

PD AM-752

ASW-55777

Office of Population
Bureau for Science and Technology
Agency for International Development
Washington, D.C. 20523
Under Contract Nos. DPE-3024-C-00-4063-00
and DPE-3024-Z-00-7079-00
Project No. 936-3024

17

REVIEW OF THE FAMILY PLANNING
TRAINING WORLDWIDE PAC II PROJECT
1984 - 1987

000673
000191
5

by

Patricia Baldi, RN
Robert Blomberg, DPH
Carolyn Long
John McWilliam
Judith Rooks, CNM, MPH
Sheila Ward, MPH

Edited and Produced by:

Population Technical Assistance Project
International Science and Technology Institute, Inc.
1601 North Kent Street, Suite 1101
Arlington, Virginia 22209
Telephone: (703) 243-8666
Telex No.: 271837 ISTI UR

(Report No. 87-121-065)
Published May 27, 1988

TABLE OF CONTENTS

GLOSSARY	iii
EXECUTIVE SUMMARY	v
I. INTRODUCTION	1
I.1 Scope of Work	1
I.2 Methodology	2
II. IMPACT OF PAC II	3
III. PAC II PROJECT DESIGN	7
III.1 Summary	7
III.2 Purpose	7
III.3 Output Elements	7
III.4 Types of Assistance	8
III.5 Content Areas	9
III.6 Contract Objectives	9
IV. APPROPRIATENESS OF PURPOSE AND OUTPUTS OF THE PROJECT	12
IV.1 Purpose	12
IV.1.1 Summary Analysis	12
IV.1.2 PAC Worker Role in Provision of Temporary Methods of Family Planning	12
IV.1.3 Need for Training	13
IV.1.4 Need for Large Numbers of Widely Distributed Workers	15
IV.2 Output Elements	15
IV.2.1 National Institutional Development	15
IV.2.2 Targets and Content of Training	23
IV.2.3 Regional Programs	27
IV.2.4 Provision of Technical Assistance	30
V. EVALUATION AND OPERATIONS RESEARCH	32
VI. CONTRACTING MODE FOR NEXT CONTRACT	34
VI.1 Central Funding	34
VI.1.1 Rationale	34
VI.1.2 Advantages	34
VI.1.3 Disadvantages	35

VI.2	Worldwide Design	36
	VI.2.1 Need for Continued PAC Assistance Worldwide	36
	VI.2.2 Applicability of Worldwide Approach	36
VI.3	Single Worldwide Contractor vs. Multiple Contractors	37
	VI.3.1 Advantages of Single Worldwide Contractor	37
	VI.3.2 Advantages of Multiple Contractors	37
VII.	SUMMARY OF RECOMMENDATIONS	39

APPENDICES

- A: Executive Summaries of the Evaluation Reports of PAC II Contracts with Development Associates, Inc., Program for International Training in Health, and RONCO Consulting Corporation
- B: Scope of Work of the Evaluation of the PAC II Project
- C: Output Elements of the PAC II Contracts
- D: Examples of Family Planning Research Related to Training

GLOSSARY

A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary nurse-midwife
APROFAM	Asociación Pro-Bienestar de la Familia
ASBEF	Association Senegalaise pour le Bien-etre Familiale
CA	Cooperating Agency
CBD	Community-based distribution
CPR	Contraceptive prevalence rate
DA	Development Associates, Inc.
DCN	Division of Nursing
ENC	Enrolled community nurse
FEMAP	Federation Mexican de Asociaciones Privadis de Plantificacion Familiar
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
LAC	Latin America and the Caribbean (region)
LDC	Less developed country
MCH	Maternal and child health
MOH	Ministry of Health
NENA	Near East and North Africa (region)
NFP	Natural family planning
OR	Operations research
PAC	Paramedical, auxiliary and community
PHC	Primary health care
PHN	Public health nurse

PVO	Private voluntary organization
RAPID	Resources for the Awareness of Population Impact on Development
RONCO	RONCO Consulting Corporation
TA	Technical assistance
TBA	Traditional birth attendant
TOT	Training of trainers

EXECUTIVE SUMMARY

1. INTRODUCTION

A review of the experience of the first 2-1/2 years of the 10-year PAC II family planning training project was undertaken based on the data gathered during the mid-term evaluations of the five-year contracts of the three organizations carrying out the project. The project's purpose is to strengthen or develop the capacity of less developed country (LDC) institutions and agencies to design, implement and evaluate training programs for paramedical, auxiliary and community (PAC) personnel and thus enable PAC workers to provide safe, culturally acceptable family planning services. Whereas the PAC I project focused on training large numbers of PAC workers, PAC II emphasizes institutional development and places particular importance on improving the skills of those who train, manage or supervise other PAC personnel.

This report concentrates on the impact of the project thus far, the appropriateness of the project design to meet current and projected future needs, and the contracting mode for the next contract.

2. PROJECT IMPACT

Although the project is only in its early stages, progress has been made in a number of the six impact areas stipulated in the project paper.

PAC contractors for Asia and for the Latin America and the Caribbean (LAC) region have already assisted in training more people than the numbers expected by the end of their five-year contracts. The PAC contractor for Africa is on target for its work there. The contractor for the Near East/North Africa region (NENA), however, has trained fewer personnel than expected.

Training institutions in the LAC and Asia regions are more mature and can use PAC II resources very efficiently; relatively small contractor efforts in these regions can result in large improvements in the institutions' performance. PAC contractors responsible for Africa and NENA, on the other hand, are working with nascent institutions which require more intensive groundwork.

The project paper calls for both in-service and pre-service training for nurses, nurse-midwives and auxiliaries. Little effort has been made by PAC II contractors in Asia and NENA to develop pre-service curricula. In Latin America, contractor efforts have yielded few results. Only in Africa has

some achievement been documented. The lack of emphasis on this area may have been appropriate, however, in view of the relatively more important need to develop in-service family planning training programs.

The role and responsibility of non-physician family planning service providers received attention from the contractors in all regions, and examples of the increase in status and responsibility of PAC workers were documented. Much more needs to be done to enhance the status of PAC workers and to generate more host government funds for their training.

It was difficult to document any increase in contraceptive prevalence due directly to PAC training. Although some examples were found of training having increased contraceptive use, training alone is not sufficient to achieve significant improvements in contraceptive prevalence rates.

Access to family planning services increased in rural areas in Asia and LAC, where the contractors' work has been directed at PAC workers who are based in rural areas. In Africa, where the PAC contractor's ability to increase family planning for rural people is tied to the ability of government ministries of health to provide basic health services beyond the cities and towns, less impact has been seen.

3. PROJECT DESIGN

The project purpose is valid because training of nurses, midwives, and other PAC workers is essential if temporary family planning methods are to be made available within family planning programs. In addition, institutionalizing the capability to train these categories of workers is necessary to multiply the effects of external assistance and to create changes that will persist after aid is withdrawn.

The overall project design has provided a flexible framework within which contractors have been able to implement an appropriate variety of PAC training activities. There were considerable differences among the contractors, however, with regard to the objectives they set forth. Only two objectives were common to all three contractors--national institutional development and regional institutional development.

4. OUTPUT ELEMENTS

4.1 National Institutional Development

Experience under PAC II suggests that building national institutional capacity is a long-term enterprise. Even in the

LAC region, where institutions are relatively mature, constant turnover of trained people implies the need for extended involvement. In Africa, the prospect of institutionalization in the near future is remote. Family planning policies and service delivery are at nascent stages; most services are being delivered through ministries of health, which, given their lack of autonomy as organizations, do not lend themselves easily to institutional development efforts.

PAC contractors are pursuing two major types of institutional development: 1) activities to strengthen national training institutions for PAC workers, and, 2) activities to create training systems for specific countries, these primarily in Africa. The latter is a much broader concept, may require an approach to technical assistance different from that traditionally used in strengthening an institution, and may take a significantly longer period to accomplish.

Three special issues have arisen during the early efforts to institutionalize training under PAC II and lessons learned in these areas should influence programming decisions in the near future. The issues relate to programming emphasis, specifically: 1) What kind of a mix should there be between pre-service training for nursing personnel and in-service training for these groups? 2) How much effort should go to training CBD workers and how much to clinic-based service delivery personnel? and 3) Should efforts be made to train personnel to work in integrated primary health care (PHC)/family planning programs?

o Pre-Service/In-Service Training

The emphasis on encouraging and assisting pre-service nursing, midwifery and auxiliary health worker schools to integrate family planning into their curricula will not reduce the need for continuing in-service training. Pre-service family planning training can provide a knowledge base, but it cannot provide skills that are adequate for the delivering of services. Skill training must occur in-service. Different program strategies are needed to carry out pre- and in-service training. In order to influence pre-service training, it is necessary to negotiate with nursing boards. In contrast, service agencies are usually free to develop their own in-service courses.

o Clinic-based/CBD Training

Training to support both clinic-based and CBD service delivery was anticipated in the PAC project. Little guidance was given on which type of training to emphasize, however. In Latin America, the PAC contractor works primarily with private sector organizations that rely extensively on community-based distributors to provide services. Many thousands of these CBD workers are already in place, but many more are needed. The PAC

contractor's assistance enables these organizations to prepare these additional workers.

In Africa, a very different approach is used by the PAC contractor. Training focuses on providing clinical skills for ministry of health PAC service providers. The focus on government services is due in part to the relatively weak private sector and in part to the acute need to assist public sector programs that are just being put into place. It is expected, however, that CBD programs will soon follow. The need for training in this area should be anticipated.

o Family Planning and Primary Health Care

Significant strides have been made in some countries to implement PHC programs. This represents an opportunity for family planning. With donors and governments allocating more money to PHC, family planning training and services may now be attached to other related health interventions, thus potentially expanding coverage while reducing the cost of the family planning component. Although family planning has not received the attention it deserves in many PHC programs, where PHC is being vigorously pursued, efforts should be made to include family planning in the training and service components.

4.2 Training: Targets and Content

4.2.1 Training Targets

The priority accorded to trainers, managers, and supervisors in the PAC II project paper was appropriate. Increased efforts should be made to reach these target groups.

4.2.2 Training Content

Training of Trainers A major weakness among all PAC II contractors has been their inattention to developing indicators of the quality of training. Nowhere in PAC II documentation, for example, is there a definition of a "trained" trainer. The result has been a somewhat unsystematic approach to training of trainers, which reflects lack of agreement on what trainers need to learn in order to be able to train PAC workers.

Clinical Skills Training The lack of quality indicators is also a problem with respect to service delivery skills, both for CBD and clinical providers. A set of standards for CBD training is being developed by one contractor, however, and clinical service protocols are being developed by another. When completed and tested, these guidelines may be useful in the regions.

Client Focus In determining the kinds of family planning services to provide and the types of training required, PAC II contractors have sometimes focused on the needs of the service provider, rather than the client. Client needs and desires were assumed, perhaps correctly, perhaps not. Increased attention should be directed to understanding the client's perspective and designing training and programs to meet the needs of specific client groups.

New Content Areas The potential for exposure of nurses, midwives, and clients to AIDS through family planning service provision may be great. Although two PAC contractors have developed a general curriculum on AIDS prevention, more attention should be given to training to assist PAC workers to avoid on-the-job infection with AIDS.

Training curricula should be updated periodically and, as new contraceptives are introduced, information on them should be incorporated into the PAC training courses. New teaching methods may also require rethinking the way content is being taught to increase the effectiveness of training programs.

Training Materials Development and Production PAC II experience suggests that the quality of training is hampered by a lack of adequate training materials for trainers and trainees. A major effort will be required to develop curricula and materials and then produce and disseminate them. Besides more collaboration among cooperating agencies to disseminate their materials more widely, actions will be required at the country level to develop relevant materials, and at the regional level to produce and disseminate materials. More use should be made of commercial channels for dissemination.

4.3 Regional Programs

4.3.1 Regional Training and Regional Institution Building

Regional training has been undertaken by all three PAC contractors. Courses have been conducted, a regional master training network is being developed, and regional and interregional study tours have been provided.

