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EVALUATION OF THE
MATERNAL, CHILD HEALTH, AND
FAMILY PLANNING
IN-SERVICE TRAINING PROGRAMME

Ministry of Health
Division of Family Health
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ABBREVIATIONS

LIST OF ABBREVIATIONS USED IN THE DOCUMENT

| | |
|---------|--|
| CNO | CHIEF NURSING OFFICER |
| CO | CLINICAL OFFICER |
| DFH | DIVISION OF FAMILY HEALTH |
| DTC | DECENTRALISED TRAINING CENTRE |
| ECHN | ENROLLED COMMUNITY HEALTH NURSE |
| ECN | ENROLLED COMMUNITY NURSE |
| EN | ENROLLED NURSE |
| FP | FAMILY PLANNING |
| GOK | GOVERNMENT OF KENYA |
| IDT | INSTITUTE FOR DEVELOPMENT TRAINING |
| IEC | INFORMATION EDUCATION AND COMMUNICATION |
| INTRAH | PROGRAM FOR INTERNATIONAL TRAINING IN HEALTH |
| IUCD | INTRA-UTERINE CONTRACEPTIVE DEVICE |
| JHPIEGO | JOHNS HOPKINS PROGRAMME FOR INTERNATIONAL EDUCATION GYNECOLOGY AND OBSTETRICS |
| KCPS | KENYA CONTRACEPTIVE PREVALENCE SURVEY |
| KDHS | KENYA DEMOGRAPHIC HEALTH SURVEY |
| KECN | KENYA ENROLLED COMMUNITY NURSE |
| KRCHN | KENYA REGISTERED COMMUNITY HEALTH NURSE |
| KRN | KENYA REGISTERED NURSE |
| MCH/FP | MATERNAL CHILD HEALTH/FAMILY PLANNING |
| MOH | MINISTRY OF HEALTH |
| NGO | NON-GOVERNMENTAL ORGANIZATION |
| ORT | ORAL REHYDRATION THERAPY |
| PHN | PUBLIC HEALTH NURSE |
| POPTEC | POPULATION AND TECHNICAL SERVICES PROJECT |
| SDP | SERVICE DELIVERY POINT |
| STD | SEXUALLY TRANSMITTED DISEASES |
| USAID | UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT |

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FOREWORD

During the past five years, there has been an unprecedented increase in demand for maternal child health and family planning (MCH/FP) services. In response, there has also been rapid expansion of public sector MCH/FP facilities, as well as increasing private sector involvement (voluntary organizations, private offices/clinics, community-based auxiliaries, and commercial distributors). All of these various MCH/FP activities -- both public and private -- fall under the general guidance of the Kenya National MCH/FP Programme. In carrying out the Programme, the National Council for Population and Development takes a lead role in population policy development and advocacy for family planning, while the Ministry of Health, Division of Family Health is specifically charged with the operational responsibility for providing and/or overseeing the provision of integrated MCH/FP services.

As the key provider and overseer of MCH/FP services in the country, the Division of Family Health is directly concerned with several interrelated operational components, each of which is critical to the success of national MCH/FP efforts. These critical components include: responsive implementation policy guidance; efficient management at national, mid, and service provider levels; adequate infrastructure, including facilities, equipment and supply logistics, and an adequate pool of trained MCH/FP service providers.

This evaluation is concerned with the last component mentioned above -- training of MCH/FP service providers. More specifically, this evaluation focuses on the post-basic MCH/FP Training Programme operated by the Division of Family Health, which is the major producer of certified MCH/FP manpower for the public sector, and to a lesser extent for private facility-based services. The evaluation generally takes into account the Training Programme's broad role as national producer of certified MCH/FP manpower in and outside of Government, and also considers the operational environment within which the Programme functions in the Ministry and Division. However, the major thrust of this evaluation is a review of the technical and administrative operations of the Programme, with concentration on the family planning aspect of the training, including performance outcomes in MCH/FP facilities operated by the Ministry of Health.

