

## VI.2. Regional Offices

The WCA regional staff in Abidjan, Ivory Coast, consists of a director, a training officer and three support staff members. In addition, there are two consultants: a clinical specialist, currently working on in-service training protocols and regional training activities, and a computer specialist, who is computerizing financial systems and training plans and training the support staff. Presently, this staff is overseeing project activities in nine Francophone countries: Burkina Faso, Chad, Ivory Coast, Mali, Niger, Rwanda, Senegal, Togo and Zaire.

The East African regional staff, based in Nairobi, Kenya, consists of a director, a training officer and two support staff. Recently added was a nurse who has been working as a consultant to standardize the pre-service/in-service training and to strengthen the links between training and service delivery. The East African regional office has been involved in activities in nine countries: Botswana, Kenya, Mauritius, Nigeria, Sierra Leone, Somalia, Swaziland, Uganda and Zimbabwe.

Both regional offices are currently focusing on building a group of African consultants to provide TA to various country projects, thus eliminating the need for American and European consultants and contributing to the development of TA capabilities on the continent.

Both regional directors are highly regarded by ministries, government organizations and USAID missions in countries where INTRAH is working. Both they and their operations, however, are overextended. The directors travel an inordinate amount of the time; e.g., the WCA director has been away from Abidjan 70 percent of the time this year, although his contract calls for only 40 percent travel. Requests for INTRAH activities are expected to continue and to grow, and funds will probably be available from African regional sources to cover these requests. Without additional staff, however, the regional offices will be unable to respond to all of them.

### VI.3 Management of Subcontracts and Subprojects

#### VI.3.1 Institutional Development

In each of INTRAH's country projects in Africa, a national from the subcontractor (usually the MOH) is designated as Project Director, and another is designated as Project Coordinator. These two people are responsible for the management and logistical requirements of the project, and, where possible, for the financial aspects as well. How well these responsibilities are carried out depends on the level of preparation and experience of the ministry officials assigned to these roles.

INTRAH's institutional development strategy is to work directly with these existing host country institutions wherever possible, providing necessary TA to strengthen their management and training capacity. INTRAH does not wish to place coordinators in countries, because they would function outside of the government structure and therefore not contribute to the strengthening of management capacity within the government institutions. This approach is appropriate.

In the West African countries visited, all subcontracts are managed directly by the governments (the MOH in Burkina Faso and Kwara, Benue and Lagos states in Nigeria, and the Association Zairoise pour le Bien-etre Familiale [AZBEF] in Zaire). In places where strong capability is already in place, such as in two Nigerian states, the subcontracts run very smoothly.

In Burkina Faso, where the MOH personnel are unfamiliar with such contracting procedures, and in Zaire, where the family planning organizational structure is particularly complex, additional INTRAH management time and TA is necessary. In Zaire, both the USAID mission and Projet des Services de Naissances Desirables (PSND), one of the Zairian subcontractors, are requesting that INTRAH place a project coordinator in Kinshasa because of the coordination requirements among the various organizations involved in family planning and the communication difficulties in that country.

In order to respond to the need for additional TA and management oversight in Burkina Faso and Zaire, the WCA regional director needs to be able to hire an additional staff member who can take over some of the monitoring and TA needed in the region.

#### VI.3.2 Financial Management

INTRAH's mechanism for financial management of subcontracting is very effective, providing for efficient use of resources, a minimum of bureaucracy for country programs, and

clear tracking of funds. An important factor in INTRAH's successful financial management is that INTRAH's administrative staff help design financial mechanisms in the field in cooperation with appropriate host country people. The absence of a French speaker on the financial management staff, however, places an added burden on the WCA regional director during contract negotiations in the field.

In East Africa, Coopers and Lybrand, a public accounting firm, serves as the financial controller link between INTRAH and the MOH in both Kenya and Uganda. Although this arrangement provides no opportunity for INTRAH to assist these government agencies to improve their own financial management methods, in these instances, the use of a private accounting firm is the only stable approach for a two- or three-year contract. When governments are better able to handle fund accounting, Coopers and Lybrand will assist in training their financial managers.

This firm also holds subcontracts for financial management of the INTRAH East Africa regional office and has been used for professional staff recruitment in the region, a valuable service.

Coopers and Lybrand also holds the subcontract for the financial management of the INTRAH WCA regional office. The day-to-day accounting and reports, however, are handled by a locally recruited financial officer. The WCA regional office now has the capacity to code and monitor costs without relying on Coopers and Lybrand reports, which are done only every second month and are apparently not timely enough to be helpful in financial planning. The INTRAH financial officer has also been trained in computer cost coding (and he in turn has trained the accounting assistant). At this point, therefore, the regional office could reduce the contract with Coopers and Lybrand, continuing to rely on them only for audits.

The computer consultant is also computerizing all the national training plans so that updated versions can be sent to the countries regularly. This will also enable the regional director to access future training workshops by dates and country, which will aid in planning.

In Asia, the various institutions assisted by INTRAH are responsible for fiscal management, except in Nepal, where a private firm has been given this responsibility, similar to the arrangement with Coopers and Lybrand in Africa. In addition, this firm has taken on other monitoring responsibilities.

## VI.4 Reporting, Monitoring and Evaluation

### VI.4.1 Reporting

INTRAH has developed a structured and detailed report format which must be followed in reporting any activity undertaken for an INTRAH project. Reports are written following every needs assessment, project development visit, contract negotiation, training workshop and project review. The report format requires complete documentation of each trip including schedule, purpose, background, accomplishments, findings, conclusions and recommendations. While this system generates a good deal of written material, the format also provides a good summary of the essential elements and outcomes of any undertaking. In a situation like INTRAH's, where inputs from many sources are involved, both completeness and clarity are important.

Although the current report format builds in some repetition, INTRAH's trip reports have gotten shorter over time. Some still find reports cumbersome, but the general impression was that the reports, together with the debriefings held in-country after each activity, are useful and appreciated.

### VI.4.2 Project Monitoring

INTRAH's skill at project design, as well as its subcontract format and computerized "training plans," lay the groundwork for good project monitoring (see Section IV.1.2). Financial disbursements are tied to INTRAH's receipt of reports which document completion of specified project outcomes.

Most INTRAH projects are visited by an INTRAH staff member every 3-4 months, depending on various factors. During some trips the INTRAH or subcontractor (IHP or TRG) staff person may be intensely involved with the project, for instance as an actual trainer; other visits are only for monitoring. The training plan document guides and facilitates the monitoring because it specifies who is supposed to do what and when. The INTRAH staff person determines whether or not the expected activities occurred, recording any difference between what actually occurred and what was called for by the plan, and conducts interviews and reviews reports to assess the quality of the activity and any problems perceived by key staff of the implementing institution. Given INTRAH's organizational structure (see Section VI.1.1.1), and the inherent constraints of intermittent monitoring, the INTRAH staff do a remarkably competent job. Of course, more would be better in most cases; many projects could benefit from the more frequent and intensive monitoring which might be possible if countries were assigned to

individual staff members. Nevertheless, the relatively small number of actual INTRAH field/project staff is able to maintain quite a large number of successful projects in the field.

The main shortcoming observed was that in Nepal and Sri Lanka, where INTRAH staff appeared to pay insufficient attention to project outcomes, trip reports contained only data on quality of training, omitting data produced by the information feedback system (see Section IV.2.4.3).

#### VI.4.3 Evaluation

The INTRAH contract stipulates two types of evaluation requirements: as an inherent part of training programs (see Section IV.2.4), and as a separate responsibility of INTRAH's Evaluation Unit to assess the quantitative and qualitative effectiveness of INTRAH-sponsored training at the country program level. In respect to the second activity, special efforts were to be made to identify innovative training approaches and to compare their cost-effectiveness. These evaluations were to be based in part on information gathered by host country evaluations during training programs to be undertaken by INTRAH staff, with the cooperation of host country evaluators.

INTRAH's first attempt to undertake country-level evaluation took place in Nigeria, with a six-state evaluation of its activities. Other follow-up evaluations have taken place in Benue State, Nigeria; Uganda; Kenya; and Sri Lanka. While this is a good start, considerably more evaluations are needed for INTRAH to fulfill its contractual obligations.

Some work is being done by a graduate student at Chapel Hill on the cost-effectiveness of INTRAH training. Since INTRAH uses basically the same approach to training in most of its projects, however, the opportunity is limited to make comparisons. If INTRAH were to experiment with different models of TOT to test the effect of reducing the level of curriculum development and/or needs assessment (see Section IV.2.2), however, it might develop some conclusions of use to the international family planning training community.

#### VI.5 INTRAH's External Relations

##### VI.5.1 INTRAH's Relationship with AID

VI.5.1.1 INTRAH's Relationship with AID/Washington.  
INTRAH has a good working relationship with the AID Office of Population. Trust has been established between INTRAH and its AID Cognizant Technical Officer (CTO), and both parties respect each other's positions. The CTO provides administrative and, on

occasion, technical guidelines regarding the types of activities in which INTRAH should become involved; attends INTRAH's yearly planning meeting; and consults as needed, sometimes on a daily basis. INTRAH's only complaint was the inability of the CTO to visit field projects because of AID's funding restrictions.

VI.5.1.2 INTRAH's Relationship with AID Missions and Bilaterals. INTRAH also has maintained good relationships with AID missions. A briefing and debriefing are held at the beginning and end of every field visit. While there has been occasional miscommunication concerning participation of host country nationals at INTRAH-sponsored workshops outside the country, these have been minor incidents which were handled immediately and have not recurred. INTRAH has been very careful to inform AID missions of its views and intentions in countries and has taken into account the advice of the missions. INTRAH staff were repeatedly described as being very responsive to needs of AID missions.

INTRAH has cooperated very closely with bilateral programs. In Thailand, INTRAH provided technical input and some U.S. training in conjunction with a major provincial training needs assessment exercise with the bilateral covering the in-country costs. In Nepal, INTRAH moved to support training activities that were found to be needed after the bilateral contract was signed and funds could not be made available through that mechanism. Filling such gaps represents an important role for centrally funded projects, and INTRAH has worked well with the bilaterals and AID missions in this regard.

VI.5.1.3 Need for More Direction. The only problem foreseen is in relation to the situation in Africa, where overextended regional offices are expected to be unable to respond to competing requests for assistance (see Section VI.1.1.2). In this regard, AID/Washington, the REDSO offices and the AID missions need to communicate about how program priorities will be set so that the INTRAH regional offices have a clear understanding of how to respond.

## VI.5.2 Collaboration with Other Cooperating Agencies

The addition of a regional office in Abidjan has made it easier for INTRAH to collaborate with other AID contractors in WCA. Both formal and informal collaboration has taken place with CAS. Columbia University, for example, had an established office in Abidjan before INTRAH's arrival. The two groups have mandates sufficiently different that they are not in competition with each other and work together in a number of ways. For example, they share an express courier contract. According to the WCA regional director, INTRAH suggested that Columbia consider an operations

research undertaking in Togo and contacted Chad to explore possibilities there. INTRAH has also taken the initiative to suggest that the Centers for Disease Control and Africare conduct a survey of clinics in Togo.

In Burkina Faso, INTRAH collaborated with the Population Communication Services (PCS) Project of John Hopkins University to design and establish a joint project. PCS has a contract with the Ministry of Family Welfare and National Solidarity, and INTRAH has one with the Ministry of Public Health. PCS concentrates on IEC, and INTRAH on TOT and clinical family planning skills for service providers. Together, INTRAH and PCS developed a plan for integrating the work of the two host country agencies.

In Niger and Zaire, INTRAH conducted needs assessment visits in collaboration with MSH. Together, they identified areas for intervention and then jointly conducted program development visits in both countries.

In Ivory Coast, INTRAH and the Pathfinder Fund are working collaboratively to train trainers in IEC.

In Nigeria, direct collaboration is occurring between the INTRAH program manager and the Africare program (supplying clinical equipment and training to some Nigerian states). There was good exchange of information between the two programs and a true spirit of cooperation aimed at assisting the country to fulfill its clinical service objectives.