A part of the regional emphasis in the PAC II project paper, however, relates to strengthening regional training institutions. Such centers have not proven to be as appropriate as originally envisaged; all three PAC contractors have experienced difficulty in implementing this aspect of their programs. Where the capacity to meet particular training needs has not been available at the country level, institutional capabilities in other countries have been used. Such centers can continue to be used on an as-needed basis for regional training needs.

4.3.2 Networking

Although some actions have been taken by the PAC contractors to exchange information, much more needs to be done. Efforts to share information, particularly lessons learned, among PAC contractors and other A.I.D. contractors should be intensified. In addition, new PAC workers should be included in the information chain on family planning, training, and the like, through all available means.

4.4 Provision of Technical Assistance (TA)

Technical assistance has been the key element in making this project work, and, generally, the TA furnished by both contractor staff and consultants has been favorably received. TA could be improved, however, in two areas. First, more attention needs to be given to follow-up TA. Development and refinement of skills of trainers takes time, ongoing learning, and feedback. Second, the provision of TA through regional resources should be encouraged whenever possible. Increasingly, PAC contractors for Africa and NENA have shifted the focus of attention and resources to the field. In both regions, regional offices have been set up and staffed with highly qualified professionals from LDCs. (A regional office was not deemed necessary in either the LAC region or in Asia.) In addition, a small but growing group of LDC consultants in all regions is beginning to provide TA to training and curriculum development efforts. These trends should be encouraged and strengthened in the second half of PAC II.

5. EVALUATION AND OPERATIONS RESEARCH

Elements of what was required for evaluation appeared in a number of sections of the project paper and seemed to create confusion among some of the PAC contractors. What seemed to be missing in the project paper and in the evaluation efforts of some of the contractors was a clear understanding of what evaluation was to accomplish. Among the basic questions that need to be answered are: How many of those trained will be delivering services six months or a year later? Were the training objectives met within established time frames? Are there better and more cost-effective ways of meeting the same objectives? It may be too early to make an overall judgment about the quality of the contractors' performance in the area of evaluation because much of their effort is planned for the last two years of the contracts.

With regard to operations research, a growing body of findings and lessons learned is available that would be relevant to improving the quality of family planning services provided by PAC workers, but few of those findings have been incorporated into PAC training.

6. CONTRACTING MODE

6.1 Central Funding or Bilateral Funding?

The centrally funded approach used to implement this project has proven to be appropriate. There are a number of reasons for this. The approach has provided for flexible, short-term support and rapid response to requests; has assisted individual missions and been responsive to regional bureau strategies; has ensured a considerable degree of coordination for training activities worldwide; has filled the gap in places where there are few bilateral population programs; has provided relevant training expertise at the headquarters level for project direction and monitoring; has provided a better opportunity to work with the private sector than might be available under bilateral agreements; has provided a critical mass of people who are concentrating on improving PAC training; and has fostered regional and interregional exchanges between PAC trainers from two or more countries.

PAC training is still needed in all the currently designated regions. Asia and the LAC regions are generally more advanced in family planning and have relatively high contraceptive prevalence. Prevalence has been accomplished in some countries in these regions, however, primarily through the use of sterilization. In these cases, more and better trained PAC workers will be required to balance programs by providing more and better temporary contraceptive services. Also, even in Asia and LAC, there are countries or areas within countries that are only beginning to provide family planning services.

In addition, it is desirable for the PAC II contractors to have some continuing involvement with the more advanced, less needy countries. These countries can contribute to PAC training in less developed locales by participating in international courses, networking, and serving as test sites for new approaches to improve PAC training and service delivery.

6.2 Regional Contractors or a Worldwide Contractor?

The advantage of the current situation, with different contractors operating in different parts of the world, includes the contractors' long experience in particular geographical areas, their different approaches and the potential for learning from each other, and the spirit of competition to match or outperform each other that is fostered. Implementation of the project through a single contractor, however, might also offer some advantages. The use of a single contractor would reduce overhead costs and provide opportunities to specialize in substantive areas, to gather extensive data on specific issues, and to implement interregional communication/exchange.

Chapter VII provides of a list of 19 recommendations for the PAC II project.

I. INTRODUCTION

This report reviews the first 2-1/2 years of a 10-year family planning training project for paramedical, auxiliary and community (PAC) personnel. PAC II, approved in 1984, is a worldwide project.¹ The purpose of the project is to strengthen or develop the capacity of less developed country (LDC) institutions and agencies to design, implement and evaluate PAC training programs and thus enable PAC workers to provide safe, culturally acceptable family planning services. The report recommends changes of emphasis within the project to make the training of PAC workers more effective.

The report is based on data gathered during the mid-term evaluation of the three contractors carrying out the project--Development Associates, Inc. (DA), for the Latin America and Caribbean (LAC) region; Program for International Training in Health (INTRAH), for the Africa and Asia regions; and RONCO Consulting Corporation, for the Near East and North Africa (NENA) region. The evaluation was carried out during the second and third quarters of 1987. Visits to contractor headquarters and to selected countries were made by four teams of evaluators. Summaries of these evaluations are found in Appendix A. The reports are available at the Population Technical Assistance Project office of the International Science and Technology Institute, Inc.

I.1 Scope of Work

The scope of work for the evaluation of the PAC II project is found in Appendix B. During the briefing session for the preparation of the PAC II review, Office of Population staff provided guidance on issues to be included in the report. The main questions to be addressed in the assessment were the following:

- What has been the impact of the project so far?
- Are the purpose and objectives of the project still appropriate?
- Is the project's strategy appropriate to meet the objectives?
- Is there a continuing need for PAC training assistance in each of the geographic regions? If so, what kinds of assistance are needed, and do

¹PAC I, a five-year project (1979-84) for the training of paramedical workers in family planning, focused on organizing and conducting training courses for large numbers of PAC workers in LDCs.

- the needs vary for each region?
- Are changes in the project design necessary, and if so, what new activities/directions should be pursued?

I.2 Methodology

The leaders of each of the four contract evaluation teams, Patricia Baldi, Robert Blomberg, Carolyn Long, John McWilliam, Judith Rooks and Sheila Ward, met for four days in Washington, D.C., in late October 1987 to review the findings of the contract evaluations and the PAC II project paper. Each issue in the scope of work was discussed and a consensus was reached, which forms the body of this assessment.

II. IMPACT OF PAC II

Measuring the impact of a 10-year project after only 2-1/2 years of implementation is very difficult. Significant impact may only be ascertained after the project has been completed. The data presented in this chapter, therefore, should be viewed as only preliminary indicators of the progress being made in the project. The discussion addresses the impact measures stipulated in the project paper.

- o Less developed countries (LDC) participating in the project will have increased numbers of PAC personnel delivering more kinds of services than before.

Worldwide, PAC II training has prepared many types of workers to provide a wide variety of services. These workers come from both government and private institutions and represent both family planning and integrated maternal and child health (MCH) service programs. PAC training in Africa has focused primarily on professional- and auxiliary-level nurses and midwives who deliver a variety of temporary family planning methods, including IUDs, in government-supported, clinic-based integrated family planning/MCH services. PAC II assistance in LAC has emphasized training of community-based distribution (CBD) workers, who provide mainly pills, condoms and vaginal barrier methods. Several kinds of community-based workers have been trained in Asia, including family planning village volunteers, CBD workers, and traditional birth attendants (TBA) and medical practitioners. Training in NENA has supported improvements in both clinical and community-based family planning service delivery by training supervisory midwives and community-level workers. Training to support natural family planning (NFP) methods has also been provided, and all programs emphasize training in counseling and patient-education skills to promote informed choice.

PAC contractors in LAC and Asia have already assisted in training more people than the numbers expected by the end of their five-year contracts. The PAC contractor for Africa is on target for its work there. The contractor for the NENA region, however, has trained fewer personnel than were expected by this time, perhaps because an entirely new unit had to be developed to implement the contract (see Appendix C).

- o Training institutions will be able to maintain programs with decreased project support.

PAC contractors responsible for LAC and Asia are working primarily with mature institutions that are capable of technical and, in some cases, financial self-sufficiency. More mature training units use external inputs very efficiently; relatively small PAC contractor efforts result in large

improvements in performance, and the changes are integrated into competent, ongoing training programs that produce lasting results. PAC contractors responsible for Africa and NENA, on the other hand, are working with institutions in the nascent stages and therefore require more intensive groundwork.

NENA countries that were not involved in the PAC I project need to develop a base of trained PAC workers and an adequate service base before they can fully benefit from the institution-strengthening emphasis of PAC II. Some programs in Tunisia and Turkey, however, are already at the point where they should be able to continue some training activities independently or with declining technical support.

In Africa, progress has been slower. Only a small number of Nigerian states, those which have received intensive attention and a significant proportion of resources under PAC II, and the country of Zimbabwe, which has a long history of family planning program assistance, are capable of maintaining PAC II training programs with decreasing levels of technical assistance (TA). More commonly in Africa, PAC training has found little to build on: There is often no institutional base, few or no nurses with family planning experience and skills, inadequate numbers of clients to provide necessary clinical experience for trainees, and weak to nonexistent policy-level support. A lot of necessary foundation-laying work has been accomplished since the start of PAC I, and a genuine demand for family planning services is building within African communities.

- o National nursing/midwifery/auxiliary pre-service curricula will be revised to include family planning.

No efforts to develop pre-service curricula have been made by PAC II contractors in Asia or NENA, and in Latin America this activity has yielded few results. The only appreciable achievements in this area have been in Africa, where family planning units are being prepared for the pre-service curricula of nursing/midwifery schools in at least two countries, and pre-service tutors are included in most of the in-country training teams. A new family planning unit is now ready to be implemented in 100 basic nursing schools in Zaire.

- o Roles and responsibilities of non-physician family planning service providers will receive official recognition.

Although the majority of family planning providers are nurses, midwives and other PAC workers, there is little recognition of their important role in family planning through status or remuneration. By focusing the attention of PAC contractors on non-physician family planning service providers, progress is being made in enhancing the status of PAC workers

and, in some cases, in obtaining more host government funds for their training. Although the examples below illustrate this progress, more needs to be done.

- In Turkey, the system of community networks being developed by the MOH will involve teachers, agents of the Ministry of Agriculture and village religious leaders, all of whom are expected to support the midwife's role in family planning at the local level.
- In Jordan, where family planning is just being accepted by the government, the PAC contractor has used the training of PAC workers to enhance their status in the medical community. Jordanian nurses and physicians are being trained together in the same workshops for the first time. Doctors participating in the course are receiving some instruction from a nurse.
- In Mexico, the head of the government family planning program attends the ceremony at which CBD workers receive their certificates.
- In Brazil, the PAC contractor has helped a group of family planning nurse practitioners start their own professional organization, an effort that should lead to greater recognition and acceptance of their role.
- In Sri Lanka, male village community leaders have given their approval to the female community leaders who are educating village women about family planning.
- In Nepal, the PAC contractor has given the MOH's Division of Nursing (DON) responsibility for managing the money for its TBA training project. The central staff of the DON has delegated some of that responsibility to district public health nurses and the auxiliary nurse-midwives who teach and supervise TBAs at local health posts. This is the first time nurses have had authority for project funds; they have handled the responsibility well, thereby gaining respect in the eyes of their non-nurse supervisors at the local level.
- The decision to train nurse/physician teams at the regional clinical skills course in the Philippines contributes to recognition of the importance of nurses and midwives, as well as physicians, in providing family planning services.
- In the Nigerian states of Benue, Kwara and Lagos, progress is being made to include family planning training for nurses and midwives within official state plans and budgets.

o **Contraceptive prevalence rates (CPR) will improve.**

Because PAC training is a necessary but not sufficient input to increase contraceptive prevalence, achievement of this goal is hard to assess. PAC contractors often target and pace their projects to correspond with larger family planning program plans, but in most cases it is not possible to determine which of many inputs and improvements are most responsible for increasing contraceptive use.

Nevertheless, service data collected by community workers trained through PAC II-supported programs in Asia document their effectiveness. Village volunteers in Sri Lanka, for example, raised contraceptive prevalence among the families they served from less than 20 percent to more than 70 percent over a two-year period. Traditional medical practitioners in Nepal are selling condoms and pills in villages that have no access to other sources of family planning supplies, and trained Nepali TBAs are referring women to family planning clinics.