This report is intended to provide new insights and provoke new thoughts about the current and future operations of the Training Programme, particularly those aspects concerned with family planning service provision and supervision.

The reader's comments and reactions to the findings and recommendations of this report will be most welcome.

*Dr. A. O. Oyoo, Director
Division of Family Health
Ministry of Health
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This evaluation and report represent many tedious hours and days of effort on the part of dedicated individuals within the Division of Family Health and the Population/Health Office of U.S. Agency for International Development, Kenya. Over the years the MCH/FP Training Programme has evolved as one of those many good examples of Government and donor cooperation. The Programme is equally well-endowed by Government and donor support. Thus, it was appropriate that the DFH and USAID should share equally in carrying out this evaluation exercise.

Initially, the evaluation experienced long delays in getting started. However, what might at first have appeared as lack of interest on the part of some offices turned out to be more a concern that the activity, because of its importance, should not be undertaken until such time as full attention and support could be given to it. The evaluation was originally authorized by the Ministry of Health in September, 1988 at which time a senior-level Steering Committee was appointed by the Director of Medical Services. Although various appointed members of the Committee provided input on organizing the evaluation exercise, it proved to be impossible overtime to arrange for the full Committee to sit. Finally, through delegation of responsibilities a functioning Coordinating Committee was convened in July, 1989 and design work was able to begin. Once the activity got underway, the support and attention provided by everyone involved, was outstanding. The following individuals provided invaluable service to the effort.

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In addition, USAID arranged for local support from the Population Council, Inc. which, through its representative Lewis Ndhlovu administered all aspects of local financing, survey logistics, data processing and analysis. Mr. Ndhlovu was an indispensable member of the design team, set up the various programs for data input and analysis, and served as full-time member of the field team, (in addition to doing a masterful job in handling of the local administration). Throughout, the Population Council availed its administrative support and data management staff, offices, meeting rooms, computers, and in general contributed generously to facilitating the evaluation exercise. Dr Andrew Fisher, Director of the Population Council's Africa OR/TA Project edited this report.

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Mrs. Martha Warratho,
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SUMMARY OF FINDINGS AND RECOMMENDATIONS

BACKGROUND

Over the past decade, the Kenya National Family Planning Programme has greatly increased the services available to clients as well as the geographic coverage of the programme. To keep pace with this expansion, the Maternal Child Health/ Family Planning (MCH/FP) Training Programme of the Ministry of Health (MOH) has also been required to increase its activities. Since 1972, 5,127 health workers have received post basic (in-service) training in family planning and over half of these (2,752) have been trained in the past five years.

This evaluation of the MOH MCH/FP training programme was undertaken in order to document the quantity and quality of the training which has already been accomplished, and to make recommendations for future activities. Field work and data collection for the evaluation exercise began 16 October 1989 and ended in November. Detailed observations of health workers job performance were made at 42 Service Delivery Points (SDPs) in 20 districts by five field teams. At these SDPs, 128 service providers were interviewed along with 36 supervisors. In addition, 420 client records were randomly selected and examined. All 11 District Training Centers (DTCs) were visited and 34 of the 36 MOH MCH/FP trainers were interviewed. Altogether, 13 data collection instruments were used to obtain information for this evaluation report.

FINDINGS

Training Output

- A. Between 1972 and 1989, 5,127 MOH workers received MCH/FP training. Approximately 82 percent (4,234) of these workers were service providers; the remainder were supervisors.
- B. Of the 5,127 trained since 1972, only 2,267 or 44 percent are estimated to be currently providing MCH/FP services.
- C. Of all 15,416 workers in the MOH, only 15 percent have been trained in MCH/FP and are currently providing services.
- D. The annual number of MOH staff trained in MCH/FP has gone from 163 in 1985 to 878 in 1989 -- a 439 percent increase.