On the other hand, although their mandates are clearly linked, INTRAH has not worked closely with the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). Collaboration with JHPIEGO is necessary in order to maximize the efficiency of pre-service curricula in African schools of nursing and midwifery.

Collaboration is also taking place in East Africa. Ongoing meetings and discussions occur between INTRAH and other CAS in Uganda, particularly with the Enterprise Project. In addition, there is a close relationship with the Family Planning Association of Uganda.

In Kenya INTRAH works with the African Medical and Research Foundation (AMREF), Pathfinder, the Association for Voluntary Surgical Contraception (AVSC) and Family Planning International Assistance (FPIA). INTRAH and FPIA have just received approval for a joint project with the National City Council of Nairobi.

## Recommendations

### Headquarters

o INTRAH should begin to share project development and monitoring responsibilities with key staff of IHP and TRG in order to lessen the burden on project management staff of the responsibility of monitoring (#9).

o Skills of staff providing training and TA in CBD and in supervision and management need to be upgraded, and evaluators need to upgrade their skills in adapting evaluation concepts and methodologies for use in LDCs (#10).

o INTRAH should reexamine the role and staffing of the evaluation unit at Chapel Hill and limit its role to performing the following functions:

- collection and analysis of data at the end of country projects working with host country national staff; and
- analysis of aggregated country data to assess contract performance.

Training in evaluation should not be a regular function of this unit (#11).

### Regional Headquarters

INTRAH should augment its existing high caliber regional staff in both the East and West Africa offices. In East Africa, a training and evaluation methodologist should be hired to assist in the development of training skills and in the preparation of training materials such as checklists, rating scales, manuals and videotapes. In West Africa, at least one additional staff person should be hired to assist the regional director in the project development, monitoring and technical assistance necessary for the Francophone projects.

More authority should be delegated to regional offices (#12).

**VII. RECOMMENDATIONS**

## VII. RECOMMENDATIONS

### VII.1 Major Recommendations

#### Strategy Re: Distribution of Contract Resources

1. INTRAH requires full funding in order to continue its ambitious program in Africa. The demand for family planning services in Africa has increased rapidly in just the past several years. Now is a critical period for developing the service capacity to meet the growing needs.

2. To permit intensification of its efforts in Africa, INTRAH should limit its efforts in Asia during the remainder of this contract.

Specifically, INTRAH should undertake no new in-country projects with the exception of a possible extension of the TBA training program in Nepal; should continue to work with the two regional institutions with which it already has relationships; and should continue to support and participate in meetings of its Asia TAC, whose membership should be expanded and whose purpose should be broadened.

#### Training Process

##### TOT

3. INTRAH should address the problem that its TOT sequence, particularly in Africa, is attempting to cover too much ground and as a result is failing to teach any one aspect adequately. To improve the quality of training, INTRAH should experiment with new approaches that would increase the time allotted to teaching trainers how to use experiential training methods in the classroom. For example, one approach would be to reduce or eliminate the time now given to curriculum development or other subjects that may not be critical to the trainers. In conjunction with this change, INTRAH should initiate special training workshops for curriculum developers, who would be drawn from existing INTRAH-trained trainers and who would become country experts on curriculum development.

4. INTRAH should also experiment with various ways to accelerate its TOT training in order to create more core training teams to train PAC workers. This approach should be used in those countries where demand for family planning is creating a need for large numbers of trained family planning workers. These experiments would focus on how to shorten the length of training without lessening the essential elements required of the core trainers to carry out PAC worker training.

5. In all cases, INTRAH should ensure that adequate follow-up TA is provided to INTRAH-trained trainers. It should make sure that the consultant or staff member who assisted in the TOT workshop course participates in the graduates' initial workshop, be alert to subsequent trainer needs, and continue to provide TA on a routine basis until it is satisfied that trainers have achieved a satisfactory level of competence. Follow-up should also be provided for those trained in special skills such as curriculum development and materials design (see Recommendations 3,4, and 7).

#### Evaluation

6. INTRAH should simplify its approach to training host country nationals in evaluation (assessment) of in-country training efforts, keeping in mind two goals: (1) that assessment should be undertaken primarily to enable trainers to identify weaknesses in training so as to revise the curriculum accordingly; and (2) that it should differentiate between people who have acquired the minimal knowledge and skills, including decision-making skills, to undertake their jobs in the field, and those who have not.

#### Materials

7. Efforts in training materials development should be reoriented away from materials produced at and/or distributed from Chapel Hill, and toward training and other support to assist host country trainers to create simple materials for their own use. This may require a reduction in the number of training materials staff at Chapel Hill and an increase in the human resources (staff or consultant time) at INTRAH's two African regional offices. INTRAH should continue to seek ways to produce and distribute larger quantities of the most valuable materials it develops.

For Africa, the approach might be to produce regional prototypes which could be adapted for specific countries. Subject areas that should receive priority are equipping and managing of family planning clinics, the role of nurses in family planning, and criteria for clinical service evaluation.

#### Regional Training

8. Given the experience in Africa so far in regional institutional development, INTRAH should continue to explore other means for regional training but deemphasize the priority given to regional institutional development in the contract. This may mean contract modification.

## Management

### Headquarters

9. INTRAH should begin to share project development and monitoring responsibilities with key staff of IHP and TRG in order to lessen the burden on project management staff of the responsibility of monitoring.

10. Skills of staff providing training and TA in CBD and in supervision and management need to be upgraded, and evaluators need to upgrade their skills in adapting evaluation concepts and methodologies for use in LDCs.

11. INTRAH should reexamine the role and staffing of the evaluation unit at Chapel Hill and limit its role to performing the following functions:

- collection and analysis of data at the end of country projects working with host country national staff, and
- analysis of aggregated country data to assess contract performance.

Training in evaluation should not be a regular function of this unit.

### Regional Headquarters

12. INTRAH should augment its existing high caliber regional staff in both the East and West Africa offices. In East Africa, a training and evaluation methodologist should be hired to assist in the development of training skills and in the preparation of training materials such as checklists, rating scales, manuals and videotapes. In West Africa, at least one additional staff person should be hired to assist the regional director in the project development, monitoring and technical assistance necessary for the Francophone projects.

More authority should be delegated to regional offices.

## VII.2 Secondary Recommendations

### Revised Strategy for Africa

13. INTRAH needs to continue its current efforts to develop training teams capable of providing family planning service skills, primarily to the nurses and midwives who run government maternal and child health services.

14. INTRAH needs to increase its efforts to introduce the concept of CBD of family planning services to African family planning policy makers, program managers and PAC trainers through special observation/study tours. INTRAH should also be prepared to support nascent CBD programs with individually planned internships, technical assistance provided by Asian experts, and new training programs (see Recommendation 23).

15. INTRAH should give increased attention to supervisors of the PAC workers being trained through INTRAH projects. Supervisors should always be oriented to the purposes of the training and the desired new PAC worker behaviors.

#### Needs Assessment

16. INTRAH should conduct thorough training needs assessments, including field observations, prior to the development of any new projects, and as part of future TOT courses. It should work with host country nationals in this process to increase their skills in needs assessment and to ensure that projects meet host country needs. Specifically, supervisors should assist INTRAH and the core training team in conducting training needs assessments and also in follow-up performance assessments.

#### Clinical Training

17. The need for IUD insertion training in the initial family planning skills training courses for nurses and midwives in Africa should be evaluated on a country-by-country basis. In some cases, IUD clinical training may need to be offered later to nurses who have already demonstrated competence in the other aspects of family planning practice and who are working in sites at which there is demand for IUDs.

#### Operations Research and Impact Evaluation

18. INTRAH should select a few key programs for operations research and should ask appropriate CAs or host country research institutions to conduct these more sophisticated studies to assess selected INTRAH programs. INTRAH has made an effort in this direction and this should be encouraged by AID. In Asia, for example, where INTRAH has been very responsive to opportunities to support innovative training and service delivery programs, some of these deserve further evaluation at the level of operations research (see Recommendation 22). Likewise, experimental approaches to TOT should be evaluated (See Training Process, Recommendations 3 and 4).

19. Where data for impact evaluation (i.e., service delivery statistics) are readily available from existing service delivery

organizations, these data should be routinely used by INTRAH staff to evaluate programs.

### Regional, Interregional and U.S.-based Training

#### Regional Training

##### Regional Centers

20. In Africa, experimental utilization of regional training institutions should be continued to assess which, if any, might deserve more resources.

##### Master Trainers

21. Efforts should be continued to develop master trainers who are capable of serving as consultants to provide TA to PAC training programs in their respective regions. Representatives of these national groups should become part of a regional trainers network.

The master trainers should be drawn from the proposed group of curriculum development and materials specialists (see Recommendations 3 and 7) as well as from existing core training teams. INTRAH should work with these individuals to ensure that each master training network includes all training skills (task analysis, curriculum design, training methodology, evaluation, etc.). It should promote experience-sharing and problem-solving among master trainers. Participants in the regional network should be expected to impart their skills to national core training teams with INTRAH support. The INTRAH master trainer network should be available to other CAS working in family planning in the region.

##### TAC

22. Consideration should be given in Asia to widening the purpose and membership of the TAC. It might be refashioned as a regionwide PAC Training Leadership Group, with representatives from countries with which INTRAH has not been able to work so far. India, for example, which is the largest and most influential country in the region and which provides much of the foreign-based training for nurses from other Asian countries, could then be included in the Asia TAC. Broadening TAC membership might lead to identification of specific needs in new countries, which INTRAH or other CAS could fill. A reconstructed TAC could also examine operations research findings relevant to improving the performance of family planning service workers (see Recommendations 2 and 18).

### Interregional Training

23. INTRAH should continue to use PDA and IMCCSDI to meet selected needs for training of Africans. It should also consider sending groups of Africans to observe and study successful Asian family planning service programs: i.e., the village volunteer program run by the FPASL and the Nepali CRS program (see Recommendation 14).

### U.S.-based Training

24. Unless there is a compelling reason for U.S. training, efforts should be made by INTRAH and its subcontractors to hold training events either in-country or regionally where there are field practice sites.

**APPENDICES**

APPENDIX A

CABLED RESPONSES FROM USAID MISSIONS REGARDING INTRAH PERFORMANCE

UNCLASSIFIED  
Department of State

INCOMING  
TELEGRAM

PAGE 01  
ACTION AID-00

SUVA 03003 230438Z

5317 087306 AID5712

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ACTION OFFICE ANEA-02  
INFO ANPD-05 AMAD-01 PDPR-01 PPPB-02 ANMS-01 ANTR-06 STHE-02  
SAST-01 POP-04 IT-06 HHS-09 OMB-02 RELO-01 /043 A0  
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INFO LOG-00 OES-09 /009 W  
-----346226 230438Z /38

R 230437Z JUN 97  
FM AMEMBASSY SJVA  
TO SECSTATE WASHDC 0638  
INFO AMEMBASSY PORT MORESBY

UNCLAS SUVA 03003

AIDAC FOR ANE/EA, W. ACKERMAN

E. O. 12356: N/A

TAGS: N/A

SUBJECT: POPULATION: EXTERNAL EVALUATION OF FAMILY  
PLANNING TRAINING FOR PARAMEDICAL, AUXILIARY AND  
COMMUNITY (AC) PERSONNEL II, PROJECT NO. 936-3031 AND  
THE CONTRACTOR FOR THE ASIA REGION, INTRAH OF THE  
UNIVERSITY OF NORTH CAROLINA IN CHAPEL HILL

REF: STATE 188748

1. USAID/RDO/SP HAS PARTICIPATED WITH INTRAH IN SEVERAL  
SOUTH PACIFIC ACTIVITIES, PRIMARILY IN MELANESIA (PNG  
AND THE SOLOMON ISLANDS), AND WOULD BE PLEASED TO  
SUBMIT COMMENT FOR CONSIDERATION BY EXTERNAL EVALUATION  
TEAM. USAID COMMENT MOST APPROPRIATELY MADE BY PATRICK  
C. LOWRY M. D., MPH, USAID HPN ADVISOR.