Although still low, contraceptive prevalence rates in Africa are increasing and enrolled community nurses trained by the PAC contractor in East Africa are beginning to keep service statistics.

A study conducted by an organization with which a PAC contractor works in Mexico documents increases in contraceptive use associated with every increment of training (i.e., "retraining") of CBD workers. A related finding was that more than 70 percent of the family planning users enrolled by PAC contractor-trained CBD workers were women using a family planning method for the first time.

o **Access to family planning services will increase in rural areas.**

The PAC contractor's ability to increase family planning services for rural people in Africa is tied to the ability of government MOHs to provide basic health services beyond the cities and towns. This is limited in many countries, so that PAC impact in most rural areas of Africa is probably quite low. In Asia, however, all of the PAC contractor's work has been directed at PAC workers who are based in rural communities. In time, some of the successful project ideas from Asia will be transferred to PAC training projects in Africa.

The PAC contractor's work in LAC is targeted at training CBD workers in both urban and rural communities. The community network supported by the PAC contractor in Turkey is designed to assist the family planning work of rural midwives.

III. PAC II PROJECT DESIGN

III.1 Summary

PAC II was designed as a centrally funded worldwide project with implementation through region-specific contracts. Four separate but interrelated contract competitions were conducted--one each for Africa, Asia, the LAC region and the NENA region. The same contractor won the contracts for both Africa and Asia, so there are only three, instead of four, regional contractors.

Whereas the PAC I project focused on training large numbers of PAC workers, PAC II emphasizes assisting "the LDC institutions themselves to develop the capability to carry on effective, self-sustaining family planning training programs for PAC workers." Although PAC II continues to provide family planning training for many categories of workers, the project paper places particular emphasis on improving the skills of those who train, manage or supervise other PAC personnel. The project is intended both to alleviate shortages of PAC workers and to strengthen the management and skills-training capacity of local training organizations.

III.2 Purpose

The purpose of the project as set forth in the project paper is "to strengthen or develop the capacity of LDC institutions and agencies to design, implement and evaluate training programs for PAC workers, and thus to enable the workers to provide safe, culturally acceptable family planning services." To carry out this purpose, the project paper indicated the project should focus on two types of training:

--Pre-service training to schools of nursing, midwifery and auxiliaries to emphasize development of family planning curriculum and integration of family planning into current curricula.

--In-service training to develop or strengthen new or existing in-service family planning training institutions or programs for nurses, midwives, auxiliaries and community workers who are already providing services.

III.3 Output Elements

Four output elements were set forth in the project paper and can be summarized as follows:

1. In-country training institutions, both private and governmental, which will have added family planning content or strengthened existing family planning content in their training programs for PAC workers.
2. Regional training institutions, which will be able to provide TA and training in response to country and regional training needs.
3. Trainees, including PAC workers and the people who supervise them and/or manage the programs in which they work, who will be trained in various content and skill areas. Trainers and managers/supervisors will receive priority.
4. Short-term TA visits, which will be made in response to specific requests and needs.

Thirteen quantifiable outputs, which arise from the four output elements, are required of each contractor (see Appendix C).

III.4 Types of Assistance

Five types of assistance were called for in the project paper to achieve the project objectives and purpose:

1. Working with training institutions to strengthen their ability to design, conduct and evaluate family planning training programs for PAC workers.
Each contract specified the percentage of effort that should go into developing regional, as compared with in-country, institutions; i.e., 20 percent of the contractor's resources for Africa were designated for developing regional training capability, 50 percent of the contractor's resources for NENA, 65 percent of the contractor's resources for LAC, and 70 percent of the contractor's resources for Asia.
2. Direct training, i.e., conducted by contractor staff or consultants.
3. U.S.- and third-country training for limited numbers of selected individuals.
The anticipated numbers of people to be sent for U.S. training during the five-year contracts were 200 from Africa, 36 from NENA, 36 from LAC and 20 from Asia. The purpose was to provide mid- and high-level managers, supervisors, trainers and policy makers with training that was not available in their own countries.

4. Short-term TA to respond to requests from the USAID missions, host country governments, or other family planning organizations for assistance to meet specific needs, including requests for technical input to facilitate implementation of non-PAC-funded projects, such as bilateral projects.
5. Evaluation of training, including evaluation of individual trainees, of every individual training activity, and of the entire program of training activities conducted in each country.
In addition to evaluating training activities conducted directly through the project, the contractors were expected to follow up and systematically evaluate the results obtained in "second-generation training," i.e., training conducted by trainers prepared through contractor activities. The project paper and contracts called for the three PAC contractors and A.I.D. to work together to develop and agree upon common evaluation questions, criteria and reporting forms to be used by all contractors so that comparable data could be collected.

III.5 Content Areas

The project emphasized training in four content areas: management and supervision, training of trainers (TOT), service delivery skills, and pre-service curriculum and instruction.

III.6 Contract Objectives

The overall project design has provided a very flexible framework within which contractors have been able to implement PAC training activities. As can be seen from the translation of project purpose, outcomes and activities to contract objectives (see Table 1), there were considerable differences among the contractors in regard to the objectives they set forth. Only two objectives were common to all three contractors--national institutional development and regional institutional development.

Table 1 - OBJECTIVES OF PAC II PROJECT AND PAC II CONTACTS

Type and Source	INTRAH	DA	RONCO
1. National Institutions (Purpose, Output 1 and Type of Assistance 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.	Increase the training capabilities of LAC institutions and agencies in the area of family planning training for PAC workers by identifying and utilizing effective strategies.	The number of in-country institutions with the capability to effectively plan, implement and evaluate family planning training projects including the coordination of all training cycle inputs in support of training will increase.
2. Regional Institutions (Purpose, Output 2 and Type of Assistance 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.	Achieve technical capability in four content areas: management and supervision, Training of Trainers, service delivery skills and pre-service curriculum and instruction so that existing LAC training institutions can maintain training programs with minimal additional technical support.	The number of regional training institutions able to design and support family planning training projects (through technical assistance, financial support, consultation and advice services) will increase.
3. National Institutions Pre- and In-Service (part of purpose)		Substantially increase the number of pre-service institutions which offer high-quality family planning instruction to their students.	A number of national pre- and in-service training curricula will be revised to include an adequate family planning component.
4. Focus on variety of PAC workers and skill areas (output 3)	Provision of encouragement and appropriate assistance to participating host country family planning programs' efforts to adopt innovations in the training, development and support of a wide variety of professional, paraprofessional and traditional categories of personnel to enhance the planning, management, delivery	Within the technical framework of this contract, expand the number of trained PAC workers able to provide family planning services.	A number of family planning service providers will provide increased and improved services.

Type and Source

INTRAH

DA

RONCO

Priority on supervisors (Output 3 and Type of Assistance 3)

A number of mid- and upper-level supervisors and managers will more effectively manage and/or coordinate the different components of family planning service delivery (including provision of services, training, logistics, IEC activities, etc.).

5. Other sources of training (Type of Assistance 3)

Supplement institutional development at the regional and in-country level with selective direct, U.S., third country and inter-regional training activities.

6. Evaluation (Type of Assistance 5)

(See (4) above)

Evaluate PAC training activities at all levels to accurately assess the impact of the expenditure of PAC training funds and identify efficient cost effective strategies for training all levels of PAC workers.

Effective evaluation strategies and a comprehensive database for formative and summative evaluation purposes will be developed and or applied to all training efforts at every level (overall program, training project, training activity and training session).

7. Networking (not specifically called for in for project paper)

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.

Several regional and national or provincial networks for the exchange and diffusion of experiences, models and innovations in the training of family planning/PAC personnel will be developed, supported and sustained.

8. Targeting policy makers (not specifically called for in project paper)

A number of policy makers in the region will more effectively promote and support family planning training (through better understanding of both its role and the link between training and service delivery) as a result of program efforts.

IV. APPROPRIATENESS OF PURPOSE AND OUTPUTS OF THE PROJECT

IV.1 Purpose

IV.1.1 Summary Analysis

The project purpose is based on two underlying premises: (1) that nurses, midwives, and other PAC workers are appropriate groups to train and (2) that training capability for these categories of workers should be institutionalized.

The following section (Section IV.1.2) will explore whether PAC workers will continue to be an appropriate target group. The issue of institutional development will be discussed in the section after that (Section IV.2.1), in the context of project outputs.

Training of PAC workers will continue to merit attention for three reasons: (1) PAC workers are essential if temporary family planning methods are to be made widely available within family planning programs; (2) training is essential if PAC workers are to perform adequately; and (3) training of large numbers is justified because the impact of PAC workers depends on their widespread availability. These reasons are explored below.

IV.1.2 PAC Worker Role in Provision of Temporary Methods of Family Planning

Nurses, midwives, and auxiliary and community workers are the major providers of temporary methods of contraception for people throughout the world. This is even true in the United States, where nurse-midwives and nurse-practitioners serve 9 out of 10 clients in organized family planning programs. Although oral contraceptives and IUDs were first provided only by physicians, nurses were soon trained in many countries to provide these methods. Later it was shown that community workers could screen women for contraindications to oral contraceptives. Because of their social and cultural similarity to the people they serve, community workers are particularly effective as family planning counselors and can play a vital role in community-based distribution of vaginal methods, condoms and pills. The new, longer-lasting, temporary method, the subdermal hormonal implant, will provide new roles for PAC workers. At first, they will be important in providing counsel and support to users of this method; later, nurses can be trained in insertion and removal. Even condoms, breastfeeding and abstinence can be used more effectively if the community health advisors (ranging from TBAs and primary health care [PHC] workers to nurse-midwives and physicians) accept the need for family planning and

understand how these methods work. Social marketing also relies on trained community workers--in this case, pharmacists or other contraceptive salespeople. In short, it is evident that PAC workers will be needed if temporary methods are going to be used and form a major part of national family planning programs.

The corollary question is whether A.I.D. will continue to support provision of temporary methods. Here, too, the answer is certainly yes. First, the inclusion of temporary methods is an essential ingredient of A.I.D.'s policy of informed choice; only temporary methods offer the means to space children. Second, in order to delay the first pregnancy which is becoming an important need in some developing countries, temporary contraception is needed. Third, family planning programs that offer a variety of methods, both permanent and temporary, can enroll more clients than programs that offer only one or a very limited number of methods.

IV.1.3 Need for Training

There are three justifications for training PAC workers: (1) a complex of knowledge, attitudes and skills needed to deliver family planning services must be learned, (2) well-trained PAC workers do a better job of increasing contraceptive prevalence than those who have not been trained, and (3) PAC workers must be informed of all family planning methods if they are to provide services or counseling to ensure that clients have an informed choice of the contraceptive options available to them. These three justifications are discussed below.

- o Complexity of knowledge, attitudes and skills to be learned

It is not easy to learn how to be an effective family planning service provider. Even the least trained community worker has to learn considerably more than how to use a checklist to screen women for contraindications and how to instruct them in the use of condoms and pills.

Part of the job, of course, requires technical knowledge of the various contraceptive methods: how they work, how to administer or use them, their advantages, side effects and complications, and who are the right candidates for the various methods. In addition, however, it may require the ability to make important decisions--for instance, how to distinguish between side effects and early signs of serious complications--often without experience or the backup of someone who knows more.

Far more difficult--and equally important--the PAC worker must learn how to take on a new role. This role requires communication skills and includes purposeful interviewing, active

listening, problem solving through counseling, providing reassurance and support, transmitting knowledge and skills to others, and assessing whether the other person understands what to do. The new role requires a respect for the learning level of the client and interactive discussion on what is best for an individual.

PAC workers must also provide some services and make some decisions that were previously reserved for physicians. This requires confidence as well as knowledge and skill.