Future Projections

- A. If current trends in training output continue, it is estimated that an additional 7,050 MOH workers will need to be trained in the five year period between 1990 and the end of 1994. This is more than all the workers trained in the 18 year period between 1972 through 1989.
- B. If demand for family planning services accelerates and if attrition among previously trained workers is higher than in the past, then a far larger number than 7,050 will need to be trained in the next five years.

Profile of Current MCH/FP Workers

- A. Of 128 MCH/FP workers interviewed, 78 percent were ECN or ECN/Ms, 48 percent work in Health Centers and 40 percent in hospitals.
- B. On average, the 128 workers have slightly over 4 years of service experience with the MOH, although 35 percent have over 11 years experience and many of these workers will be retiring in the next ten years.
- C. Of all 128 MCH/FP workers interviewed, 80 percent had never received a family planning update course.

Work performance

- A. Observation of work performance indicated that MCH/FP trained staff obtained adequate historical information from their clients, routinely gave a physical examination which included blood pressure measurement and a pelvic examination.
- B. Observation of new client counselling indicated that 100 percent of clients were counselled on the use of orals, IUD, and condoms; 92 percent on Depo Provera; 88 percent on foaming tablets; 68 percent on natural family planning; 50 percent on the diaphragm; but only 39 percent on voluntary surgical contraception.
- C. During client revisits, MCH/FP workers always arranged a revisit, usually took blood pressure, and in about two thirds of the time enquired about side effects.
- D. Among 413 client records examined at 42 SDPs, 55 percent had been prescribed the pill, 11 percent the IUD, 27 percent Depo Provera, 4 percent condoms or foam tablets, and 0.5 percent tubal ligation.

Clinic Management

- A. In 59 percent of 42 SDPs visited, no contraceptive stock control records were maintained.
- B. In the 42 SDPs, stock-outs were observed in 38 percent for Depo Provera, 36 percent for Eugynon, 9 percent for Microgynon, 5 percent for Microlut, 14 percent for the IUD T380, 83 percent for the IUD T200, and 43 percent for the Lippes Loop.
- C. Acceptable procedures appear to be followed with regard to disinfection and sterilization of equipment when adequate supplies are available. However, there is often a short supply of disinfectant, sterile gloves, and other equipment.

Supervision

- A. Almost 90 percent of the 36 supervisors interviewed were either KRNs (33 percent), PHNs 36 percent), or ECNs 22 percent).
- B. 45 percent of the supervisors had 10 or more years of experience.
- C. 90 percent of the supervisors report that they have no standard supervisory guidelines to follow.
- D. Administration appears to be the major job function of the supervisors.
- E. Approximately one third of the supervisors report a lack of transport as a hinderance to their work.
- F. 43 percent of MCH/FP staff reported that they receive no supervision, and 60 percent of these workers cannot name their supervisor.
- G. 60 percent of the supervisors have never received any formal preparation in supervision.
- H. 75 percent of the supervisors say they have never received a contraceptive update course.

Training Course Content and Process

- A. There is little difference between the 7 week certificate training course for ECNs and the course offered for KRN and COs.
- B. Various areas of course content and approaches to presenting classroom material need to be improved.
- C. In general, the 7 week course uses good quality reference materials although there are sometimes shortages of basic materials such as the "Blue Book" .
- D. Supplementary training materials on AIDS (HIV), STDs, IUD insertion, NORPLANT are generally not available to trainees.
- E. Trainers have materials which describe what should be taught but lack a standard instructional which describes how the subject matter should be taught.
- F. The average classroom hours at DTCs is 70 with clinical practice being another 130 hours.
- G. A substantial amount of trainer time is devoted to administrative tasks and to concerns related to the temporary and ad hoc nature of the training arrangements many of which use hotels for classrooms.
- H. Most trainers favor a re-establishment of the 9 week course, although a knowledge test given to 7 week and 9 week course trainees showed no difference in scores.
- I. A considerable amount of time in the training course is devoted to travelling to and from practice sites and waiting for the required type of client-acceptors to present themselves.
- J. Although a number of training of trainers (ToT) courses have been conducted by the DFH and INTRAH, no ToT curriculum has been developed.