2. LOWRY WILL BE VISITING AID/W FROM O/A JULY 20 TO O/A  
JULY 24. ACTION REQUESTED: WOULD APPRECIATE SOUTH  
PACIFIC DESK OFFICER (ACKERMAN) ALERTING LOWRY TO THE  
REF CABLE, AND REQUESTING HIM TO SUBMIT WRITTEN  
COMMENTS ON BEHALF OF USAID/RDO/SP TO MS. MARILYNN A.  
SCHMIDT OF S&T/POP/IT. DILLERY

JUN 23 1997

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12

ACTION  
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Department of State

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ACTION AID-00

NAIROBI 23475 00 OF 02 101733Z 2193 090337 A100207  
- CORE TRAINING TEAM DEVELOPMENT (NAIROBI 1985)

ACTION OFFICE POP-01  
INFO AFCD-02 AFE-03 AFDP-05 AFA-02 AFPD-04 AFTR-05 AMAD-01  
PDPB-01 PPPB-02 STRE-02 SACT-03 IT-05 MHS-09 OMB-02  
RELO-01 AFNG-03 STDA-01 /055 43

- TRAINING OF TRAINERS FOR NATURAL FAMILY PLANNING  
(PHILIPPINES) 1986.

- SKILLS IN MANAGEMENT OF TRAINING INSTITUTIONS - (USA)  
1985.

INFO LOG-03 COPY-01 OES-09 /010 W  
-----273361 101740Z /40 43

- TRAINING NEEDS ASSESSMENT SKILLS DEVELOPMENT (NAIROBI)  
1987.

P 101400Z JUL 87  
FM AMEMBASSY NAIROBI  
TO SECSTATE WASHDC PRIORITY 0208

OTHER REGIONAL ACTIVITIES PLANNED:

UNCLAS NAIROBI 23475

- EVALUATION STRATEGIES AND TOOLS FOR CORE TRAINING  
TEAMS (NAIROBI) 1987.

C O R R E C T : D C O P Y (TEXT)  
AIDAC

- ADVANCED TRAINING OF TRAINERS (BANGKOK) 1987.

FOR ST/POP/IT, MARILYN A. SCHMIDT

- CONSULTATION SKILLS (NAIROBI) 1988.

E.O. 12356: N/A  
SUBJECT: POPULATION EXTERNAL EVALUATION OF FAMILY  
PLANNING TRAINING FOR PARAMEDICAL, AUXILIARY AND  
COMMUNITY (PAC) PERSONNEL II, PROJECT NO. 935-1031 AND  
THE CONTRACTOR FOR THE AFRICA REGION, INTRAH OF THE  
UNIVERSITY OF NORTH CAROLINA IN CHAPEL HILL

B. PAC II ASSISTANCE THROUGH INTPAH HAS CONTRIBUTED TO  
THE CURRENT SUCCESSSES OF DIVISION OF NURSING (DON) AND  
DFH FP TRAINING:

REF: STATE 183170

- DON ACTIVE IN ALL PROVINCES, SELECTION OF TRAINEES AND  
POST-TRAINING DEPLOYMENT IS GOOD  
- NATIONAL FP TRAINING TEAM IS INTACT AND ACTIVE IN  
TECHNICAL ASSISTANCE TO DISTRICT TRAINERS. DISTRICT  
TRAINERS FULLY INVOLVED IN TRAINING AT PROVINCIAL LEVEL  
AND IN TRAINEE FOLLOW-UP. THE TRAINING NETWORK IS NOW  
IN PLACE WITH MINIMAL INTRAH ASSISTANCE. RECENT  
ASSESSMENT IN KIAMBU DISTRICT SHOWED THAT ECH TRAINING  
IN FP MANAGEMENT HAS MADE SUBSTANTIAL DIFFERENCE IN ECH  
PERFORMANCE AND DELIVERY OF FP SERVICES.

PER REF PARA 6

A. INTRAH HAS PARTICIPATED IN KENYA BILATERAL PROJECTS  
AS FOLLOWS:

- DFH HAS SUCCESSFULLY PREPARED PROVINCIAL TRAINERS AND  
UP-DATED HDOTRS. TRAINERS' SKILLS; REVISED MCH/FP  
CURRICULUM IN USE. DFH CONTINUING TO DRAW FROM  
EXPERIENCE GAINED AND NEEDS IDENTIFIED DURING PERIOD OF  
INTRAH ASSISTANCE. A NEW DECENTRALIZED TRAINING CENTRE  
WAS RECENTLY OPENED AND STAFFED BY MCH PERSONNEL TRAINED  
WITH INTRAH ASSISTANCE.

1. UNDER FAMILY PLANNING SERVICES AND SUPPORT (FPSS),  
INTRAH PROVIDED ASSISTANCE IN TRAINING OF 625 MCH/FP  
WORKERS IN THE MINISTRY OF HEALTH (MOH), AT A COST OF  
DOLL 350,000. 50 PER CENT OF FUNDS WERE BUY-INS FROM  
BILATERAL SOURCES.

- INTRAH HAS ASSISTED IN PREPARATION AND OPENING OF THE  
CENTER FOR AFRICAN FAMILY STUDIES (CAFS). CAFS IS  
PROVIDING REGIONAL TOT AND CONTRACEPTIVE UPDATE COURSES,  
WHICH ARE ALSO BEING ATTENDED BY KENYAN HEALTH PERSONNEL  
FROM THE DON AND DFH.

2. UNDER FAMILY PLANNING SERVICES AND SUPPORT INTRAH  
ASSISTS THE MOH DIVISION OF FAMILY HEALTH (DFH) IN  
STRENGTHENING TRAINING CAPABILITIES OF EP CLINICAL  
MANAGEMENT TRAINERS AT MOHTRS, PROVINCIAL/DISTRICT  
LEVELS. 125 MOH TRAINERS WILL HAVE PARTICIPATED IN  
INTRAH-ASSISTED ANNUAL TRAINING WORKSHOPS OVER A 4 YEAR  
PERIOD.

C. FACILITATING/CONSTRAINING FACTORS:

3. UNDER FPSS INTRAH ASSISTED THE DFH AND AMREF IN  
REVISING THE MOH'S BASIC IN-SERVICE TRAINING  
CURRICULUM.

1. USE OF PAC I EVALUATION RESULTS IN DESIGN OF PAC II

4. UNDER FPSS INTRAH IS PARTICIPATING IN A MOH EFFORT  
TO STRENGTHEN LINKAGES BETWEEN PRE-SERVICE, IN-SERVICE  
AND ON-JOB NIPSE TRAINING IN FP. INTRAH WILL ASSIST IN  
WORKSHOPS FOR NIPSE INTRON PLANNED FOR SEPTEMBER, 1987  
IN WHICH WAYS WILL BE FOUND TO LIMIT DUPLICATION, AND  
INCREASE EFFECTIVENESS OF FP TRAINING AT ALL LEVELS.

2. BILATERAL PROJECTS AND AVAILABILITY OF BUY-INS.

5. IN ADDITION TO SUPPORT OF BILATERAL PROJECTS  
IN-COUNTRY, INTRAH ALSO PROVIDES OPPORTUNITIES FOR  
TRAINERS AND MANAGERS TO DEVELOP/STRENGTHEN SKILLS  
THROUGH REGIONAL TRAINING ACTIVITIES. TO DATE, KENYAN  
HEALTH PERSONNEL HAVE PARTICIPATED IN:

3. EFFORTS OF THE DON TO ESTABLISH AN IN-SERVICE  
TRAINING SYSTEM FOR NURSES WHICH CONCENTRATES ON MCH/FP  
SKILLS DEVELOPMENT AT THE BASIC AND IN-SERVICE TRAINING  
LEVELS.

- TRAINING EVALUATION (USA) 1985 (FOR IN-COUNTRY  
EVALUATORS).

D. LONG-TERM POTENTIAL IMPACT:

- TRAINING EVALUATION FOLLOW-UP (NAIROBI 1986 WORKSHOP  
FOR IN-COUNTRY EVALUATORS)

1. A THREE-TIER CLINICAL MANAGEMENT TRAINING SYSTEM NOW  
EXISTS OPERATED BOTH WITHIN THE DON AND THE DFH. THIS  
NETWORK OF TRAINING CAPACITY HAS POTENTIAL FOR  
CONTINUING TO INCREASE THE NUMBER OF HEALTH PERSONNEL  
TRAINED IN MCH/FP, AND HAS VASTLY IMPROVED THE MOH'S  
ABILITY TO CONDUCT REFRESHER COURSES, UP-DATES, AND  
ON-JOB FOLLOW-UP/TECHNICAL SUPPORT.

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2. CAFS TOT CAPABILITY IS NOW INSTITUTIONALIZED WITH THE POTENTIAL FOR REACHING LARGE NUMBERS OF HEALTH WORKERS IN THE REGION WITH MCH/FP TRAINING.

3. DFR HAS NOW STRENGTHENED THE TRAINING CAPACITY OF ITS DECENTRALIZED TRAINING CENTERS, INCLUDING THE CAPACITY FOR PRECEPTORSHIP.

E. A POOL OF LOCAL EXPERTISE HAS BEEN DEVELOPED WHICH CAN NOW BE DRAWN UPON FOR CONSULTANCY IN KENYA AND THE REGION.

F. 1. DFM HAS INCREASED NUMBER OF FP ECM GRADUATES THROUGH OPENING OF A NEW TRAINING CENTRE.

2. WE BELIEVE QUALITY OF TRAINING TO HAVE IMPROVED THUS IMPROVED QUALITY OF SERVICE DELIVERY.

3. KIAMBU DISTRICT HAS CITED IMPROVED SERVICE DELIVERY THROUGH IMPROVED CLINICAL AND CONTRACEPTIVE SUPPLY MANAGEMENT.

4. TWO NEW TRAINING CENTRES WILL BE OPENED IN JULY I.E. HOMA-BAY FOR ECMS AND NYEK. FOR RN/ECD.

G. CONTINUING NEED: YES. KENYA HAS BEEN IN THE FOREFRONT OF INSTITUTIONALIZING FP CLINICAL MANAGEMENT SKILLS TRAINING WITHIN THE GOVERNMENT'S SYSTEM. WITH THE INCREASED AWARENESS AND DEMAND FOR FP SERVICES THUS CREATED, THE MOH CAN BE EXPECTED TO CONTINUE EXPANDING ITS CAPABILITIES FOR STRENGTHENING THESE SKILLS AMONG HEALTH WORKERS. IT IS REASONABLE TO ASSUME THAT SUCH NEEDS EXISTS IN MINISTRIES OF HEALTH THROUGHOUT THE REGION. FOR THE FUTURE, PARTICULARLY IN KENYA, PAC ASSISTANCE COULD PROBABLY BEST BE APPLIED TO STRENGTHENING OF PRE-SERVICE TRAINING AND ON-JOB COUNSELING/SUPERVISORY METHODS.

H. AS REPORTED BY THE MINISTRY OF HEALTH, INTRAM ASSISTANCE HAS MADE A SIGNIFICANT IMPACT ON THE SUCCESS OF THEIR TRAINING EFFORTS TO-DATE. TRAIL

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IT-06 HHS-09 OMB-02 RELO-01 ANSA-02 STDA-01 1043 AD

INFO LOG-00 OES-09 /009 W  
-----234431 261216Z /38

P 261213Z JUN 87  
FM AMEMBASSY NEW DELHI  
TO SECSTATE WASHDC PRIORITY 7481

UNCLAS NEW DELHI 15809

AIDAC

FOR: S&T/POP/IT

E.O. 12356 N/A  
SUBJECT: POPULATION: EXTERNAL EVALUATION OF F.P. TRAINING  
FOR PAC PERSONNEL IN PROJECT NO. 930-3031 AND THE  
CONTRACTOR FOR THE ASIA REGION, INTRAH OF THE UNIVERSITY  
OF NORTH CAROLINA, CHAPEL HILL.

REF: STATE 188748.