Finally, it may require an attitudinal change on the part of the provider, especially when family planning is a new concept that is not well accepted within the local social milieu. Family planning service providers, to be effective, must believe that child spacing and limitation of family size is good for themselves and other families in their culture and that the methods they provide are appropriate and safe.

o Increase in contraceptive use as a direct result of effective performance

Research has shown that good PAC worker performance increases acceptance and continuation of contraception use, and that poor PAC performance results in less effective services. These studies consistently identify communication skill, including both a positive attitude and the ability to convey correct information, as a key ingredient of good worker performance.

Examples of the negative effects of poor counseling are more plentiful than examples of the positive effects of good counseling. Both kinds of examples, however, show that if a project is to achieve its planned targets relating to increasing acceptor and contraceptive prevalence rates, it is important to ensure that PAC workers are well skilled in working with the population groups they must affect.²

o Informed Choice

The number of contraceptive options is growing and there is a need for the family planning provider to be taught the various options available to clients, the advantages and disadvantages of each method, the side effects, if any, and where clients can obtain the contraceptive method of their choice.

²See Appendix D for examples of some of the research undertaken.

IV.1.4 Need for Large Numbers of Widely Distributed Workers

Unlike sterilization, a one-time procedure with limited need for follow-up, temporary methods of contraception require periodic contact between the user and the person who not only supplies the contraceptive products, but also screens for problems and provides counseling, reassurance and advice. Even the IUD, which works for several years and needs minimal active involvement on the part of the user, still requires that users have access to trained health or family planning workers who know about IUDs, realize the significance of the signs and symptoms of serious IUD complications, can distinguish between innocuous side effects and serious complications, and can reassure women who are experiencing the former and refer or treat those with major complications. The need for users of temporary family planning methods to have access to a knowledgeable and supportive family planning worker means that trained PAC workers should be widely and conveniently distributed throughout LDC societies. Social factors, such as tribal identification or ethnic group, also need to be taken into account; e.g., studies have shown that people are most likely to accept family planning advice from someone who is socially similar to themselves.

Societies in which family planning is available from many sources (village volunteers, retail sales, PHC workers, employment-based health care programs, government clinics, private clinics, TBAs and private physicians) can meet the family planning needs of a far greater proportion of people than those in which only one or two types of family planning workers are available.

IV.2 Output Elements

IV.2.1 National Institutional Development

IV.2.1.1 Summary. The supposition underlying the evolution from PAC I to PAC II--i.e., that A.I.D. should be assisting host countries to train PAC workers rather than providing direct training--was valid in 1984, when the project was developed, and is still valid today. Building national institutional capacity is necessary to multiply the effects of external assistance and to create changes that will persist after aid is withdrawn.

What has been learned over the past three years is how difficult it is to achieve this objective. The PAC II project paper had estimated that about four years of effort would be required to strengthen a PAC training institution in Africa, three years in NEHA, two to three years in Asia and about two years for institutions in the IAC region. This was clearly an underestimate. Experience under PAC II suggests that 3 years is

the minimal time span necessary and that 10 years may not be an unrealistic expectation for many institutions. Even in the LAC region, where institutions are relatively mature, constant turnover of trained people implies the need for extended involvement. Several "generations" of trainers and managers may have to be trained before changes become part of the continuing ethos, identity and standards of the institution, rather than their being associated with only one or two particular individuals. Particularly in Africa, the prospect of institutionalization in the near future is remote. Not only are family planning policies and service delivery at a nascent stage, most family planning services are being delivered through Ministries of Health (MOH), which, given their lack of autonomy as organizations, do not lend themselves easily to institutional development efforts.

One reason for A.I.D.'s underestimate of the time needed to achieve the project purpose may have been that it did not spell out in the project paper what it meant by institutional capacity. Nowhere in the documentation is there an analysis of the various steps that must be taken before an institution can operate without external assistance. Moreover, a distinction needs to be made between strengthening national training capacity and strengthening national training institutions. The terms are used interchangeably in the project paper, and the PAC II contractors have provided assistance to both types of activity. Strengthening national training capacity, however, is a much broader concept, placing more emphasis on strengthening the training system of a country than on strengthening one institution. It may therefore require an approach to technical assistance different from that traditionally used in strengthening an institution, and it may take a significantly longer period to accomplish.

IV.2.1.2 Defining National Institutional Development.

As stated above, PAC contractors seem to be pursuing two types of institutional development. One focuses on activities to strengthen national training institutions for PAC workers, and the other focuses on creating a training system within countries.

In Latin America and Asia, some training institutions have been established, and here, the role of the PAC II contractor should be to provide TA for the specific needs of these institutions.

In Africa, where PAC training is usually implemented through MOHs, the contractor is instead putting in place a set of the building blocks that together can function in each country as a training system. There are a considerable number of these building blocks that need to be in place before a country can be considered to have reached an acceptable level of technical self-sufficiency in training. They include such activities as

- o Training of a cadre of local trainers. This means that TOT does not end with the production of a core group of 10-12 trainers from which 2-3 proficient trainers emerge, but continues until enough fully-skilled trainers are produced in each country to implement the country's training plan.
- o TA to a small group of trainers in each country on how to develop a training plan, which would include training needs assessments, development of a training strategy, design of training events and a follow-up system, production of materials, logistical support and evaluation.
- o Identification and training of a small group of trainers in curriculum development and preparation of materials.
- o Development of rational selection criteria to be used by ministries in choosing trainees.
- o Sensitization of leadership, including RAPID presentations for high-level government officials, and systematic orientation of managers and supervisors of family planning service providers.
- o Development of an appropriate training management system, which would include logistical and material support, transportation, finances, selection of training sites and practicum sites.
- o Training of preceptors, who supervise and advise trainees during their on-site practicums.
- o Development of appropriate evaluation tools to enable assessment of training events and necessary adaptation and refinement of training approaches.
- o Institutional budget line items to at least partially support training efforts.

Although the approach of developing a training system is sound for the short term, over the long run a training system must be housed in some type of institution. Many institutions are possible: 1) family planning training efforts might be based at a school of nursing or an International Planned Parenthood Federation (IPPF) affiliate; 2) within a MOH, perhaps in the PHC subsection of the MCH division of an MOH; or 3) with a national training team whose members are employed in several organizations.

Each of these institutions has its advantages and disadvantages.

Basing in-service training efforts at a school of nursing could serve to make the pre-service teaching faculty aware of the need to include family planning within the pre-service curriculum. Moreover, the experiential training methods used in in-service training could be adopted for courses at the pre-service level. Housing training efforts at an IPPF affiliate could enhance its institutional development efforts.

Housing training efforts in a MOH might have favorable results if there were a strong national family planning policy and the ministry had political support. Most ministries of health, however, are vulnerable to external political decision making, national budget decisions, frequent transfers of civil servants, and a general lack of autonomy to function as independent organizations. Housing family planning training within the PHC subsection of the MCH division of a MOH is an option that deserves careful consideration. Such integration would facilitate the trend toward client-centered service and would help legitimize the training capacity of the ministry. This is particularly important because training is always a vulnerable area when ministries are faced with budget constraints.

Finally, increasing the training capacity of a national training team whose members are employed in a variety of institutions might lead eventually to development of the institutions that employ those individuals.

Recommendation

1. National institutional development for family planning training should remain the primary focus of the project. A distinction should be made between strengthening the national training capacity and strengthening specific national training institutions. A.I.D. should provide guidance on a country-by-country basis in the approach to institutional development that should be followed.

IV.2.1.3 Special Issues

IV.2.1.3.1 Summary. The following discussion focuses on three special issues that have arisen in the course of implementing PAC II. In each case the question is where should programming emphasis be placed: (1) on pre- or on in-service training? (2) on training of clinic-based providers or on training for CBD providers? and (3) on programs that provide free-standing family planning services or those that integrate services into primary health care (PHC) training? Although a

clear choice can be and is made in all three areas, it is important to remember that any such programming decision based upon these issues should be made in the context of two broader principles: (1) variety among services and providers is essential to the effectiveness of these services and (2) using different institutions may offer an opportunity to experiment and learn what kind of service is preferable in a particular circumstance.

IV.2.1.3.2 Pre-Service or In-Service Training for Nursing Personnel. The project paper calls for both in-service and pre-service training for nurses, nurse-midwives and auxiliaries (hereafter referred to as "nursing personnel"). To date, emphasis has gone to in-service training. This is appropriate; PAC II contracts should de-emphasize pre-service training.

There are several reasons that little attention has been given to pre-service training. The opportunities have been quite limited. In Africa and Brazil, where nurses and midwives are the major strength of the health care system, PAC II training has been provided. Elsewhere in LAC and in some countries in Asia and the NENA region, however, there are more physicians than nursing personnel. The nursing personnel are so heavily involved in hospital care, plus management and supervision of services, that they rarely provide direct patient care in preventive services.

Even in Africa, however, where nurses and midwives are the major family planning service providers, it is probably not reasonable or efficient to try to provide actual service delivery skills, especially IUD insertions, during pre-service nursing education. Of the many pre-service students, only a small percentage will ever work in family planning service settings, and of these, fewer yet may work in locations where the demand is substantial for clinical methods (IUDs). In addition, any specific skills acquired during pre-service training may erode between skill acquisition and placement in an actual family planning service position. Skills not used are lost, and the training is wasted.

Part of the problem in the implementation of family planning training for nursing personnel is that the PAC II contractors did not undertake adequate training needs assessments that spelled out the multiple aspects of the role of any given group of nursing personnel. Instead, they have more or less added an overview of family planning and some clinical service delivery skills to a curriculum that is basically dealing with curative care.

Increasingly, the role of nursing personnel has broadened. With the advent of the PHC approach (see section

IV.2.1.3.4), it may include not only MCH/family planning responsibilities but also administration, supervision, environmental sanitation, school health, mental health, training, community organization and even transport and vehicle maintenance. Many of these skills are not now provided in pre-service training and it is unlikely that they can or should be. In general, the governing principle should be that, at best, pre-service family planning training can only provide a knowledge base, but cannot provide adequate skills to deliver services. This training must occur in-service.

Experience under PAC II has also shown that quite different program strategies are needed to carry out pre- and in-service training. In particular, pre-service training changes frequently require formal negotiation with nursing boards, while there is more freedom for agencies that provide services to develop their own in-service courses.

Focusing PAC II efforts on pre-service training for auxiliary nurse-midwives (ANM) is also questionable at this time. Although ANMs occupy key positions in the health care strategies of many countries, they are often the weak link. They tend to be young, unmarried and inexperienced. They often come from locations other than where they are posted, a situation that does not meet their social needs or help them gain the acceptance and respect from local people that is needed for them to perform effectively. Moreover, they are not well enough trained to work without firm supervision. Thus, they lack not only the better training of professional nurses but also the community roots and acceptance of less trained workers, such as TBAs. There is a limit to the amount of family planning skills training that can be included in an 18-24 month pre-service program whose graduates are expected to perform a wide range of health service functions with limited backup and supervision. Their direct supervisor is usually a male health worker who provides curative care and knows less than they do about family planning. Typically, ANMs have to rely on a centrally located public health nurse (PHN) for technical supervision, of which they do not receive nearly enough.

Some countries, particularly in the Asia region, have begun to reassess their reliance on ANMs: Nepal is going to stop training this cadre because they do not stay in rural areas once they are trained, and Thailand plans to provide additional training to qualify them as professional nurse-midwives. On the other hand, auxiliary-level workers are still important in many countries.

In sum, the emphasis on encouraging and assisting pre-service nursing, midwifery and auxiliary health worker schools to integrate family planning into their curricula will not reduce the need for continuing in-service training. In-service family planning training will be necessary for nursing, midwifery and auxiliary health workers to provide family planning services.

Recommendation

2. PAC II resources should be concentrated primarily on in-service training of nurses, midwives and other PAC workers.

IV.2.1.3.3 Clinic-based or CBD. Neither the project paper nor the contract scope of work included specific guidance on whether the prime targets of training should be clinic-based personnel or CBD workers. A look at the results expected from the contract, however, suggests that both types of training were anticipated: Revision of pre-service curriculum for nursing/midwife/auxiliary personnel would provide more clinic-based personnel, whereas increase of access to family planning services in rural areas implies an increase in CBD workers (see sections II.3 and II.7).