Trainers' Performance

- A. There is a relatively high turnover of trainers. Out of 28 positions in 1986-88, 12 were replaced.
- B. The DHF has found it difficult to meet the need and demand for trainers.
- C. 75 percent of the trainers use lectures as the major method of instruction.

- D. The average training session is 90 minutes long.
- E. Only 60 percent of the trainers have participated in a Training of Trainers course.
- F. 54 percent of the trainers have not received the contraceptive update course.
- G. Only 3 out of the 36 trainers have a Degree in Advanced Nursing which includes preparation in nursing teaching.

Training Administration

- A. Records on placement of trainees after training, and current work status are generally not maintained by DTCs or by Nairobi Headquarters.
- B. The organizational structure of the training programme tends to be flat. Staff functions in the specific technical and administrative areas of registration and certification, curricula and materials development, supervision and evaluation, finances and administration need to be strengthened.

Decentralized Training Centers

- A. All 11 DTCs were found to be operational but most had serious deficiencies in terms of physical site and permanency of location.
- B. Trainee housing is most often a problem.
- C. Transportation between the DTC and the practical training sites is very often a problem.
- D. Most DTCs are dependent on the district administration office to find venues for training and dependent on the district health administrators for transportation and funds.
- E. The DTCs frequently find themselves with cash flow problems.

RECOMMENDATIONS

1. **Develop a training policy and plan.** The training programme currently lacks a policy framework and a detailed plan for future expansion. Current projections suggest that the annual output of trainees will double by 1994. This suggests the need in the immediate future to expand existing facilities and later possibly to increase significantly the number of new trainers and facilities. A policy and plan to handle this increase in activity needs to be developed now.
2. **Develop a training information system.** It is virtually impossible to make long-range manpower projections and training plans without detailed information on current and past trainees. A training information system needs to be established which can document current manpower utilization, project future requirements with reasonable accuracy, and most importantly, undertake management decisions which ensure the optimum redeployment and productivity of those persons trained. This evaluation report highly recommends the approach of establishing targets on the basis of need, and introducing a method of assessing the current manpower situation and calculating future needs.
3. **Readjust organizational structure.** Currently the headquarters office handles all administration and also conducts the same schedule of courses as other DTCs. The organizational structure of the training programme needs to be changed to provide staff with specific technical and administrative functions such as registration and certification, materials and curricula development, supervision and evaluation, and finances and administration. The staff responsible for these functions should not also be responsible for training, except possibly to undertake the ToT and contraceptive update courses. Alternative offices such as the Nairobi Province or Nairobi City Council should be considered as additional DTCs.
4. **Improve the skills of trainers.** The trainers course curriculum needs to be strengthened and standardized, and all trainers should receive the training of trainers course as well as the contraceptive update course. Trainers should receive instruction in teaching methodology and have detailed teaching guides. An effort should be made to recruit trainers with Diplomas in Advanced Nursing.

5. **Develop a specific plan for upgrading and/or changing existing DTCs.** The present situation of using hotels and other such locations as DTCs is inadequate. Detailed plans need to be made to establish residential training facilities. Ideally, each DTC should have its own transportation and not have to rely on other facilities in the district. A comprehensive, separate assessment of needs should be undertaken and finances identified to improve the physical set-up of DTCs.
6. **Establish a specific group of trained clinical instructors.** Trainees are currently assigned to one or more training sites for their 4 week practical experience. They are either guided and instructed by a service provider in that facility and the classroom trainer styles of teaching and learning experiences are not as efficient as they should be. There is a need to develop a cadre of trained clinical instructors who can adequately guide trainees.
7. **Develop a training of trainers curriculum.** It is important that a detailed ToT curriculum be developed. Emphasis needs to be placed on trainers developing skills in the use of prepared instructional materials. The Programme may need to engage outside assistance with the development of various ToT curriculum components.
8. **Arrange to procure large, bulk supplies of basic training and reference documents.** The basic set of training and reference materials found in the DTCs is often inadequate. Books and manuals are in short supply. Thousands of volumes are needed to be able to distribute them liberally to training institutions. Supplementary materials on special topics such as NORPLANT, IUD insertions, STDs and AIDS (HIV) should also be purchased and made available at all DTCs.
9. **Focus on strengthening the quality and existing infrastructure before increasing new outlets.** The Programme management and administration is not large enough or strong enough to support significant expansion of training facilities at this time. Although a DTC alternative to the DFH needs to be established to relieve headquarters staff of direct training responsibilities, efforts over the next two years should focus on strengthening existing staff skills and training facilities and at a later time concentrate on expansion of facilities. Other independent NGO training institutions should be identified to supplement MOH capacity in MCH/FP training.