- 1 INTRAH HAS NOT DONE WORK IN INDIA.
- 2 INTRAH STAFF VISITED MISSION IN 1985. CLEARANCE FROM GOI FOR THE VISIT WERE NOT OBTAINED. THEREFORE, UNOFFICIAL MEETINGS WITH MINISTRY OF HEALTH AND FAMILY WELFARE (MOHFW) OFFICIALS WERE HELD. MOHFW WAS INTERESTED. INTRAH STAFF ALSO MET WITH THE TRAINED NURSES ASSOCIATION OF INDIA (TNAI) WHO WERE MOST ANXIOUS TO HAVE INTRAH'S HELP IN CONDUCTING EDUCATION FOR NURSES AND AUXILIARY NURSE MIDWIVES (ANMS). SUCH A PROGRAM WOULD INCLUDE GOVERNMENT NURSES AND ANMS AS THE TNAI MEMBERSHIP IS FOR ALL NURSING PERSONNEL.
- 3 RECENTLY MISSION PLAYED A BIG ROLE IN REVISING THE EXISTING ANM CURRICULUM. MISSION ANTICIPATES A ROLE FOR INTRAH IN THIS FIELD.
- 4 MISSION ALSO HAS BEEN ASSISTING MOHFW IN DEVELOPING AN INSTRUCTIONAL VIDEO TAPE FOR TRAINING OF TRADITIONAL BIRTH ATTENDANTS. COULD INTRAH PROVIDE APPROPRIATE ASSISTANCE IN THIS FIELD.
- 5 PLEASE LET INTRAH KNOW OF OUR INTEREST. DEAN

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ACTION AID-00

KATHMA 04616 00 OF 02 240027Z 2696 080107  
C. INSTITUTIONALIZATION. SEE 5 ABOVE.

ACTION OFFICE PCR-01  
INFO FPA-02 ANCP-02 FVA-01 AMAD-01 STHE-02 SAST-01 IT-00  
PVC-02 FVPP-01 FELO-01 ANCA-02 STDA-01 /B27 PL

INFO LOG-02 COPY-01 GES-09 /010 W  
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FM AMEMBASSY KATHMANDU  
TO SECSTATE WASHDC 2334

UNCLAS KATHMANDU 04616

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FOR ST/POP/IT, MARILYNK SCHMIDT

E.C. 12356: N/A  
SUBJECT: POPULATION: INTRAH EVALUATION

REF: STATE 188748

1. USAID COMMENTS, SOLICITED REFTEL, FOLLOW BELOW.
2. INTEGRATION WITH BILATERAL PROJECTS. INTRAH HAS BEEN ATTENTIVE TO COORDINATION WITH ONGOING MISSION PROGRAM, AND INTRAH ACTIVITIES HAVE BEEN CLEARED WITH MISSION AND COMPLIMENT MISSION FP PROGRAM. IN ADDITION, WE HAVE USED INTRAH TO SUPPORT ACTIVITIES WITH DIVISION OF NURSING WHICH COULD NOT BE SUPPORTED UNDER OUR BILATERAL, BUT WHICH WE THINK ARE WORTHWHILE.
3. IMPLEMENTATION. WE ARE SATISFIED THAT INTRAH HAS IMPLEMENTED INDIVIDUAL ACTIVITIES REASONABLY WELL. MOH FOLLOW-UP IN THE ABSENCE OF INTRAH CONSULTANTS IN COUNTRY HAS OFTEN BEEN LESS SATISFACTORY.
4. A) FACILITATION/CONSTRAINTS. CENTRAL FUNDING HAS FACILITATED INTRAH ACTIVITIES BY DISPENSING WITH NEED TO PROGRAM BILATERAL FUNDS THROUGH MINISTRY OF FINANCE. THIS CAN ONLY BE DONE ONCE A YEAR AND HAS THE EFFECT OF QUOTE FREEZING UNQUOTE BILATERALLY-FUNDED PROGRAMS ONCE THE GOV'S YEARLY BUDGET IS FINALIZED. CENTRAL FUNDS HAVE NOT BEEN PROGRAMMED THROUGH THE MOF TO DATE, AND WE HAVE THUS HAD MORE FLEXIBILITY IN PROGRAMMING THESE FUNDS.  
  
B) THE CHIEF CONSTRAINT TO THE INTRAH PROGRAM HAS BEEN DISTANCE AND INTRAH'S NECESSARILY OCCASIONAL IN-COUNTRY INVOLVEMENT WITH THE PROGRAM. WE DON'T THINK THIS IS THE BEST WAY TO UPGRADE TRAINING CAPABILITY AND IMPROVE SERVICE DELIVERY IN NEPAL, AND, IN RETROSPECT, WOULD HAVE PREFERRED LONGER-TERM TA.
5. LONG-TERM IMPACT. INTRAH HAS ENABLED THE MOH TO CONDUCT TRAINING IN IMPORTANT AREAS. THIS ALONE REPRESENTS PROGRESS IN THAT MOH STAFF GAINED EXPERIENCE IN DESIGNING AND CONDUCTING THE TRAINING, A PROCESS WHICH WAS WELL ASSISTED BY INTRAH PERSONNEL WHEN THEY WERE IN COUNTRY. WHETHER THIS TRAINING WILL BE EVALUATED, CONTINUED, AND CONTINUED WITH THE SAME DEGREE OF QUALITY WITHOUT INTRAH ASSISTANCE, IS PROBLEMATIC. WITH REGARD TO PERFORMANCE OF INDIVIDUAL TRAINEES, PRE AND POST-TRAINING TEST SCORES INDICATE THAT IMPACT MAY NOT BE GREAT. AN EVALUATION OF TRAINEE PERFORMANCE HAS NOT BEEN CONDUCTED, BUT THIS IS NOT ENTIRELY INTRAH'S FAULT SINCE THE MOH DECLINED TO USE INTRAH FUNDS FOR EVALUATION.

7. FP SERVICE DELIVERY. ASIDE FROM ADDITIONAL TBAC PROVIDING AN UNCERTAIN MIX OF SERVICES IN FIVE DISTRICTS AND TRADITIONAL HEALERS WORKING FOR CRS IN TWO DISTRICTS, IT IS DOUBTFUL THAT SERVICE DELIVERY HAS SUBSTANTIALLY INCREASED AS A RESULT OF INTRAH TRAINING. (NEPAL HAS 75 DISTRICTS.) IN FAIRNESS, IT SHOULD BE NOTED THAT MOST INTRAH TRAINING WAS NOT PROVIDED TO ACTUAL SERVICE PROVIDERS BUT TO SUPPORT PERSONNEL (SUPERVISORS, STOREKEEPERS, ACCOUNTANTS). THE EFFECT OF SUCH TRAINING ON SERVICE PROVISION ARE INDIRECT AND NOT READILY EVIDENT OVER THE SHORT TERM.

8. THERE IS DEFINITELY A CONTINUING NEED FOR PAC TRAINING IN NEPAL. THIS TRAINING NEEDS TO BE PROVIDED IN THE CONTEXT OF CONCOMITANT IMPROVEMENTS IN THE SUPERVISION OF PAC WORKERS AND THE ROUTINE PERFORMANCE EVALUATION OF WORKERS AND SUPERVISORS. GIVEN THE DIVERSITY AMONG COUNTRIES IN THE REGION (EG. BETWEEN NEPAL AND THAILAND), WE THINK THAT THE PURSUIT OF REGIONAL TRAINING STRATEGIES IS ILLUSORY. FOCUS SHOULD BE ON INDIVIDUAL COUNTRIES (AS IT LARGELY SEEMS TO BE) WITHOUT REGIONAL RHETORIC.

9. WORTH OF AID'S INVESTMENT. AS NOTED IN (6) ABOVE, WE DO NOT KNOW IF FP SERVICES HAVE BEEN SIGNIFICANTLY EXTENDED AS A RESULT OF INTRAH ACTIVITIES.

10. COMMENT.

A) OUR FEELINGS ON INTRAH'S NEPAL PROGRAM HAVE BEEN MIXED. ON ONE HAND, WE HAVE BEEN IMPRESSED WITH THE HIGH LEVEL OF PROFESSIONALISM, DEDICATION AND GOOD SENSE EXHIBITED BY INTRAH STAFF AND CONSULTANTS (PRINCIPALLY LYNN KNAUFF, MAUREEN BROWN AND ERNIE PETRICH). WE HAVE ALSO BEEN SATISFIED THAT THE INTRAH PROGRAM HAS FOCUSED ON IMPORTANT TRAINING NEEDS AND HAS BEEN REASONABLY WELL IMPLEMENTED. ON THE OTHER HAND, WE HAVE BEEN WORRIED THAT INTRAH VISITS TO NEPAL EVERY THREE OR FOUR MONTHS MAY NOT HAVE BEEN SUFFICIENT TO CREATE LASTING IMPROVEMENTS. EARLY ON IN THE INTRAH PROGRAM, KNAUFF INQUIRED AS TO THE ADVISABILITY OF INTRAH'S ASSIGNING A PERSON FULL TIME TO NEPAL, AND WE ENCOURAGED THAT APPROACH. EVIDENTLY FUNDING WAS TOO TIGHT TO PERMIT THIS; WE THINK A BETTER PROGRAM WOULD HAVE RESULTED HAD IT BEEN POSSIBLE.

B) THERE WAS ALSO INITIAL DISCUSSION RE ASSISTANCE IN TRAINING EVALUATION FROM INTRAH WHICH NEVER MATERIALIZED. (JIM VENEY, A UNC EVALUATION SPECIALIST, CAME TO NEPAL WITH KNAUFF AND BAKER ON ONE OF THEIR INITIAL VISITS, BUT WAS NEVER HEARD FROM AGAIN.) WE THINK MORE ATTENTION TO EVALUATION, ESPECIALLY WITH THE CRS PROGRAM WHERE TA FOR EVALUATION WAS TO HAVE BEEN A MAJOR INTRAH INPUT, WOULD HAVE BEEN USEFUL.

C) WE HAVE ALSO BEEN SOMEWHAT CONCERNED OVER AN EMPHASIS ON PROCESS RATHER THAN CONTENT IN DESIGNING AND IMPLEMENTING INTRAH TRAINING. WE DO NOT WISH TO BELITTLE THE IMPORTANCE OF PROCESS; THE DETAILS OF HOW TO DESIGN AND CONDUCT TRAINING PROGRAMS ARE IMPORTANT, ESPECIALLY IN COUNTRIES LIKE NEPAL WHERE THIS CAPACITY IS QUITE LIMITED. HOWEVER, PROCESS IS ESSENTIALLY A MEANS TO AN END, AND THAT END IS ACHIEVED PRIMARILY THROUGH THE CONTENT OF WHAT IS TAUGHT. WE THINK INTRAH HAS TENDED TO LEAVE CONTENT TO THE MOH WHILE FOCUSING MORE ON TRAINING METHODOLOGY. THIS IS UNDERSTANDABLE GIVEN INTRAH'S STATUS AS A TRAINING RATHER THAN A TECHNICAL PROGRAM AND SINCE FOCUSING ON CONTENT IS A

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LARGER, MORE DIFFICULT AND TIME-CONSUMING JOB WHICH  
INTRAH WOULD HAVE BEEN HARD-PUT TO UNDERTAKE THROUGH  
QUARTERLY VISITS.

11. RE TIMING OF NEPAL VISIT, BE ADVISED THAT MISSION  
BACKSTOP OFFICER WILL BE ON HOME LEAVE FROM JULY 15 TO  
SEPTEMBER 15  
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ACTION AID-00

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INFO LCG-00 COPY-01 CIAE-00 EB-00 DODE-00 EAP-00 /001 W  
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FM AMEMBASSY MANILA  
TO SECSTATE WASHDC 7207

UNCLAS MANILA 29155

AIDAC

FOR SET/POP/IT, MARILYNN SCHMIDT

E.O. 12356: N/A

SUBJECT: PAC II PROJECT ASSESSMENT - INTRAH

EEGIM SUMMARY. THIS CABLE PROVIDES MISSION COMMENTS ON  
INTRAH WORK IN COUNTRY AS PART OF THE SET/POP FUNDED  
EXTERNAL MID-TERM EVALUATION OF THE PAC II PROJECT. END  
SUMMARY.

REGRET DELAYED RESPONSE. HOWEVER HOPE THIS EVALUATION  
PROVES BENEFICIAL TO YOUR ASSESSMENT.