In Latin America, the necessity to program primarily with private sector organizations has had profound implications with regard to the kinds of programming with which the PAC contractor has become involved. Private sector providers in Latin America rely extensively on community-based distributors, village or barrio volunteers to provide services. Although many thousands of these CBD workers are already in place, many more are needed.

Governments, on the other hand, are frequently the principal providers of clinical services, and because of the difficulty of becoming involved with government programs in Latin America, (due in part to the major role played by another donor in supporting the training of government health workers), the PAC contractor has had relatively less involvement with clinical programs. In addition, clinical training is far more time consuming and costly than CBD training. In Latin America, clinical training generally focuses on providing services that cannot be provided by CBD workers, such as IUD insertion.

The PAC contractor's approach to the Africa region is very different. There, the contractor has worked mainly with ministries of health in providing clinical training. This is due, in part, to the lack of private health sector development in some countries and to the vital need to assist the public sector programs that are just being put in place.

The PAC contractor for Africa expects that CBD programs will soon begin to be established and has, therefore, taken the initiative to introduce family planning policy makers, managers and PAC trainers to CBD programs through observation/study tours. The successful experience of the Asia region in CBD programs is being transferred by this interregional exchange.

Recommendation

3. In Africa, particularly, more emphasis should be given to training for CBD. Family planning training target groups should include TBAs, community health workers and PHC workers. In countries with no CBD programs, observation/study tours of CBD programs should continue to be conducted for family planning policy makers, managers and PAC trainers to prepare them for CBD program implementation.

IV.2.1.3.4 Family Planning and PHC. A continuing issue in family planning is the relative effectiveness of free-standing as compared with integrated service delivery in which various aspects of basic health care are integrated at the community level. The project paper laid the groundwork for involvement in integrated programs with its statement that the contractors could use "host government's MCH training program for PAC workers ... as a base for in-country family planning training." This presumably would be the case where "family planning service providers work within an integrated system of maternal/child health and family planning." The opportunities are growing for involvement in integrated programs. Many LDCs and international donors have committed themselves to the PHC approach. Significant strides have been made in some countries since the approach was first enunciated. As part of this effort, PHC programs in some countries are attempting to integrate family planning into their training and service delivery.

The growth of PHC represents an opportunity for family planning. With significant funds from governments and donors going into PHC, family planning training and services may now be attached to other health interventions, thus potentially reducing the cost for the family planning training component. Such integration would stretch available resources and would also represent an appropriate and holistic response to client health needs.

Becoming involved in PHC programs, however, poses a number of risks for family planning service provision. Program planners must be cognizant of the potential difficulties. The PHC and MCH/FP components of ministries of health are not always in the same unit and may not interact well. The family planning component of pre-service curricula for PHC may also be weak; in particular it may lack a clearly enunciated description of the knowledge, attitudes and skills related to family planning that PHC workers must have to fulfill their roles. Moreover, full-scale PHC programs are much more difficult to organize and administer than are unipurpose family planning programs. The workers are expected to learn how to perform a great number of tasks, with the result that they may not learn all skills fully. Finally, the logistical systems needed to supply the workers with

the commodities required for the provision of PHC are difficult to establish and maintain, particularly in those LDCs where such services are most vitally needed.

Recommendation

4. In countries where PHC is being pursued, ways to incorporate family planning content into the training of PHC workers should be investigated. Special attention should be given to curricula and materials development for PHC workers to ensure that they develop the attitudes, knowledge and skills necessary for their role in the provision of family planning services.

IV.2.2 Targets and Content of Training

IV.2.2.1 Training Targets. The priority accorded to trainers and managers in the project paper was certainly appropriate in the context of institutional development. The need to train trainers is indisputable, given that the overall purpose of the PAC II project is to develop and strengthen programs to train PAC workers. In addition to trainers, the PAC contractors have given significant emphasis to training and other inputs to strengthen supervision of PAC workers. In Asia and the LAC region, the PAC II contractors aimed their TOT efforts at supervisors of community workers through well-designed projects that combine the roles of trainer and supervisor in an efficient way. In Africa, as the PAC II contractor's program evolved, it began to include routine supervisor training.

Recommendation

5. The emphasis given in the project paper to the training of trainers, supervisors and managers was well founded and additional efforts should be made by the contractors to reach this priority group.

IV.2.2.2 Training Content.

IV.2.2.2.1 TOT A major weakness among all PAC II contractors has been their inattention to developing quality indicators for training. Seldom do the objectives for individual training events or the pre-tests given trainees reflect a clear notion of the level of skills and knowledge needed by trainees to carry out their tasks. Although this has been true for all types of training, it has perhaps been most obvious in the area of training of trainers (TOT). Nowhere in PAC II documentation does a definition exist of a trained trainer. The result has been a

somewhat unsystematic approach to TOT, which reflects a lack of agreement on what PAC trainers need to be able to do. The PAC II contractors need a common definition of a trained trainer to be able to collaborate more fully in the training of this cadre.

PAC II TOT has generally attempted to include too much material in too little time. It usually starts with the scientific and technical information on family planning and manual skills normally associated with PAC training, and adds a heavy infusion of newer, participant-active training methods, plus some training methodology, curriculum development, training needs assessment and evaluation. In some areas TOT is moving toward introducing "competency based" training, in which the learning objectives and training content are determined by analysis of the attitudes, knowledge and skills necessary to perform the tasks that constitute the trainee's specific job(s).

Long as it is, this list of topics is considered by some as too short to provide adequate TOT. Examples of other issues thought desirable are training in how to change attitudes and in how to teach complex but essential communication and decision-making skills; an introduction to operations research findings on family planning service provision; instruction on the development of materials to support training; training in teaching methods; and an introduction to principles and practices of supervision.

Experience with PAC II contractors in Africa and NENA has shown that only a limited number of trained trainers became genuinely proficient in the use of participatory methods. Competency-based training has rarely been used in individual training events, partly because of lack of time and partly because of lack of adequate training in needs assessment. Likewise, trainers have not received sufficient preparation to develop new curricula or adapt current materials to meet changing needs. In short, this experience suggests that by giving everyone a little of everything, resources have been diluted and that overall, the expected time frame for developing institutionalized training capacity is usually not realistic. The most important lesson in this regard is that development and refinement of skills of trainers takes time and must be reinforced by ongoing support and feedback. With about seven years remaining in the project, however, there will be time for the development and refinement of skills needed by trainers.

Recommendation

6. In the Africa and NENA regions, more attention should be paid to devising methods to enhance the skills of existing trainers and to provide them with the ongoing support and resources they need to improve their effectiveness.

IV.2.2.2.2 Clinical Skills and CBD Training. The lack of quality indicators has also hampered training in service delivery skills, for both CBD and clinical providers. Progress is being made here, however. The PAC II contractor for Latin America is presently developing a set of standards for CBD training that could be used in the IAC region and adapted for use elsewhere. The PAC II contractor for Africa is also developing clinical service protocols that outline elements of service. More attention, however, needs to be focused on the clinical environment in which clinical service providers will be working. Training content should take into account the equipment and facilities at existing service sites, as well as the level of knowledge and practice of aseptic procedures.

Recommendations

7. For service providers, quality indicators of training need to be clearly defined, updated or revised to reflect accurately the effectiveness of the training in serving clients. The PAC II contractors should also share what they develop for possible adaption in other regions.

IV.2.2.2.3 Focus on Clients. In determining the kinds of family planning to provide, the PAC II contractors have tended to focus primarily on the service provider rather than on the client. Client needs and desires were assumed, perhaps correctly, perhaps not. The lack of a client focus in the training content may affect service provision. For example, males, young adults and fertile women in various age groups may require different approaches if they are to be influenced to adopt family planning.

Recommendation

8. Training programs should take into account the needs of the client and some assessment of their needs should be part of the training process.

IV.2.2.2.4 New Content Areas. The PAC II evaluation trips revealed the potential for exposure of nurses, midwives and clients to acquired immune deficiency syndrome (AIDS) through family planning service provision, e.g., IUD insertions and the reuse of syringes. Service providers and clients are not being protected from transmission of the virus through proper use of gloves and effective sterilization of syringes or appropriate use and disposal of single-use syringes. Two PAC contractors have developed a general curriculum for AIDS prevention, and a training module is being developed by one contractor for use with

different levels of PAC workers on preventing transmission of AIDS to them as workers. This is a vital area of concern that should receive attention by all contractors.

With the wider distribution and use of NORPLANT^R and the likelihood of other new contraceptives being tested and made available in the near future, PAC contractors should be aware of the new technologies and ready to assist in their use by updating their curricula and teaching materials.

Family planning training should not be viewed in a static way; new family planning technologies, better methods of teaching, new knowledge from operations research and changing needs, such as an epidemic like AIDS, require that curricula be revised and improved teaching methods employed.

Recommendation

9. Training should be undertaken on how to safeguard PAC workers against the transmission of AIDS; training modules should be developed for this purpose.

IV.2.2.2.5 Training Materials Development and Production. PAC II experience suggests that the quality of training is hampered by a lack of adequate training materials for trainers and trainees. It also appears that efforts to produce materials within the context of regular TOT training have not been fully successful.

Materials that would be most relevant are those produced locally by people who have expertise in developing training materials. Materials produced by PAC contractors and those from other countries and regions, however, can also be useful for training.

One of the PAC contractors has developed a computerized system and library for referencing and storing training materials. Mechanisms and funds are required, however, to produce, publish and disseminate needed materials in greater volume. Particular attention needs to be given to production and dissemination of training materials on region-wide bases. (The WHO Regional Training Center in Lome, Togo, and AMREF in Nairobi, Kenya for example, have developed such a production and publishing capacity.) More ambitious undertakings, such as textbooks, can be published through existing commercial channels, e.g., Heinemann has offices in Nigeria and Kenya. Materials can also be disseminated through nursing schools, IPPF and its affiliates, ministries of health, and where appropriate, through commercial channels.

Recommendations

10. The PAC contractors should disseminate as widely as possible both the materials they produce and relevant materials developed by other Cooperating Agencies (CAs) and family planning agencies.

11. In view of the great need for skilled personnel to work in curricula development, resources must be concentrated on small groups of trainers in each country, the purpose being to provide them with sufficient training and technical assistance to make them proficient in the development of curricula and materials.

12. Regional capacity to publish training manuals and other materials should be established, perhaps at one of the strong national centers used for regional training (for instance, at the WHO Regional training center in LOME, Togo) or through existing commercial channels (such as Heinemann). Dissemination through existing channels should also be explored.

IV.2.3 Regional Programs

IV.2.3.1 Appropriateness of Regional Training. The PAC II project paper stipulated the percentage of program funds to be allocated for regional training programs. Of the funds allocated to each geographic region, a certain percentage was to be allocated to regional training and a certain percentage to in-country training. With regard to regional training, 50 percent was allocated in the NENA region, 70 percent in the Asia region, 65 percent in the LAC region and 20 percent in the Africa region.

Regional training has been undertaken by all the PAC contractors. Regional master training networks are being developed which reinforce training concepts among the trainers and are expected to be a future resource for technical assistance in the region. Regional and interregional study tours have been effective, particularly with regard to CBD programs and clinical training.

A part of the regional emphasis in the PAC II project paper, however, is on the strengthening of regional training institutions. This has not proven to be as appropriate as originally envisaged. The rationale for the establishment and strengthening of regional institutions was in part to substitute for U.S.-based training. Such training was considered expensive and therefore justifiable only for a few types of personnel. Additionally, U.S.-based courses were not believed to be as relevant as courses in the same geographic area or in a country with similar problems or at an equivalent level of development. By contrast, in the words of the project paper,

regional institutions were considered to be "relatively inexpensive" and generally "culturally acceptable." Regional institutions were also seen as an alternative to in-country training. With the large number of countries requiring specialized training, building up specialized institutions for family planning training in each country seemed unrealistic.