MISSION CONDUCTED EXTENSIVE DOCUMENT REVIEWS AND  
DISCUSSIONS WITH THE TRAINING GROUP WITH WHOM INTRAH  
WORKS IN COUNTRY. AT THE BEGINNING OF PAC II PROJECT IN  
1984, THIS TRAINING GROUP WAS PART OF THE INSTITUTE OF  
MATERNAL AND CHILD HEALTH (IMCH). EARLY THIS YEAR, THE  
CORE OF TRAINERS TRANSFERRED TO THE INTEGRATED MATERNAL  
CHILD CARE SERVICES AND DEVELOPMENT INCORPORATED  
(IMCCSDI). DISCUSSIONS DID NOT FOCUS ON AGENCY  
AFFILIATION. CONTINUITY OF PROGRAM WAS ESTABLISHED AS  
THE ORIGINAL TRAINING GROUP MEMBERS HAD TRANSFERRED IN  
TOTO, TO THE NEW ORGANIZATION.

FOCUS OF REVIEWS AND DISCUSSIONS CENTERED ON THE  
FOLLOWING AREAS:

- (1) TRAINING SUPPORT PROVIDED TO AGENCIES INVOLVED IN  
THE POPULATION PROGRAM;
- (2) INTRAH STAFF/CONSULTANT VISITATIONS;
- (3) INTERNATIONAL FELLOWSHIPS/TRAINING PROVIDED, AND
- (4) SELF-RELIANCE INITIATIVES.

MISSION COMMENTS ON SUBJECT EVALUATION FOLLOWED FRAMEWORK  
PROVIDED IN REFED A, PARA 6. THE ABOVE AREAS OF CONCERN  
ARE USED AS INPUT TO THE FRAMEWORK'S DISCUSSION.

A. INTRAH'S EFFORTS HAVE BEEN INTEGRATED WITH BILATERAL  
PROJECTS THROUGH THE UTILIZATION OF THE GROUP'S TRAINING  
EXPERTISE BY THE COMMISSION ON POPULATION (POPSON)  
CENTRAL AND REGIONAL OFFICES FOR CLINICAL AND  
NON-CLINICAL TRAINING ACTIVITIES. TRAINING COURSES  
CONDUCTED BY THE GROUP ARE:

- I. TRAINING OF TRAINERS (TOT)
  1. TRAINING OF REGIONAL POPULATION TRAINERS OF  
PARTNER AND PARTICIPATING AGENCIES
  2. TRAINING OF IMCH FIELD OFFICERS
- II. TRAINING OF FP SERVICE DELIVERY/FP TECHNOLOGY
  1. BASIC FAMILY PLANNING COURSES
  2. DMPA TRAINING FOR SERVICE PROVIDERS
  3. REFRESHER COURSES ON FP TECHNOLOGY
  4. NIP WORKSHOP
- III. COMMUNICATION IN FAMILY PLANNING

1. WORKSHOP ON COUNSELLING FOR VSC
2. WORKSHOP ON COMMUNICATION FOR FP

B. PAC II SUB-ACTIVITY IMPLEMENTATION IS SUCCESSFUL TO  
THE EXTENT THAT THE SKILLS OF PERSONNEL WHO TRAIN, MANAGE  
OR SUPERVISE OTHER PAC WORKERS HAVE BEEN STRENGTHENED.  
THESE SKILLS HAVE BEEN PARTICULARLY IMPORTANT IN THE  
CONDUCT OF TRAINING IN MANAGEMENT/SUPERVISION, TRAINING  
OF TRAINERS, SERVICE DELIVERY SKILLS AND PRE-SERVICE  
PREPARATION.

C. FACTORS THAT FACILITATED PAC II IMPLEMENTATION  
ARE:

1. GROUP'S COMMITMENT TO SERVING THE PHILIPPINE  
POPULATION PROGRAM
2. GROUP'S EXPERTISE AND RECEPTIVENESS TO LEARN AND  
IMPART NEW SKILLS
3. INTRAH'S SUPPORT WHICH WAS MANIFESTED IN THE  
FOLLOWING MANNER:
  - A. RECOGNITION OF THE GROUP'S COMPETENCE BY  
TAPPING THEM FOR INTERNATIONAL CONSULTANT WORK OR  
INTERNATIONAL CLINICAL SKILLS TRAINING PROGRAMS
  - B. FOLLOW THROUGH ACTIVITIES FOR THE GROUP'S  
TRAINING DEVELOPMENT
  - C. COMMUNICATION NETWORKING.

D. PAC II'S SIGNIFICANT LONG TERM IMPACT IS ITS  
CONTRIBUTION TO THE SKILLS DEVELOPMENT OF THE HUMAN  
RESOURCES WHO COME FROM BOTH THE PRIVATE AND PUBLIC  
SECTORS THAT ARE IMPLEMENTING THE PHILIPPINE POPULATION  
PROGRAM.

E. INTRAH'S EFFORTS HAVE BEEN GREATEST AND FULLY

UTILIZED IN TRAINING INSTITUTIONALIZATION. THE GROUP  
EXHIBITS THE COHESIVENESS OF A TEAM WELL BUILT IN ALL  
WORK ASPECTS AND IN FACT, HAS HAD CONSIDERABLE EXPERIENCE  
IN LOCAL AND INTERNATIONAL TRAINING ACTIVITIES. THE  
INTERNATIONAL EXPOSURES (AS CONSULTANTS AND AS TRAINERS  
IN CLINICAL TRAINING PROGRAMS) WHICH HAD BEEN ARRANGED BY  
INTRAH HAVE BEEN HELPFUL TOWARDS PROVISION OF THE GROUP'S  
SELF-RELIANCE INITIATIVES. INTRAH ITSELF HAS SERVED AS A  
GOOD EXAMPLE OF A TRAINING INSTITUTION FOLLOWING THROUGH  
WITH ALL ITS ACTIVITIES AND TRAINED PERSONNEL. THE  
TRAINING GROUP HAS ALWAYS EMULATED THIS PRECEPT IN THEIR  
ACTIVITIES.

F. DELIVERY OF FP/MCH SERVICES BY TRAINED PAC PERSONNEL  
HAS IMPROVED AS A RESULT OF INCREASED MOTIVATION TO  
INCREASE SELF-CONFIDENCE AND SKILLS ENHANCEMENT TO  
INCREASE COMPETENCE. AN INCREASE IN THE NUMBER OF PAC  
PERSONNEL HAS ALSO BEEN REALIZED DUE TO PROJECT  
ACTIVITIES.

G. THERE IS A CONTINUING NEED FOR PAC TRAINING  
ASSISTANCE IN THE COUNTRY.

- 1) BECAUSE OF THE GREAT NUMBER OF PAC PERSONNEL  
PROVIDING FP/MCH SERVICES, WHO NEED SKILLS UPGRADING,  
TRAINING FOR THEM WITH INTRAH ASSISTANCE IS A NECESSITY.  
THERE SHOULD BE AN INCREASED AND CONCERTED EFFORT IN THE  
PROVISION OF TRAINING PROGRAMS/PROJECTS TO REACH  
MAJORITY, IF NOT ALL, OF THE PAC PERSONNEL.
- 2) FOR THOSE HIGHLY TRAINED, A MOTIVATIONAL NEED IS  
THE EXPOSURE TO OTHER, BRIGHT IDEAS THAT ARE GENERATED  
THRU INTERNATIONAL FELLOWSHIPS. FOR THOSE OF THE  
ORIGINAL CORE GROUP THAT HAVE NOT PARTICIPATED IN THE  
ADVANCED TRAINING, MISSION HIGHLY RECOMMENDS THAT THEY  
UNDERGO THIS TRAINING.
- 3) INTRAH SHOULD CONTINUE TO EXPAND THE  
SELF-RELIANCE SCHEMES AS PART OF THE INSTITUTIONALIZATION

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H. AID'S INVESTMENT IN PAC II GENERALLY AND INTRAH  
SPECIFICALLY HAS DEFINITELY BEEN WORTHWHILE IN PROMOTING  
FP EDUCATION AND SERVICES IN THE COUNTRY. PLATT

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ACTION OFFICE POP-04  
INFO AFPA-03 AFPD-04 AFTR-05 AMAD-01 POPR-01 PPPB-02 STHE-02  
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R 090742Z JUL 87  
FM AMEMBASSY KIGALI  
TO SECSTATE WASHDC 6701  
INFO AMEMBASSY NAIROBI

UNCLAS KIGALI 03254

AIDAC

SECSTATE FOR ST/POP/IT: MSCHMIDT

NAIROBI FOR REDSO/ESA: ADANART

E. O. 12356: N/A

SUBJECT: POPULATION: EXTERNAL EVALUATION OF FAMILY PLANNING  
- TRAINING FOR PAC PERSONNEL II AND INTRAH

REF: STATE 183170

1. MISSION AND GOR HAVE BEEN VERY PLEASED WITH  
INTRAH'S WORK IN RWANDA. SOME EXAMPLES OF THEIR FINE  
EFFORTS ARE:

--ABIDJAN REGIONAL OFFICE HAS KEPT CLOSE CONTACT WITH  
OAR/R AND ONAPO;

--CONSULTANTS HAVE BEEN THOROUGH IN THEIR BRIEFINGS  
WITH THE MISSION;

--CONSULTANTS HAVE ALL HAD STRONG FRENCH LANGUAGE  
SKILLS WHICH HAS BEEN VITAL;

--PROJECT HAS BEEN FLEXIBLE WHEN NECESSARY TO  
ACCOMMODATE SPECIFIC NEEDS IE, CHANGING NUMBERS OF  
STUDENTS AND TRAINING NUMBERS OF STUDENTS AND TRAINING  
SITES AS APPROPRIATE;

--MISSION REPORTS ONE DRAWBACK IN PROJECT-INSUFFICIENT  
FOLLOW-UP. THOUGH THE REGIONAL OFFICE IS MAKING EVERY  
EFFORT TO CORRECT THIS WEAKNESS IN PROJECT DESIGN  
MISSION SUGGESTS FUTURE PROJECTS OF THIS NATURE ADD  
ENOUGH RESOURCES OR REDUCE TOTAL ACTIVITIES SO THAT A  
FOLLOW-UP COMPONENT CAN BE INCLUDED.

3. MISSION HAS ALSO EXPERIENCED LAST MINUTE RUSHES  
WHEN TICKETS AND ADVANCES FOR PARTICIPANTS HAVE BEEN  
LATE IN ARRIVING. SUGGEST NECESSARY ARRANGEMENTS BE  
MADE WELL IN ADVANCE. UPSTON

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PAGE 01 COLOMB 04213 251306Z 1983 085107 A103303

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ACTION AID-JB

ITS EXTENSIVE VOLUNTEER SERVICE PROGRAM HAS BEEN  
EFFECTIVE AND WELL-RECEIVED. SPAIN

ACTION OFFICE POP-04

INFO IPA-01 ANDP-03 ANPD-05 AMAD-01 PEPR-01 PPPH-02 ANHC-01  
ANTR-06 STAG-02 STHE-02 SACT-01 IT-06 HHS-09 OMB-02  
RELO-01 ANSA-07 /OSU AB

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R 250854Z JUN 87  
FM AMEMBASSY COLOMBO  
TO SECSTATE WASHDC 3088

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AIDAC

E.O. 12356: N/A

SUBJECT: POPULATION: EXTERNAL EVALUATION OF FAMILY  
- PLANNING TRAINING FOR PARAMEDICAL, AUXILIARY  
- AND COMMUNITY (PAC) PERSONNEL IN  
- PROJECT NO. 536-3031 AND THE CONTRACTOR FOR  
- THE ASIA REGION, INTRAH

REF: STATE 184748

1. PLEASE PASS TO MARILYNN A. SCHMIDT, ST/POP/IT.
2. USAID AND THE FAMILY PLANNING ASSOCIATION OF SRI LANKA (FPAC) CONCUR IN VISIT OF JOHN McWILLIAM AND JUDITH ROOKS TO CARRY OUT SUBJECT EVALUATION, O/A AUGUST 31 - O/A SEPTEMBER 3, 1987.
3. COMMENTS ON PAC PROJECT INPUT AND INTRAH EFFECTIVENESS ARE TAKEN FROM THE DRAFT REPORT OF MAY 1987 EVALUATION OF USAID'S CENTRALLY-FUNDED POPULATION ACTIVITIES. BEGIN QUOTE. SINCE 1980, FPAC HAS NURTURED A COMMUNITY BASED VILLAGE HEALTH PROJECT THAT USES YOUNG FEMALE VOLUNTEERS TO MOTIVATE COUPLES FOR FAMILY PLANNING, REFER OR ACCOMPANYING NEW ACCEPTORS TO GOSI CLINICS, DO FOLLOWUP VISITS AND PROVIDE RELIABLE INFORMATION AND EDUCATION. SOME FEW VOLUNTEERS MAINTAIN DEPOT. FOR SALE OF PILLS AND CONDOMS. BY 1986, THESE ACTIVITIES REACHED 24 DISTRICTS (2 INACTIVE BECAUSE OF TERRORIST ACTIVITIES) WHILE 43,000 VOLUNTEERS HAVE BEEN TRAINED, ONLY 6,000 ARE ACTIVELY SUPERVISED ON A CURRENT BASIS. REPORTS ON TRAINING ACTIVITIES ARE COLLECTED FOR 2-3 YEARS, THEN THE FPAC MOVES TO A NEW AREA WHILE IT IS NOT CLEAR HOW MUCH RESIDUAL VOLUNTEER ACTIVITY REMAINS AFTER ACTIVE SUPERVISION ENDS, EACH OF THE 6,000 CURRENT VOLUNTEERS IS ASSIGNED TO 15 ELIGIBLE COUPLES, SO THAT MINIMUM CURRENT COVERAGE IS 60-90,000 OR 1-4 PERCENT OF MWR IN SRI LANKA. WITH SUPPORT FROM USAID, INTERNATIONAL TRAINING IN HEALTH (INTRAH) BEGAN ASSISTING FPAC IN TRAINING THE VOLUNTEERS BEGINNING IN 1975. THE ASSISTANCE HAS BEEN MOST WELCOME AND, BY ALL ACCOUNTS, VERY EFFECTIVE IN IMPROVING VOLUNTEERS PERFORMANCE. NOT ONLY DID IT NEEDS ASSESSMENT SHARPEN THE CURRICULUM FOR VOLUNTEERS, INTRAH TECHNICAL ASSISTANCE ALSO GAVE PROGRAM MANAGERS A MORE SYSTEMATIC OBJECTIVE-ORIENTED APPROACH TO THEIR WORK. ACCORDING TO THE 1987 FPAC ANNUAL REPORT, CONTRACEPTIVE PRACTICE PREVALENCE IN 5 OF THE EARLIEST PROJECTS WAS A 74 PERCENT, FROM 16 PERCENT AT BASELINE. THE DENOMINATOR FOR THESE CALCULATIONS WAS ELIGIBLE COUPLES, EXCLUDING THOSE WOMEN CURRENTLY PREGNANT. END QUOTE. A MAJOR EVALUATION FINDING WAS THAT INTRAH ASSISTANCE PROVIDED TO FPAC IN SUPPORT OF

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INFO FPA-02 ANDP-03 ANPD-05 AMAD-31 PDPR-01 PPPB-02 ANTR-06  
STHE-02 SAST-01 IT-06 HHS-09 OM3-02 RELO-01 ANEA-02  
STDA-01 /048 AQ

INFO LOG-00 OES-09 /009 W  
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FM AMEMBASSY BANGKOK  
TO SECSTATE WASHDC 3017

UNCLAS BANGKOK 30045

AIDAC

FOR SCHMIDT, ST/POP/IT

E. O. 12356: N/A  
SUBJECT: POPULATION: EXTERNAL EVALUATION OF FAMILY  
PLANNING TRAINING FOR PARAMEDICAL, AUXILIARY AND  
COMMUNITY (PAC) PERSONNEL II, PROJECT NO 336-3031 AND  
THE CONTRACTOR FOR THE ASIA REGION, INTRAH OF THE  
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

REF: STATE 188748

1. INTRAH ASSISTANCE TO THAILAND IS MAINLY IN THE  
FORM OF TECHNICAL ASSISTANCE AND FUNDING SUPPORT FOR  
SHORT-TERM TRAINING IN THE U.S. AND THIRD COUNTRIES  
FOR MINISTRY OF PUBLIC HEALTH (MOPH) OFFICIALS AND  
POPULATION AND COMMUNITY DEVELOPMENT ASSOCIATION (PDA)  
TRAINERS. MOST OF THIS TRAINING TOOK PLACE IN 1985,  
E. G., TOT TRAINING SKILLS UPDATE AND SKILLS FOR  
MANAGING EFFECTIVE TRAINING ORGANIZATIONS

INTRAH ASSISTANCE HAS GREATLY STRENGTHENED TRAINING  
AND EVALUATION SKILLS OF MOPH AND PDA TRAINERS. WITH  
THE KNOWLEDGE GAINED FROM THE ABOVE MENTIONED  
TRAINING/WORKSHOPS, THE FAMILY HEALTH DIVISION (FHD)  
OF MOPH CONDUCTED TRAINING NEEDS ASSESSMENT (TNA)  
WORKSHOPS FOR PROVINCIAL TRAINERS AS WELL AS TRAINERS  
FROM OTHER DIVISIONS OF THE MOPH. A TOTAL OF 159  
TRAINERS FROM FOUR PROVINCES AND OTHER MOPH DIVISIONS  
RECEIVED THE TNA TRAINING. THE TNA TRAINING HELPED  
INCREASE CAPABILITIES OF THE PROVINCIAL TRAINERS AND  
THE TRAINERS OF OTHER DIVISIONS OF THE MOPH IN  
PLANNING AND SETTING UP TRAINING PROGRAMS. PROVINCES  
ALSO DEVELOPED AND REVISED CURRICULA BASED ON TNA  
FINDINGS.

2. FUTURE SUPPORT FROM INTRAH WILL BE NEEDED FOR  
EXPANSION OF THE TNA TO OTHER PROVINCES. IN ADDITION,  
INTRAH SHOULD PLAN TO REVIEW THE TRAINING CONDUCTED BY  
PROVINCIAL TRAINERS AS WELL AS TRAINING CONDUCTED BY  
THE TRAINERS OF OTHER DIVISIONS CITED ABOVE. BASED ON  
THIS REVIEW, INTRAH MAY HELP THE MOPH IMPROVE  
CURRICULUM, TRAINING MATERIALS AND THE CONDUCT OF THE  
TRAINING. BROWN

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**APPENDIX B**  
**SCOPE OF WORK**

Appendix B

SCOPE OF WORK

Scope of Work for Evaluation of Project 936-3024  
Family Planning Training for  
Paramedical/Auxiliary/Community Personnel II (PAC II)

for Contract with

Program for International Training in Health (INTRAH)  
Contract DPE-3031-C-00-4077

III. Purpose and Scope of the Evaluation

The purpose of this evaluation is twofold:

--to assess the validity of the project design, to examine how well it is being implemented and to make general project and specific recommendations for each of the four geographic regions;

--to assess the progress being made by each contractor toward achievement of project objectives.

Recommendations made on both the project and contract-specific evaluations will contribute to decisions on project effectiveness and continuing need.

The questions to be addressed in the external evaluation include but are not limited to the following:

A. Project Design

(NOTE: This section will be addressed by the team which prepares the overall project evaluation report. However, each evaluator will be asked to submit any observations made during contract-specific evaluations which might contribute to this section.)

1. Are the purpose and objectives appropriate to improve and increase family planning service delivery and were they derived from an accurate assessment of needs?

2. Is the project's strategy, (as outlined in the four output elements of each contract) appropriate to meet each objective?

3. Are family planning programs and PAC training needs sufficiently uniform worldwide to permit a global project design, or, should there be significant variations in the scope of work of the PAC contractors by region?

B. Meeting Project Objectives Through Implementation of Major Activities or Outputs

1. To what extent is each contract objective being achieved at this stage of implementation?

2. Overall, how well does the contractor develop strategies and plan activities to meet contract objectives and produce specified outputs?

3. Are the contractor's country needs assessments and training designs appropriate and effective tools to prioritize needs and make decisions on how to allocate project resources?

4. To what extent have the three contractors collaborated/shared information between themselves regarding common problems and approaches? Have the contractors integrated their efforts with other Office of Population and bilateral projects and if so how has this been done and has it been successful?

5. What is the current or projected usefulness or value of training materials developed, included as project/activity components, or provided as reference resources for family planning trainers and supervisors by each of the contractors?

C. Project Management

1. How have the following factors affected the implementation of contract/project activities?

--organizational/administrative set up at headquarters and regional offices;

--staffing or permanent positions;

--management of subcontracts and subprojects including procurement and monitoring procedures;

--selection of and administrative support for technical assistance (consultant) personnel.

2. What are the recommendations for improvement of project management for each contractor?

D. Reporting, Monitoring and Evaluation

1. What types of monitoring and evaluation systems have the contractors used to assess overall performance in project implementation? Do these systems guide contractors in their achievement of project objectives? To what extent have technical monitoring and trainee/training system follow-up efforts been effective in sustaining improvements and institutionalizing family planning training for PAC workers?
2. How has each contractor attempted to evaluate the impact of their training efforts on improved and increased family planning service delivery?
3. How or through what means has each contractor attempted to strengthen the capability of LDC organizations to utilize evaluation findings? Has this been institutionalized by any LDC organizations?
4. Assess the quality and usefulness of documenting second generation training, especially as it relates to demonstrating a multiplier effect attributable to contractor activities. Should this information continue to be collected? Does it impose unnecessary reporting requirements on former trainees and on contractors?

E. Project Impact

1. What impact have the contractor's population/family planning training efforts (e.g., use of training teams, use of LDC consultants) had on the institutionalization of such training?
  - o has contractor identified and utilized effective strategies to increase training capability of LDC institutions and agencies? Have sufficient training materials been developed and are they appropriate?
  - o have assisted institutions and agencies been able to maintain training programs with decreased technical support?
  - o what has been the experience on incorporating FP into basic training for health workers? Has sufficient work been accomplished in this area?
2. In what ways has contractor-supported population/family planning training affected the delivery of FP/MCH services? What increase in numbers of PAC personnel who are providing family planning services can be attributable to project activities?

3. Have any of the strategies which have been employed by the contractors to develop LDC regional training resources resulted in a technically viable regional family planning training institution? If so, what is the model and is it transferable?

4. Are any unplanned effects of any contract activities evident? Are they positive? neutral? negative?

5. What, if any, project materials or activities (e.g., training approaches, training materials, project development strategies, evaluation approaches, etc.) have applicability beyond the PAC II project?

#### F. Recommendations

1. Is there a continuing need for PAC training assistance in each of the geographic regions, i.e., Africa, Asia, Latin America/Caribbean and Near East/North Africa? What kind of assistance, and do the needs vary for each region?

2. Are changes in the project design necessary, based on the analysis of the present project design, implementation of major activities, project management, reports, monitoring and evaluation, and progress in meeting project objectives? What is the team's assessment of new activities/directions to be pursued?

3. What are the options for improving performance in the remaining period of the contract?

4. Has A.I.D.'s investment in this project been worthwhile in extending family planning services and education?

#### IV. Evaluation Procedure and Proposed Chronology

##### A. Procedure:

1. The evaluation will include interviews with the A.I.D. Office of Population staff, Population Officers who are in Washington during the time of the evaluation, HPN staff from the Africa, LAC and ANE regional bureaus, and other Agency staff.

2. Various team members will visit each contractor at their respective U.S. project headquarters for briefings and interviews with the project staff. They will visit INTRAH in Chapel Hill, North Carolina; Development Associates in Arlington, Virginia; and PONCO Consulting Corporation in Durham, North Carolina.