In practice, efforts to develop regional institutions have not been very successful. There are a number of factors that may explain this:

- The criteria for choosing institutions to be strengthened may be inadequate. In many cases, the strongest regional institution is picked. Strong institutions already have a purpose and a clientele and to them PAC contractor assistance may not represent an asset, particularly if it means a dramatic change from what they are already doing. Indeed, some institutions chosen may not even need PAC assistance since they are already doing a good job in training. Thus, for the donor/cooperating agency, the easier task may be to strengthen a weak institution, rather than a well-developed one.
- What constitutes a region or a "culturally acceptable" training environment is not easy to define. Nationalism, language differences, and cultural diversity make it extremely difficult to find the ideal location for a permanent regional training center.
- The expense for regional training centers can become a burden to donors. Whereas national training institutions may have a constituency and receive government subventions, regional institutions often do not. Governments in the region are reluctant to provide financing unless the center is located in their country. Usually, donors try to make the center somewhat responsible for self-financing by requiring a fee structure for courses. Even when this is done, however, it is still the donors who are providing the funds for the fees. There are very few regional courses in which individuals finance themselves.

Where the capacity to meet particular training needs has not been available at the country level, institutional capabilities in other countries have been used. (For instance, the Association Senegalaise pour le Bien-etre Familiale [ASBEF], the Zimbabwe National Family Planning Council, and the Asociacion Pro-Bienestar de la Familia de Guatemala [APROFAM] are all strong national family planning training centers that have conducted regional training under PAC II.) Such centers, and others as they become stronger, can continue to be used on an as-needed

basis for regional training needs. It should be noted, however, that there are limitations to the number of outside people that national centers can accommodate.

Recommendation

13. Regional training needs should be met through the ad hoc use of strong national training centers, the master training network, and existing regional training centers, e.g., in Asia. U.S.-based training should be undertaken only in exceptional circumstances in which training needs cannot be met in an LDC environment. The emphasis in the project on regional institutional development should be reduced.

IV.2.3.2 Networking. Networking and exchange of ideas were called for under various PAC II contracts, particularly at the regional and in-country levels. These activities were appropriate.

A.I.D.'s hopes were probably highest for the dividends expected to be reaped from countries within a given region learning from one another, in particular through the regional training centers. Although these centers have not really materialized, the other regional activities that have taken place have fostered an exchange of the best ideas arising from the experiences of trainers. Even more effective networking, however, seems to be occurring within individual countries. Joint needs assessments, joint project design, and exchange of information are taking place on a routine basis between A.I.D. contractors and other host country organizations, and all involved are benefiting from the interchange.

In addition, PAC II contractors were expected to compare results of different training approaches in different regions. Meetings for all three contractors have taken place, but there have been no evaluations to compare the cost-effectiveness of different training approaches (see Chapter V). Contractors have much to learn from each other's experiences and this goal is appropriate.

Finally, at the program level, observation visits of African family planning managers and policy makers to Asia have proven to be extremely effective.

Recommendations:

14. Efforts to share information, particularly lessons learned, among PAC contractors and other A.I.D. contractors should be intensified and institutionalized. Issues covered

should include technical updating, sharing of findings from operations research, contraceptive advances, new training methods, management issues, etc.

15. New PAC workers should be involved in the information chain through all available means, including use of the master trainer network and the technical advisory committees, through regional meetings, and through the inclusion of a training column for PAC workers in various organizations' newsletters.

IV.2.4 Provision of Technical Assistance

Technical assistance has been the key element in making this project work and, generally, the TA furnished by both contractor staff and consultants has been favorably received.

Experience under the project suggests two areas in which the use of TA could be improved. The first relates to follow-up TA: some PAC II contractors have done a better job of organizing, launching and participating in initial training events than in following up with additional on-the-job TA. Development and refinement of skills of trainers takes time, ongoing learning and feedback. PAC II contractors are aware of this, but have not always acted accordingly.

The second area relates to the source of TA. The PAC contractors have provided TA both from the United States and from within the various regions. The LAC region has depended more on consultants in the region. The PAC II contractors for Africa and NENA have focused their attention and resources in the field by having regional offices and staffing them with highly qualified professionals from LDCs. In all regions, therefore, a small but growing group of LDC consultants are beginning to provide TA to training and curriculum development efforts. These trends in using regional resources for TA should be encouraged and strengthened; they represent important progress towards technical cooperation among developing countries and towards regional self-reliance. In addition, the use of regional/local resources may facilitate the follow-up required to develop and refine the skills of trainers.

Recommendations

16. PAC II contractors should use their regional staff, regional consultants and the regional master trainers networks to the greatest extent possible in carrying out program TA. The technical advisory committees that have been developed by some PAC contractors should be given an expanded role in providing guidance and advice regarding TA planning, strategy and

implementation. The role of U.S.-based TA should be reduced and focused mainly on supplementing the capabilities of in-country and regional trainers and service providers.

17. TA should be established cross-regionally so that the experience gained in the training of PAC workers in one region may be applied, when appropriate, to other regions.

V. EVALUATION AND OPERATIONS RESEARCH

Guidance for the evaluation of training is described in detail in the PAC II project paper (pp. 25 and 26). Elements of evaluation, however, appear in a number of other places in the same document, which creates some confusion. Furthermore, two key points seem to be missing: a clear statement of the objectives of the evaluation and an effort to lay out the basic questions to be answered.

At this point, PAC training has raised more questions than it has answered. For instance, what changes in family planning service delivery have resulted from PAC training? Are there better and more cost-effective ways of meeting the same objectives? What training approaches work and why?

It is important to answer these questions. Poor contraceptive continuation rates in many countries speak to the need for better training for those who organize, support, and provide family planning services. FEMAP in Latin America is conducting a study of the effects of refresher training on CBD worker performance. Much more research of this type is needed to determine which approaches to training, supervising and organizing PAC workers will result in better performance and ultimately to more widespread, longer, and safer contraceptive practice.

It may be too early to make any overall judgment about the quality of the contractors' performance in the area of evaluation. For instance, the LAC contractor is planning to conduct a major regionwide evaluation for the LAC region during the last two years of its contract. Likewise, some important components of another contractor's evaluation strategy, especially performance assessments, are not scheduled to occur until the latter years of the contract. Evaluation of some key questions are purposely timed so that the results can be used during follow-on contracts, but will not be available to improve performance during the first five years.

A growing body of operations research (OR) findings is relevant to improving the quality of family planning services provided by PAC workers. Although appropriate for practical application, few of these findings have been incorporated into PAC training and supervision programs (see Appendix D).

Recommendations

18. Evaluations should focus squarely on the issue of what works and why. Evaluations of this type should include an analysis of the practices of especially successful programs and even of especially successful PAC workers at every level.

19. Close collaboration with A.I.D. cooperating agencies that conduct family planning OR should be established by the PAC contractors so that the lessons learned from the research can be applied to future family planning training. Key issues emerging from training programs should be selected for investigation by OR groups.

VI. CONTRACTING MODE FOR NEXT CONTRACT

VI.1 Central Funding

Is a Centrally Funded Project still appropriate?

VI.1.1 Rationale

The project designers chose to provide PAC training through centrally funded contracts for four reasons. They believed that a centrally funded approach would

- provide flexible, short-term support and rapid response capabilities;
- provide assistance to individual missions while also responding to regional bureau strategies;
- ensure a greater degree of coordination for training activities worldwide; and
- fill the gap in places where there were few bilateral population programs (especially in Africa).

In fact, the centrally funded approach has proven to offer all these advantages and considerably more. Although some drawbacks can be theorized, the weight of the evidence is on the positive aspects of central funding.

VI.1.2 Advantages

The PAC II contracts have proven to offer considerable flexibility. Contractors have been able to respond to evolving needs and emerging opportunities, which may not have been evident at the start of the project. Even countries with bilateral agreements have used the services of the flexible centrally funded contractor, both to meet additional needs not addressed in the bilateral agreement and to provide expertise on a programmed or ad hoc basis to support training that is part of the bilateral agreement.

In addition to these anticipated benefits, central funding has provided four other advantages:

1) Relevant expertise of A.I.D. monitor. The PAC II project has been monitored by an A.I.D. officer with expertise in nursing, midwifery, family planning service delivery and training. This mix of expertise is not widespread within the agency and is not available in most A.I.D. missions. PAC training assistance supported by a centrally funded contract has the advantage of oversight by an A.I.D. officer with relevant technical expertise.

2) Opportunity to work with the private sector. Although private voluntary organizations (PVO) may be involved in A.I.D. bilateral agreements, it is usually easier for centrally funded contractors to work with private agencies. Many of the most successful PAC II activities to date have been those in Asia and the LAC region that were subcontracted to PVOs.

3) Cumulative knowledge. Knowledge is evolving of how best to provide family planning services and to train and use PAC workers. A centrally funded project provides a critical mass of people who are concentrating on improving PAC training, who are thinking about it, studying it, and trying to do it better. A centrally funded project supports a large number of discrete training projects, many of which may be small and/or short-term. It can afford to try new things and to experiment to some degree, and what is learned in one setting can be applied in other places. Whereas those responsible for bilateral programs will become versed in all aspects of family planning in a particular country and culture, a centrally funded PAC training contractor's understanding of training and PAC worker performance will be enriched by experience in many different countries, circumstances, and levels of development.

4) International exchanges. A centrally funded contractor can arrange for exchanges between PAC trainers from two or more countries and/or regions. International courses, meetings and other experiences planned and facilitated by the current PAC II contractors have been extremely useful. PAC trainers from different countries learn from one another, they share information and, by working synergistically, often develop new ideas and understandings. The capability to bring together people who are working on the same issue in different countries for joint problem identification and problem solving is extremely valuable.

VI.1.3 Disadvantages

Lack of follow-up. Lack of adequate follow-up has been a shortcoming of some of the work conducted through PAC II to date. This is a common problem among centrally funded contracts, where work subcontracted to host-country institutions is monitored by the U.S. contractor on an intermittent basis. This problem, however, is not intrinsic to the PAC II project design. Rather, the current PAC II project paper allows contractors to provide long-term TA where needed by stationing personnel overseas for long periods of time. In addition, the regional offices maintained in Africa and in NENA can provide more intensive and consistent support to their many subcontractors. Moreover, in most cases, intermittent monitoring has been sufficient.

Lack of opportunity to coordinate training with other components of family planning service delivery. PAC training efforts carried out in isolation from other population program initiatives may not have as great an impact as does PAC training that is carefully planned and coordinated with other components of a more comprehensive, bilateral program. These isolated training events also may not justify hiring a long-term training advisor, whereas bilateral agreements might.

VI.2 Worldwide Design

VI.2.1 Need for Continued PAC Assistance Worldwide

Is PAC training assistance still needed in all four of the currently designated regions?

Although the availability of family planning services differs greatly, not only among regions but among countries within regions, even the most advanced regions still have a need for PAC worker training. For instance, although Asia and the LAC region have relatively high CPR overall, this has been accomplished in some countries predominantly by the use of sterilization. In these countries, sterilization services may need to be balanced by greater emphasis on the temporary methods that are usually provided by nurses, midwives, and auxiliary and community workers. In addition, family planning services are only beginning to be provided in some countries, e.g., Papua New Guinea, and in specific geographic areas of some countries with high national CPRs, e.g., Brazil. Intensive start-up training will also be needed to develop services for some cultural minorities, families who live in geographically isolated areas, and the poorest of the poor.

VI.2.2 Applicability of Worldwide Approach

Are family planning programs and PAC training needs sufficiently uniform worldwide to permit a global project design?

A broad, flexible, worldwide project is still desirable. Even though some regions and specific countries have considerably less need than others for access to the resources of this project, the project should permit some continuing involvement with these more advanced countries. One reason is that participants from these countries have much to contribute to the international courses, networking and other learning/sharing experiences that the PAC contractors have supported to date. Both LDC PAC trainers and the U.S. contractor staffs can learn from personnel in the more advanced countries. Solutions to new problems and better ways to deal with old problems often emerge

from these more successful countries. They are also good places to demonstrate or test new approaches to improve the effectiveness and quality of family planning services provided by PAC workers.

VI.3 Single Worldwide Contractor vs. Multiple Contractors

What are the advantages of implementing the worldwide project through a single contractor as opposed to continuing with separate regional contracts?

VI.3.1 Advantages of Single Worldwide Contractor

Most other centrally funded A.I.D. population contracts are worldwide instead of regional, and this approach might also make sense for PAC II training. At least four advantages come to mind. Using a single worldwide contractor might

- 1) Reduce overhead costs
- 2) Provide opportunities for specialization

A large contract with a worldwide perspective might offer opportunities to focus on specific problem areas--e.g. training and supervision of TBA workers.

- 3) Provide opportunities to gather extensive data on issues of general interest

TBA training, for example, now exists in each region (in Zaire, Brazil and Nepal), but always on a small scale. If all these countries were under an umbrella contract, better opportunities would exist to understand how TBAs should be trained.

- 4) Offer more opportunities for interregional communication

New kinds of interregional exchanges might be possible. For instance, people from English-speaking Jamaica and French-speaking Haiti, who cannot benefit from many of the LAC contractor's Spanish-language offerings, might be able to participate in special courses offered primarily for English- or French-speaking Africans.

VI.3.2 Advantages of Multiple Contractors

The existing contracting mode, with its three separate contractors, has worked well for the PAC II project. Three specific advantages can be identified:

1) Long-term Experience

Generally, the PAC II contractors have become specialists in their regions. DA, for example, has worked in the LAC region for about 17 years and INTRAH has been in Africa for 8 years. These contractors, with their relevant language skills and long experience and relationships in a specific region, have been a significant factor in the success of the PAC II project to date.

2) Different Approaches

Each of the PAC II contractors has developed different strategies and approaches and each has its special strengths. Moreover, they can, and do, learn from one another.

3) Competition

Competition among contractors is healthy, spurring each to attempt to match or outperform the others. Although there is a positive side to competition among contractors, there is also a negative side, specifically a reluctance to initiate communication and interchange among themselves. Although they can learn from each other and do, most meaningful cooperation among the PAC contractors has been organized by A.I.D. If multiple contracts are awarded, A.I.D. will have to continue to require the contractors to cooperate. It may be useful for A.I.D. to consider whether there is any contractual mechanism that would make collaboration a regular aspect of all the major activities of the contractors.

VII. SUMMARY OF RECOMMENDATIONS

National Institutional Development

1. National institutional development for family planning training should remain the primary focus of the project. A distinction should be made between strengthening the national training capacity and strengthening national training institutions. A.I.D. should provide guidance on a country-by-country basis in the approach to institutional development that should be followed.

2. PAC II resources should be concentrated primarily on in-service training of nurses, midwives and auxiliary health PAC workers.

3. In Africa, particularly, more emphasis should be given to training for CBD. Family planning training target groups should include TBAs, community health workers and PHC workers. In countries with no CBD programs, observation/study tours of CBD programs should continue to be conducted for family planning policy makers, managers and PAC trainers to prepare them for CBD program implementation.

4. In countries where PHC is being pursued, ways to incorporate family planning content into the training of PHC workers should be investigated. Special attention should be given to curricula and materials development for PHC workers to ensure that they develop the attitudes, knowledge and skills necessary for their role in the provision of family planning services.

Training Targets

5. The emphasis given in the project paper to the training of trainers, supervisors and managers was well founded and additional efforts should be made by the contractors to reach this priority group.

Training Content

6. In the Africa and NEHA regions, more attention should be paid to devising methods to enhance the skills of existing trainers and to provide them with the ongoing support and resources they need to improve their effectiveness.

Clinical Skills Training

7. For service providers, quality indicators of training need to be clearly defined, updated or revised to reflect accurately the effectiveness of the training in serving clients. The PAC II contractors should share what they develop for possible adaptation in other regions.

Focus on Clients

8. Training programs should take into account client needs, and some assessment of these needs should be part of the training process.

New Content Areas

9. Training should be undertaken on how to safeguard PAC workers against the transmission of AIDS; training modules should be developed for this purpose.

Training Materials Development and Production

10. The PAC contractors should disseminate as widely as possible both the materials they produce and relevant materials developed by other CAs and family planning agencies.

11. In view of the great need for skilled personnel to work in curriculum development, resources must be concentrated on small groups of trainers in each country, the purpose being to provide them with sufficient training and technical assistance to make them proficient in the development of curricula and materials.

12. Regional capacity to publish training manuals and other materials should be established, perhaps at one of the strong national centers used for regional training (for instance, at the WHO Regional Training Center in Lome, Togo) or through already existing commercial channels (such as Heinemann). Dissemination through existing channels should also be explored.

Regional Institutional Development

13. Regional training needs should be met through the ad hoc use of strong national training centers, the master training network, and existing regional training centers, as, for example, in Asia. U.S.-based training should be undertaken only in exceptional circumstances in which training needs cannot be met in an LDC environment. The emphasis in the project on regional institutional development should be reduced.

Networking

14. Efforts to share information, particularly lessons learned, among PAC contractors and other A.I.D. contractors should be intensified and institutionalized. Issues covered should include technical updating, sharing of findings from operations research work, contraceptive advances, new training methods, management questions, etc.

15. New PAC workers should be involved in the information chain through all available means, including use of the master training network and the technical advisory committees, through regional meetings, and through the inclusion of a training column for PAC workers in various organizations' newsletters.

Provision of Technical Assistance

16. PAC II contractors should use regional staff, regional consultants and the regional master trainers networks to the greatest extent possible in carrying out its TA program. The technical advisory committees that have been developed by some PAC contractors should be given an expanded role in providing guidance and advice regarding planning, strategy and implementation. The role of U.S.-based TA should be reduced and focused mainly on supplementing the capabilities of in-country and regional trainers and service providers.

17. TA should be established cross-regionally so that the experience gained in the training of PAC workers in one region may be applied, when appropriate, to other regions.

Evaluation and Operations Research

18. Evaluations should focus squarely on the issue of what works and why. Evaluations of this type would involve an analysis of the practices of especially successful programs and even of especially successful PAC workers at every level.

19. Close collaboration with the cooperating agencies that conduct family planning OR should be established by the PAC contractors so that the lessons learned from the OR findings can be applied to future family planning training. Key issues emerging from training programs should be selected for investigation by OR groups.

APPENDICES

APPENDIX A

EXECUTIVE SUMMARIES OF THE EVALUATION REPORTS OF PAC II CONTRACTS
WITH DEVELOPMENT ASSOCIATES, INC., PROGRAM FOR INTERNATIONAL
TRAINING IN HEALTH, AND RONCO CONSULTING CORPORATION

APPENDIX A

MIDTERM EVALUATION OF PAC II CONTRACTORS: DEVELOPMENT ASSOCIATES*

EXECUTIVE SUMMARY

In 1984, the Agency for International Development (AID) contracted the firm of Development Associates, Inc. (DA) to train paramedical, auxiliary and community (PAC) personnel in Latin America and the Caribbean (LAC) in the provision of family planning services. The training project, which is called the PAC II Project and which is also being conducted in Africa and the Middle East under different contractors, is to be finished by December 31, 1995. DA's contract with AID covers five years. The report that follows evaluates the first two and one-half years of DA's performance under the contract.

PAC II follows PAC I and builds on its work. While PAC I's main purpose was to train PAC personnel in the provision of family planning services, PAC II's main purpose is to increase the capability of institutions to conduct their own training programs. DA has been the contractor in the LAC region for both PAC I and PAC II.

The contract stipulated that DA increase the capability of both in-country and regional LAC institutions to provide family planning training to PAC workers. These institutions were to be strengthened in four areas: 1) service delivery skills, 2) curriculum/materials development, 3) training of trainers (TOT), and 4) management/supervision/evaluation.

DA has put more emphasis on in-country than on regional training and is succeeding in strengthening in-country institutions. Its success can be attributed primarily to its strategy of creating corps of Master Trainers who assume leadership of the training programs. DA has been unable to devote as much effort to strengthening regional institutions because all of the so-called regional institutions targeted for development under PAC II are, in fact, in-country institutions, whose resources are already stretched to the limit providing training to nationals. Despite this constraint, DA is making an effort to develop regional institutional capabilities. The long-term prospect, however, is that these centers will not be able to provide regional training without continued external support.

DA has succeeded in achieving its quantitative goals under the contract. At this point, it has exceeded 100 percent of its end-of-project goals in seven out of thirteen categories and has exceeded the anticipated 50 percent level of achievement in four others. Its performance has been consistently strongest with respect to in-country training institutions, where it has surpassed end-of-project goals for program years of assistance and number of institutions.

*ISTI report 87-118-061.

Service Delivery Skills

DA has found its greatest opportunity for involvement in strengthening service delivery skills among the various private providers of family planning services, which rely extensively on community-based distributors (CBD), village or barrio volunteers. DA's three most notable efforts in strengthening service delivery skills in the private sector have been 1) development of corps of Master Trainers, 2) improvement of training materials, and 3) experimentation with more cost-effective methods. For various reasons, DA has had far less success in the area of clinical family planning training. Constraints have included the greater cost of clinical programs, the greater time commitment required by these programs, and suspension of programs (which are mostly government-run) because of political unrest.

1) Master Trainers: The idea of the Master Trainer program was to create for each country a corps of trainers to conduct training of trainer (TOT) programs in their own countries. While more of the training of second generation trainees has been carried out by Master Trainers than originally envisioned (about one-half of 30,000 to date), this volume of training is in itself an accomplishment. The Master Trainer program has succeeded in creating a group of enthusiastic, dedicated workers who can be relied on in the task of institutionalizing family planning training.

2) Improvement of training materials: The materials being developed to improve CBD training include a comprehensive training manual entitled "Training and Quality Control for Community-based Family Planning Programs." This manual originated in a small meeting of trainers and training directors held in Miami in September 1984 at the end of PAC I. Even though it is not finished, it is being used in a number of CBD programs and is being greeted with positive reactions from trainers. When published, it promises to be an important vehicle for institutionalizing in-country capability to provide high quality CBD training.

3) Experimentation with more cost-effective methods: Because of concerns about costs and high dropout rates, DA has been encouraging local institutions to experiment with new ways to train CBD workers that are appropriate for local conditions. It is hoped that these efforts will cut down on the costs and the CBD dropout rate.

Curriculum/Materials Development

With the exception of a major effort in Mexico, DA has provided little training in curriculum/materials development. It has, however, provided considerable technical assistance (TA) to LAC institutions to assist them to develop their own training materials, and has also produced some materials itself, with the involvement of LAC personnel. The TA that DA has provided to LAC institutions has resulted in a wide variety of training materials, although the effectiveness of training programs is still hampered by the lack of adequate quantities of appropriate materials. In addition, DA has assumed responsibility among the PAC II contractors for development of a computerized database of training materials and resources to be available to all AID contractors engaged in training.

Training of Trainers (TOT)

TOT training has been conducted at APROFAM in Guatemala, whose multiple skills in family planning service training has made it DA's most important regional resource. The quality of TOT training has been very good, particularly with respect to teaching methodology. Concentrating primarily on teaching methodology and on some curriculum development, the training has not only broadened the skills of participants, but has also bolstered their morale and esprit de corps. Training has acted as an incentive to keep trainers in training jobs despite offers of more secure or lucrative jobs from other organizations. TOT is, in fact, the most successful part of DA's strategy to institutionalize family planning training capability: all institutions visited exhibited a fairly systematic approach to training and an increasing appreciation of the need for continual assessment of efforts.

Management/Supervision/Evaluation

Under PAC II, DA's long-term strategy has been to provide management training at the regional level, but this plan has been slow to materialize. Nevertheless, DA has not neglected management/supervision/evaluation training. While there have not been large numbers of trainees in these areas, DA has provided some kind of training on these topics in all but two of its target countries. At the level of top management, for instance, efforts to improve management techniques were evident in all institutions visited. Thanks to DA, it appeared that training units were becoming more methodical in analyzing the tasks that trainees would be expected to fulfill; defining related knowledge, skills and attitudinal requirements; setting priorities in the training curriculum; measuring skill achievement; and determining the areas of need for refresher courses/continuing education.

DA is also doing a good job of making evaluation an integral part its own programming process. In spite of its good efforts, however, DA needs to upgrade its management/supervisory/evaluation training.