APPENDIX C  
INSTITUTIONS VISITED BY EVALUATION TEAMS

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Appendix C

INSTITUTIONS VISITED BY EVALUATION TEAMS

Unites States

USAID Bureau of Science and Technology, Office of Population  
USAID Africa Bureau  
Program for International Training in Health (INTRAH),  
University of North Carolina, Chapel Hill  
International Health Programs of the University of  
California at San Francisco (IHP), a part of the Institute  
for Policy Studies, Santa Cruz, California  
Training Resources Group, Inc. (TRG), Alexandria, Virginia

Africa

Burkina Faso

USAID Mission  
Ministry of Public Health  
Ministry of Social Welfare and National Service  
Samandin Clinic, Ougadougou  
Yalgaço Hospital, Ougadougou  
Division of Professional Training  
Dapoya Clinic, Ouagadougou  
Central Clinic, Ouagadougou  
Midwives Clinic, Ouagadougou

Ivory Coast

INTRAH Regional Office  
Regional Economic Development Support Office/West and Central  
Africa (REDS)/WCA)

Kenya

USAID Mission  
INTRAH Regional Office  
REDSO/East Africa  
Ministry of Health  
Center for African Family Studies (CAFS)  
The Pathfinder Fund  
African Medical and Research Foundation (AMREF)  
Thika Hospital  
Family Planning International Assistance (FPIA)  
Association for Voluntary Surgical Contraception (AVSC)

Nigeria

USAID Mission  
Ministry of Health, Benue State  
Ministry of Health, Kwara State  
Ministry of Health, Lagos State

Uganda

USAID/Kampala  
Ministry of Health  
Nsambya Hospital  
Coopers & Lybrand  
Murchison Bay Hospital  
Nsambya UCMB Secretariat  
Jinja Hospital  
Mbale Hospital  
Bududa Hospital

Zaire

USAID Mission  
Projet des Services des Naissances Desirable (PSND)  
Direction de l'enseignement des Sciences de Sante'  
6e Direction  
Association Zairoise pour le Bien-etre Familiale (AZBEF)  
Fonds Nationaux d'Assistance Medicale et Sociale (FONAMES)  
Association for Voluntary Surgical Contraception

Asia

Nepal

USAID Mission  
Contraceptive Retail Sales Project (CRS)  
Family Planning/Maternal and Child Health Project (FP/MCH)  
Division of Nursing, Ministry of Health  
United Nations Fund for Population Activities (UNFPA)  
UNICEF  
DORC  
John Snow, Inc.

Sri Lanka

USAID Mission  
Family Planning Association of Sri Lanka (FPASL)  
Galle: District Action Committee of FPASL  
Matara Community Program of FPASL  
Matara District Administration

United Nations Fund for Population Activities (UNFPA)  
National Institute of Health Sciences (NHIS)  
Ministry of Health  
Institute of Workers Education, University of Colombo  
Government Midwifery Service Union

Thailand

USAID Mission  
Ministry of Public Health  
Asia Center, Population and Community Development Association  
(PDA)

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APPENDIX D

INTRAH PAC II CONTRACT OBJECTIVES AND OUTPUTS

## Appendix D

### INTRAH PAC II CONTRACT OBJECTIVES AND OUTPUTS

PAC II calls for a greatly expanded evaluation effort at all levels designed to identify cost-effective strategies and approaches to training delivery. The multiplier effect to be achieved through the training of trainers (TOT) and supervisors has been given strong emphasis under PAC II. This project requires efficient followup and systematic evaluation of TOT results obtained in second generation training.

Recognizing that not all training needs will be met with in-country programs, PAC II directs attention to the need to strengthen both regional and in-country training programs. The aim over the five year period is to have established in the Africa and Asia regions strong, technically self sufficient training institutions which can provide appropriate training to high-and mid-level managers, supervisors, trainers and policy makers at the regional level and to all types of service delivery personnel at the country level.

### ARTICLE III - OBJECTIVES

The specific objectives of this contract which in turn contribute to achievement of the goal are:

1. Provision of appropriate technical and financial assistance to training institutions, organizations and agencies in selected countries in the Africa and Asia regions in support of projects and activities which create or strengthen relevant training and service capabilities at the country level.
2. Provision of appropriate technical, managerial and financial assistance to training institutions, organizations and agencies-- equitably distributed within the region in terms of geography, language and special capability-- in support of the establishment of creditable and self-sustaining regional resources for family planning clinical, non-clinical and management training and technical assistance.
3. Provision of encouragement and appropriate assistance to participating host country family planning programs' efforts to adopt innovations in the training, deployment and support of a wide variety of professional, paraprofessional and traditional categories of personnel to enhance the planning, management, delivery and evaluation of services.
4. In both the Africa and Asia regions, fostering region-wide exchange of information, experiences and ideas among national leaders, program managers and trainers as a means of extending the impact of assistance provided directly in this program.

It should be noted that these objectives are not organized in order of priority. Contractor success will be measured by the extent to which the contractor achieves these end results as well as other criteria.

### C. Outputs

The major quantifiable outputs of this contract are identified under Article IV "Quantified Indicators of Performance." However, the other qualitative outputs which apply to both geographic regions (Africa and Asia) are identified here.

- o Host country pre-service and in-service institutions assisted under this program will demonstrate markedly increased technical self-reliance (in some cases, technical autonomy) in their abilities to plan, design, implement and evaluate training programs for PAC personnel. The comprehensiveness of these abilities may vary from institution to institution, but each institution will at least develop the basic residual abilities to develop competency-based curricula, provide training which is sound and appropriate in technique and accurate in content for the target categories of trainees, produce simple but effective training materials, and evaluate the training program meaningfully.
- o Direct trainees, both first generation and second generation, produced under this contract will demonstrate new knowledge and skills necessary for effective management, delivery and support of family planning services, according to their respective roles in the training and service systems. They will also demonstrate in their performance the confidence and job pride necessary to successfully encourage and motivate acceptors, subordinate personnel and their peers.
- o Regionally based training will be an important component of family planning training development in the region. Selected contractor-assisted institutions and organizations will demonstrate through practice the requisite strengths of management, staff technical ability and organizational stability for sustaining programs of training which provide specialized support to individual countries' efforts to build their own training capabilities. The regional training institutions will be accepting trainees sponsored by a number of host country and international agencies, as well as the contractor, and will be successfully established as credible on-going entities.
- o Both host country and regionally based institutions will be providing for substantially increased training of community-based (including CBD) workers, their supervisors, and those who plan and manage community-based service programs. The equitable distribution of primary health care services, including family planning, will benefit.
- o Policy-makers, decision makers and opinion leaders at all levels will demonstrate understanding of and active support for operational models of population/family planning policy, especially with regard

to the roles of training, management, and rural-based and community-based service deliveries. Linkages among PAC personnel at clinic-based and community-based levels, medical personnel who often administer the programs in which they work, and upper-level officials whose support is essential to their effectiveness will be clear and constructive in participating countries.

APPENDIX E  
REPORT ON TRAINING METHODOLOGY

## Appendix E

Report on Training Methodology

KENYA AND UGANDA

by

Fred Abbatt

The underlying assumption of this report is that training courses should be designed to equip the participants with all necessary skills and the underlying knowledge and attitudes to perform some aspect of their work in a competent professional way. Therefore the objectives for the course should be directly related to the work for which the trainee is being trained, the teaching/learning methods should be chosen and implemented to serve this purpose and the way in which learners are assessed should be designed to find out whether the learners will be competent to provide appropriate health care. It is the above set of assumptions which have been the basis for this evaluation.

Learning Objectives

The learning objectives for all courses investigated were stated in some detail. Usually the objectives were in an appropriate format though occasionally they referred to topics to be covered rather than learner performance. The objectives did take account of decision-making skills and communication skills - as well as the more obvious manual skills and knowledge. Little mention was made of attitudinal objectives.

At the general level, the objectives did appear to be based on a realistic appraisal of what job the learners could be expected to do,

though one could question the appropriateness of including IUD insertion (see appendix I) and the absence of supervision/training of community-based-distributors/village health workers.

On the other hand at the detailed level objectives rarely reflected a sufficiently detailed analysis of what the learner needed to learn. Generally the analysis was adequate for manual/clinical skills but was weak in the admittedly much more difficult areas of decision-making and communication. In this, INTRAH courses are no weaker than the majority of other courses in health care and so one might argue that it does not matter. However, the lack of clarity in these areas which are difficult to define (and to learn) means that the teaching is also lacking in clarity and so makes skills which are inevitably difficult to learn even more difficult.

The objectives do occasionally give a strong impression that they have been derived from a session which the teacher intends to give, rather than from an analysis of what the learner needs to learn. Thus the session determines the objectives rather than vice versa. Examples of this phenomenon include the following:

"By the end of the session participants will

- (i) Share learning insights/problems" (a description of the learning process rather than an objective)

"(ii) State what the nursing process is" (This would be plausible if the "nursing process" was later used as the basis for the nurses' work, but in fact it was treated in isolation and not referred to in any practical work; nor were the practical consequences of "the nursing process" pointed out.

This latter objective is typical of a number of objectives which relate to abstractions describing a process which are then ignored in subsequent practical teaching. Thus time is wasted in learning definitions or stages of a process which are not useful in themselves.

Despite the above comments, it should be recognised that the INTRAH courses are very fully documented and the objectives as they exist will be of significant help in communicating to new teachers or to learners what is intended to happen in each session.

#### Time Allocation

The duration of courses was generally an appropriate compromise between the ideal and the feasible (given the existing objectives). Courses generally allowed substantial periods of time for practising skills, either in simulation within the classroom or in the field situation. Particularly welcomed was the integration of practical experiences within clinics with the more theoretical classroom instruction which occurred in Uganda - but not Kenya.

The 'Training of Trainers' courses did not allow more than token practice in teaching. This was perhaps inevitable in view of the priority of training teachers in contraceptive technology and the limited time available. But whilst one may accept this situation was inevitable, one should not go further and believe that teaching skills were learnt to a significant degree. (However, it should be recognised that several teachers had learnt skills of teaching by working in teams with INTRAH trainers. This process has been effective; it would be desirable if much more of this kind of experience could be provided.)

A further point on time allocation is that rather a lot of time seems to be spent in establishing general principles (especially with regard to communication), with the inevitable consequence that less time is available to explore the practical consequences of these general principles either by discussion or in practice.

A point raised later (in Appendix I) is whether such a large proportion of time should be devoted to IUD insertions in so many of the INTRAH courses.

### Teaching Methods

The teaching methods (as specified in curricula) reflect a suitably wide range of methods and they are generally appropriate to the objective. The teaching methods used in practice are also impressive, especially in view of the limited opportunities which many of the teachers have had to develop their teaching skills. Most

importantly, considerable trouble is taken to arrange practical experience in the field despite the very real difficulties of arranging transport and adequate supervision. Within the classroom, teachers were commendably well organized and provided well structured presentations. Relationships between teachers and learners were appropriately relaxed and the learners were sufficiently confident in the relationships to ask questions, and to reveal uncertainties. Teachers made full use of the available resources (newsprint sheets, anatomical models such as Ginny, clinical equipment, etc). They also generally followed the curriculum and used techniques which require confidence and some experience (such as role play), though sometimes the technique was highly diluted. For example, brainstorming seemed to be regarded simply as an open discussion session rather than a true brainstorm; role plays were regarded almost as mini-drama with insufficient attention paid to the need for incisive feedback.

In summary, the teachers who were observed did a surprisingly competent job, especially in view of their limited training in and experience of, teaching. However, they show the potential to perform to a significantly higher level with comparatively small exposures to further training in teaching methodology.

#### Use of Visual Aids and Learning Materials

Teachers used anatomical models to teach skills such as the use of the speculum, taking a cervical smear etc. However these models were in short supply and had been borrowed for the course in Uganda. No

examples were seen of the use of overhead projectors, films, audio tapes, video tapes or transcripts of conversations, though teachers did report that some films were available for loan from N.G.O.s.

Handouts were used extensively and their production was well organized to provide a record of the course. Some of the handouts were excellent whilst others were appalling in that they provided elaborate and unnecessary definitions of simple or irrelevant concepts.

In Uganda a textbook was given to all students (the "Africa" book on FP). In Kenya the same book was only available on loan. No country specific manuals were available. No other learning materials such as case studies checklists, problem-solving exercises were seen.