Conclusion

DA can be commended on several counts, among them its excellent staff and its reliance on LAC expertise whenever possible. Its efforts to open up lines of communication between family planning workers within countries and from country to country have also been excellent: the consequent sharing of knowledge and expertise should greatly advance the institutionalization of training programs throughout the region.

MIDTERM EVALUATION OF PAC II CONTRACTORS: INTRAH*

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.

MIDTERM EVALUATION OF PAC II CONTRACTORS: RONCO*

EXECUTIVE SUMMARY

This report is a midterm evaluation of the work of RONCO Consulting Corporation, under its contract with the Agency for International Development (A.I.D.) to provide training in family training in the short term and to assist in the development of host country capacity to provide this training over the long term. RONCO is one of three contractors selected to implement A.I.D.'s worldwide Family Planning Training Project for Paramedical, Auxiliary, and Community (PAC) Personnel II Project. Its geographic area of responsibility is the Near East/North Africa (NENA) region.

In comparison with the other PAC II contractors, RONCO had considerably less experience in the area of family planning training. In addition, there are considerable discrepancies among the countries in the region (Turkey, Tunisia, Morocco, Egypt, Yemen and Jordan) in terms of their receptivity toward both family planning in general and training for family planning service providers in particular. In four of these countries, RONCO was able to build on the work undertaken by the prior contractor. Nonetheless, it has experienced considerable difficulty in achieving its contractual obligations to date.

At this point in the contract period, RONCO has fallen considerably short of its quantitative goals with respect to numbers of trainees trained, both first generation (or those trained directly) and second generation (or those trained by RONCO-trained trainers). RONCO cites A.I.D.'s emphasis on the goal of institutional development as one major problem, asserting that it is not possible to train large numbers of people while engaged simultaneously in laying institutional groundwork. As a result, RONCO has opted to concentrate on institutional development, leaving large-scale training for the second half of the contract. RONCO also cites a number of events that have conspired to set back some plans. An assessment of the absorptive capacity of Turkey and Tunisia, however, plus evidence of underspending in specific training events, suggest that with more imagination and programming insights, RONCO might well have been able to undertake additional training activities. It should be noted that A.I.D.'s emphasis on institutional development does not preclude the training of the specified number of trainees.

The contract calls for achievement of eight qualitative objectives, the most important relating to the ability of in-country institutions to plan, implement, and evaluate family planning training projects and the development of regional training capacity. In Tunisia and Turkey, RONCO's efforts have contributed to government programs that had existed at the start of the contract and that now show, in part because of RONCO's efforts, strengthened capability to carry on without external

* ISTI Report 87-119-063.

support. For a number of reasons, less progress has been possible in Egypt and Morocco, the other two countries where the previous contractor had laid some groundwork. In Jordan, where RONCO has begun a new program, national trainers have been identified and plans formulated for their training.

The contract had called for 50 percent of the resources to be applied to regional training. Although RONCO has identified three institutions that it deems promising, it maintains that none will be able to provide training without RONCO assistance at the end of the contract.

With respect to the other goals, RONCO has made good progress in generating enthusiasm among training team members, conveying to policy makers a sense of the urgency of the need for increased family planning capability in their countries, and reaching mid- and upper-level supervisors and managers who manage and coordinate different facets of family planning service delivery systems. It has also done a good job in advancing communication that was already under way among groups in Turkey, Tunisia, and Jordan. It has, however, had less success with respect to interregional networking.

RONCO's training activities, usually in the form of in-country in-service workshops, have often not provided enough time to achieve all the skill training needed. Particularly with respect to training of trainers (TOT) workshops, too little time has been available for practice in the participatory teaching methods that are being taught. Although RONCO-trained trainees are eagerly applying these methods in workshops, more RONCO follow-up is needed to ensure that these skills are institutionalized for the long term. RONCO appeared not to be providing strong materials support to training activities. Curriculum development was identified as a weak area, and the need for more training material was a pervasive theme at all the training sites visited.

To date, RONCO has done little in the area of clinical skills training, because until recently there was no enthusiasm for it among the host countries. RONCO, however, has succeeded in generating a growing concern in this area and has recently completed a survey of the current status of clinical training that is an important first step. No in-service training takes place, as this is already under way through other contracts.

RONCO's management is overcentralized, with too little authority delegated either to the regional office in Tunis that is supposed to manage training programs or to managers of the training programs themselves. Quite frequently, training events appear to have been plagued with plans that were too vague, resources that were too limited, staff changes that were made precipitously, and trainers who were overloaded. Part of the

problem may have been that RONCO staff did not always make enough effort to work with host country staff to develop their management skills.

Although on the whole RONCO staff were perceived as competent and helpful, the project's central staff would benefit with strengthening in the skill areas of curriculum development, nursing/midwifery, training methodology, research, data management, and evaluation. Monitoring and evaluation seemed particularly weak, with visible lack of good documentation about project activities to date and an absence of any plan to make evaluative data part of ongoing planning and programming. On the bright side, RONCO is attempting to develop an evaluative instrument that should enable staff to evaluate whether the project is succeeding in achieving the institutionalization goals that are key to the overall performance of this project.

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)

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;

--starting of 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?

APPENDIX C
OUTPUT ELEMENTS OF THE PAC II CONTRACTS

OUTPUT ELEMENTS OF THE CONTRACTORS

	<u>INTRAH</u>		<u>D.A.</u>		<u>RONCO</u>		<u>TOTAL</u>	
	EOP Goal	Mid-term Per- formance	EOP Goal	Mid-term Per- formanc	EOP Goal	Mid-term Per- formance	EOP Goal	Mid-term Per- formance
1. In-country training institutions								
1.1 program years of assistance	87	60.8	22	31	14	7.37	123	99.17
1.2 number of in-country institutions	31	25	21	25	6	12	58	62
1.3 number of countries	15	14	6	12	3	5	24	31
2. Regional training institutions								
2.1 program years of assistance	27	11.4	16	10	8	3	51	24.4
2.2 number of regional institutions	8	5	4	5	2	3	14	13
2.3 number of countries	6	5	4	3	2	3	12	11
3. Trainees								
3.1 in US-based program	220	47	36	46	36	18	292	111
3.2 in regional training	774	352	574	117	473	75	1,821	544
3.3 number in-country trainees, 1st gen.	14,000	19,249	8,233	10,972	3,141	1,332	25,374	31,553

	<u>INTRAK</u>		<u>D.A.</u>		<u>RONCO</u>		<u>TOTAL</u>	
	EOP Goal	Mid-term Per- formance	EOP Goal	Mid-term Per- formanc	EOP Goal	Mid-term Per- formance	EOP Goal	Mid-term Per- formance
3.4 number in-country training days, 1st gen.	70,000	105,318	41,165	29,489	28,269	6,725	139,434	141,532
3.5 number in-country trainees, 2nd gen.	74,940	15,700	44,215	31,661	30,815	3,898	150,000	51,259
3.6 number in-country training days, 2nd gen.	374,850	47,100	210,075	90,999	123,260	20,132	708,185	158,231
4. Short-term Technical Assistance (T.A.)								
4.1 Number of T.A. visits	60	18*	22	97**	20	13*	102	128

*T.A. provided on request from A.I.D. mission or REDSO and not in context of a subproject agreement.
**T.A. provided outside of subproject agreements.

APPENDIX D

EXAMPLES OF FAMILY PLANNING RESEARCH RELATED TO TRAINING

APPENDIX D

EXAMPLES OF FAMILY PLANNING RESEARCH RELATED TO TRAINING

Following are examples of family planning operations research findings which could be immediately applied, in most cases, to improve family planning training.

- A study in Indonesia found that when IUD users were counseled routinely, 90 percent were still using the method after a year and 79 percent kept their IUDs for at least two years after insertion. However, when counseling was minimal, only 52 percent were still users after a year and 29 percent after two years (Affandi et al.).
- The relatively high ratio of male to female voluntary sterilization among clients of the Asociacion Pro-Bienestar de la Familia (APROFAM) in Guatemala is attributed to the staff's favorable attitude toward both procedures. Workers counsel husbands and wives together and provide balanced information about both procedures (Santiso et al.).
- A study from Indonesia found that some women left family planning clinics with a different method from the one they really wanted, and that 85 percent of women who did not get the method they preferred discontinued use of the method within one year. The discontinuation rate for women who received the method they wanted was only 25 percent (Pariani et al.).
- When discussion groups were organized to find out why government health facilities in Imo State, Nigeria, are underutilized, many people complained about harsh, rude and uncaring attitudes of the health care personnel (Attach U86, from Population Reports J, 35-36, in press).
- Sixty-seven percent of unwanted births to women in a study in Nepal occurred for reasons that might have been obviated through more effective provision of family planning services. Although the couples lived near a family planning facility, negative perceptions of family planning services made many stay away. When some did go to the clinic, family planning workers did not draw out and refute their clients' false beliefs about the risks of specific contraceptive methods, and they often tried to force them to use the method the clinic worker thought best, even though the client wanted a different method. If the couple did not like the method they were given, they thought it was their fault and were afraid to return to the clinic (Schuler et al.).
- A study in Ghana found that health workers approved of family planning and contraception in general but often disliked specific methods, which they were reluctant to recommend (Kumah). In Nepal, workers told clients that condoms were unreliable and advised them not to use them (Schuler et al.). Twelve percent of a sample of MCH clinic nurses in Somalia thought that more than 30 percent of couples using condoms would get pregnant in a year, even

- if they used condoms correctly every time they had sex (Rooks).
- Although it is relatively easy to get initial pill "acceptors," many programs seem unable to support long-term, continuing use. Even the intensively supervised programs used for clinical trials often report one-year continuation rates of only about 50 percent. Clinical trials also show significant differences in continuation rates between programs, which suggests variation in the quality of client education and support, as well as other variables.
 - IUDs were introduced but failed to take hold in some places because, although people were trained to insert them, no one was adequately prepared to handle complications and side effects and to support women through the discomforts and concerns of the early post-insertion period. Without adequate backup, some nurses stopped inserting IUDs after experiencing one complication.
 - Similar to IUDs, injection programs also may suffer for lack of good training. During the PAC II evaluation, a physician in Nepal complained that injections were not suitable for women in her culture because she found that her clinic waiting room was full of Depo-provera patients who were concerned because they were either bleeding too little, not at all, or too often, too long and too much. She did not like dealing with these problems preferred to perform sterilizations. In reality, few of these patients were experiencing significant complications. Most returned to the clinic because they were not adequately counseled regarding their ideas and feelings about menstruation, and were not effectively taught to expect menstrual changes and to understand that cessation of menstruation in a woman who has used Depo-provera for some time is common and not a sign of pregnancy.

References:

- Affandi B, Samil RS, and Hanafiah MJ: Some Indonesian experiences with IUD. Majalah Kesehatan Masyarakat Indonesia 16(5): 307-312, 1986. In Counseling Makes a Difference, Population Reports J(35-36), in press.
- Kumah DM: Trip report, focu group training workshop, Accra, Ghana, September 24-October 24, 1986. Baltimore, Johns Hopkins University/Population Communications Services, 1986. In Counseling Makes a Difference, Population Reports J(35-36), in press.
- Pariani S, Heer DM, and Van Arsdol MD: Continued contraceptive use in fave family planning clinics in Surabaya, Indonesia. In Counseling Makes a Difference, Population Reports J(35-36), in press.
- Phillips JF, Stinson WS, Bhatia S, Rahman M, and Chakraborty J: The demographic impact of the family planning-health services project in Matlab, Bangladesh. Studies in Family Planning 13(5):131-140. 1982.
- Rooks JP: Trip report, Family health services in Somalia: Clinical training needs assessment, february 3 - March 1, 1987. Chevy Chase, MD, University Research Corporation, 1987.
- Santiso R, Bertrand JT, and Pineda MA: Voluntary sterilization in Guatemala: A comparison of men and women. Studies in Family Planning 14(3): 73-82, 1983.
- Schuler SK, McIntosh EV, Goldstein MC, and Pande BR: Barriers to effective family planning in Nepal. Studies in Family Planning 16(5): 260-270, 1985.