### The Learning of Skills

As mentioned above, a reasonable amount of time was scheduled for students to learn skills through role play/simulation in the classroom and through practice in the field. The quality of this experience was restricted by the absence of adequate checklists for helping the supervision of practice. The amount and quality of supervision cannot be reported, though in Uganda a comprehensive rota for the teaching team had been prepared. The progress of students was not recorded as such, though in Uganda a form was used for students to record each client seen and very very briefly what was done.

### Summary of the Teaching

The courses observed directly or whose curricula were studied, are certainly of benefit to the students.

However, besides this solid achievement, one should consider the issue of course optimization. It is my judgement that the recommendations with this report could lead to the achievement of a substantially greater proportion of the learning objectives in the same length of course, with the direct consequence of a higher quality of F.P. service. Alternatively a similar quality could be achieved in less time and cost, thereby allowing an increased number of service providers.

### Assessment of Courses

The assessment procedure for a course should:

- (i) provide evidence for deciding whether a student passes or fails the course and therefore qualifies for providing an F.P. service.
- (ii) guide the students' learning during the course by providing information on areas of strength or weakness.
- (iii) give feedback to the teachers about the effectiveness of their teaching so that they can adapt their teaching in order to remedy deficiencies.

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The assessment procedures for the courses are reviewed within this context. The common pattern of assessment was for students to take a written pre-test. This would be followed by a mid-course written exam followed by a final written exam which in some instances was a repeat of the pre-test. In addition, practical work would be assessed on a continuous basis with students being provided with frequent feedback. This general pattern is superficially reasonable and especially important is the emphasis given to the continuous assessment of practical skills.

However, the detailed implementation is less satisfactory. In several of the courses the pre-test is concerned with asking the kinds of question which could only be answered if one happens to know the way in which the examiner's mind works - whether one is competent in the subject of the course or not. This is damaging. It guides the student to try to learn irrelevant information, so that they can answer the post-test better; it gives a false indication of learning when pre and post-test scores are compared; it fails to serve the usual purpose of a pre-test which is to identify those areas of the learners' competence where the course needs to focus in order to remedy weakness. There were no reports of the results of pre-tests being used to alter the course design. In view of the above, the courses would be better without the type of pre-test currently employed.

The final written exams showed examples of some good problem-based questions which closely reflected the kind of situation which the

trainees would have to deal with in their jobs. However there were also a number of inappropriate matching questions and even some essay questions of the "write brief notes" type. Appropriately, the written assessment did not appear to feature prominently in the decision-making process concerning pass or fail. However, if it had, the very low pass mark of 50% would not have ensured competence. It was very difficult to fail the written exams.

The assessment of practical skills was only loosely defined. None of the usual techniques for improving reliability were adopted and there seemed to be no agreed or accepted criteria for performance. Because of this absence of documentation, it is impossible to be definite about the importance of decision-making and communication-skills in the assessment process, but they appeared to be of comparatively low importance.

In summary, it seems that too much attention is paid to an irrelevant or damaging pre-test whilst insufficient attention has been paid to ensuring that a reasonably well defined standard of performance is achieved in practical work. Day-to-day feedback to students on the quality of their practical work does seem to be provided - which is vitally important in helping learning.

## More General Issues

### Implementation

A major achievement of the programs has been the fact that a wide range of courses have taken place and the substantial numbers of people have been trained more or less according to schedule despite a number of serious constraints. This has demonstrated the capacity of INTRAH staff in the region to coordinate with governments, to adequately prepare teachers and generally manage the training process.

A further achievement is that a surprisingly high proportion of course participants are still in the post for which they were trained—reflecting well on the selection process and the level of cooperation achieved with the Ministries of Health. These are substantial achievements.

### Integration with existing training and service provision

For the most part, INTRAH has followed a policy of training service providers within the Ministry of Health through Training of Trainers courses. The 'graduates' of these TOT courses have then formed training teams who have developed their own courses in partnership with INTRAH staff. This policy has been very successful in establishing teams of trainers who are competent to continue the training process with minimal INTRAH support. On the basis of the trainers met during the evaluation visit, INTRAH have been successful in identifying competent and well-motivated trainers and have succeeded

in persuading ministries of the value of this policy so that the trainers have continued to be available for training activities.

Attention has been paid to the integration of FP within existing curricula. Whilst a curriculum document has been prepared in Kenya (in partnership with AMREF) and this has received approval, it has not been implemented in any coordinated manner in the nursing schools. This problem is recognised in the proposal for a liaison project. A central activity of this project might usefully be a training program for nursing school teachers in how to teach the new FP curriculum.

A further positive feature is the productive working relationship which has been established between INTRAH personnel, central ministries and service providers at regional and more local level.

#### The Scale and Direction of the Programs

Whilst it has to be accepted that the scale of training provided and its broad direction must be established in partnership with Ministries, it could be argued that there is insufficient urgency in addressing the problem of providing family planning services in Kenya and Uganda. This comment is made in the context of the comparatively recent changes in government policy with regard to FP in both Uganda and Kenya and the apparent demand for contraceptive service by substantial numbers in the population. The current programs have and will produce modest numbers of nurses with a fairly comprehensive range of FP skills. Alternative strategies could have aimed to prepare much

larger numbers of nurses. This could have been achieved by

- (i) advancing the programs to implement regional (within country) training teams. One TOT course could have produced 4 training teams at least, instead of the one which exists in Uganda.
  
- (ii) preparing country specific manuals on FP to support the training (which would have to be focussed entirely on the work to be done and the essential background knowledge). Then using this to cut out irrelevant teaching and speed the learning process.
  
- (iii) limiting the range of FP skills learned during this first phase of training. For example, IUD insertion is not of great value, especially in Uganda, because there is little demand for this technique and the facilities available are not really adequate.

In this way courses would have been shorter, it would have been easier to train the trainers and so, many more nurses could have been available in the field providing an essential health care function. When IUD insertion (and other techniques such as pap smears) become a widely available and realistic option then a second phase of training could be introduced.

In summary there is some feeling that the logic of carrying out a needs assessment has not been followed through rigorously in planning the training strategy.

### Teaching Quality and Efficiency

Whilst the teaching quality could be described as adequate, and probably matches or exceeds the quality of teaching in the countries' schools for nurses and medical assistants, there is an important gap between what the current teachers achieve and what they could achieve. This difference is largely due to the very small amount of training they have had in teaching methodology and so could be remedied quite quickly by intensive training on how to teach the current courses.

This gap in performance does lead to a lack of efficiency. Students take longer to learn, so courses are longer, so fewer students take part in the courses, and so fewer nurses provide FP in the field.

A further lack of efficiency is the use of a teaching team of 6 people for a class size of 20. Whilst this ratio could lead to high quality, it is doubtful whether it is a luxury which can be afforded. An initial TOT course for 20 participants could have produced 5 teaching teams of 4 people instead of 1 team of 6 people currently working in Uganda.

### Regional Support

The EPA office consisting of a director and a training advisor plus secretarial staff clearly work hard and to a high standard. But

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one training advisor cannot possibly come close to meeting the demand for training local training teams in teaching methodology. This appears to have been a major and unnecessary constraint on the effectiveness and scale of training provided.

### Flexibility and Responsiveness to local situations

Whilst it is true that training programs are adapted to the circumstances of different countries, it seems as though the INTRAH course is taken as the norm to which minor alterations are made, rather than thinking through the needs of each country individually. A further problem seems to be the long delay in responding to changing situations (which is a very rapid change in Uganda). This lack of responsiveness is due to a rather cumbersome bureaucracy and the restricted numbers and authority of regional staff.

### Follow-up Visits

A program of follow-up visits was planned for the courses on FP Management. These visits took place and an extraordinarily high proportion of course participants were visited in the field. Unfortunately the visits were used for evaluation data collection purposes rather than the stated objective of helping course participants to apply in the field situation what they had learned during the course. (This comment is based on discussion with some of those trainers involved in follow-up activities.)

Thus although superficially follow-up visits did occur, the purpose for which they were planned was not even attempted.

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### Numbers Trained

The numbers of nurses and other personnel trained is not commensurate with the need. The numbers of nurses trained in Kenya each year is less than the number of nurses completing the pre-service curriculum. In Uganda the discrepancy is much greater.

### Costs

The proportion of the total budget which is spent in the direct provision of training materials or courses seems low.

### Recommendations

#### 1. Teaching materials and equipment

Additional simulation models should be provided so that each course has access to, say, four Ginny models etc. This would enable several students to practise simultaneously rather than wait in a queue for 19 other students to practise.

Teaching equipment such as overhead projectors could allow teachers to increase their effectiveness. Consideration should be given to providing video recorders and to preparing within countries some video tapes of clinical procedures carried out in typical field conditions. Another vital area where video tapes would be useful is in demonstrating communication techniques.

Finally, it seems essential that country specific manuals on the family planning work to be done by nurses should be developed urgently. These could be produced quickly, cheaply and to a high standard. They would help to make the teaching much more purposeful and would provide a valuable reference after training.

## 2. Training in teaching methodology

Members of existing training teams could perform to a higher standard if they were given additional training in the methods of teaching and assessing the current courses. An alternative to separate courses for trainers would be a planned series of visits to courses by a master trainer to provide on-the-job training for the teachers. This would be an expansion of existing activities.

## 3. Existing Courses

All current courses should be reviewed with a view to identifying unnecessary content and points where the teaching could be made more efficient (e.g. several students practising simultaneously rather than one at a time). The value of having daily evaluation sessions should be reviewed. The procedures and techniques learned should be restricted to those which can currently be provided with existing resources and facilities. The aim should be to reduce the length of courses so as to increase the number of students who can be trained.

4. Assessment of Courses

Assessment procedures for courses should be reviewed with a view to:

- i ensuring all written assessment items are based on problems which are likely to be encountered in the field.
- ii a more rigorous pass standard is established.
- iii assessment of practical skills (including communication skills) is based on agreed checklists and rating scales to which both teachers and students have access prior to the assessment.
- iv the policy of continuous assessment of practical skills and the emphasis on practical skills be maintained.

5. Regional Office

The existing high calibre staff in regional office, Nairobi, should be strengthened by another person whose primary expertise and responsibility would lie in the development of teaching skills and the preparation of teaching materials such as checklists/rating scales, manuals and video tapes.

## 6. Scale and Direction of the Courses

The aim of INTRAH should be to encourage and facilitate the more rapid and more widespread implementation of courses in FP by ministries of health. One factor which slows the current implementation is the stated need to include IUD insertion and taking of pap smears. Existing facilities are such that IUD insertion is inappropriate in many service delivery points and laboratory facilities are such that the results of pap smears are delayed for long periods or are unavailable. Therefore consideration should be given to whether these techniques are currently appropriate, and whether greater benefit could be derived from a larger number of nurses trained in a smaller range of skills.

## 7. Community Based Distribution and Primary Health Care

Course content in both Uganda and Kenya should be revised to take account of the role of nurses in managing supplies for community-based distribution, in training and supervising community-based distributors and primary health care workers, and in keeping to appropriate records in such a way that the records can be useful in planning their own work.

Appendix I - Insertion of IUD and use of pap smear

In the longer term there can be no argument against the idea of nurses inserting IUDs and carrying out pap smears. The pap smear test is important in the early detection of disease and as a possible contra-indication. The IUD is a legitimate form of contraception and one would in principle wish to have it available for as many women as possible.

However, at the current moment pap smear tests ARE carried out, but even quite close to major centres there is such a long delay in obtaining results from the laboratory that the results are too late to be of much value. There is also a substantial problem in contacting the women who have been tested. So the benefits appear to be small.

Similarly, the demand for IUD appears to be small in Uganda (although rather larger in Kenya) and the physical facilities for IUD insertion are such that there is cause for concern with regard to the risk of infection. Therefore, for both techniques, there is a question of how appropriate they are for health care staff away from hospital.

If IUD insertion could be learnt quickly then it might be worth including in the courses for the sake of general knowledge. But teaching IUD insertion takes a high proportion of the available time and therefore means that fewer courses can be offered in a given time period or for a given sum of money.

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