10. **Offer the contraceptive update course to all former trainees,** In order to maintain the interest, enthusiasm and professional skills of MCH/FP providers as well as supervisors, the contraceptive update course should be offered to all former trainees. Additional NGO trainers and facilities may also be needed for this course.
11. **Focus more in the training course on the need to counsel clients about tubaligation and assist them with handling side effects.** The evaluation found that many new clients were not counseled about tubaligation and many revisit clients were not asked about side effects. These are two areas that need to be emphasized in the MCH/FP training course.
12. **Increase the Numbers of Supervisors and develop guidelines for them.** More supervisory coverage is needed. Since there is very little guidance given to supervisors, there is a need to develop guidelines for supervisors to follow.

Section 1

INTRODUCTION

1.0 Background on Training Program in Kenya

Shortly after independence, the Ministry of Health (MOH) began a strategic programme to bring basic modern health care within reach of the majority of the population, 85 percent of whom were (and are still) estimated to reside in rural areas. The MOH's approach was to build a network of dispensaries, health centres and hospitals extending into every area of the country, and to rapidly increase the numbers of health workers especially trained to provide primary and preventive health care. Thus, basic medical education programmes, especially those for Clinical Officers (COs) and Enrolled Nurses (ENs), began placing increased emphasis on community health, particularly maternal and child health (MCH).

Also, in 1972-73 the MOH began post-basic training in primary health care; specifically geared towards the large numbers of health workers in the area of maternal and child health. A separate post-basic programme to train health workers in the sub-specialty of family planning (FP) was also introduced. Over the next ten years, public demand and the MOH's capacity to provide MCH and FP services continued to grow. Family planning was treated as a separate service within the general mix of primary and preventive care. Clinical training in family planning was then being provided by the National Family Welfare Centre (predecessor to the Division of Family Health).

Starting in 1982, the MOH adopted a major new policy to integrate MCH and FP services. This policy was introduced through the multi-donor funded Integrated Rural Health/Family Planning Programme. This programme helped to establish a strategy whereby various antenatal, sick/well baby treatment, and family planning services would all be located in the same clinic facility, called a Service Delivery Point (SDP). The MOH additionally established that all service providers assigned to an SDP (mainly Kenya Enrolled Nurses/Midwives and Enrolled Community Nurses), should be certified to deliver the full range of MCH or FP services.

This meant that large numbers of Enrolled Nurses and other health workers already qualified in MCH/Midwifery would additionally require family planning certification. Accordingly, the specialized family planning clinical practice curriculum being offered by the Division of Family Health was expanded to include an overview refresher course in MCH to introduce the principles of integrated MCH/FP service delivery and to concentrate on family planning clinical practice. The most recent MCH/FP curriculum guideline was developed and implemented in 1986. Throughout this document reference is made to "MCH/FP" or "FP" workers and services more or less interchangeably, with the understanding that the focus is mainly with the FP component.

In the interest of meeting other staff development needs, the Training Programme has also in recent years established other courses such as the Family Planning Technology Updates, the Training of Trainers course, and a separate MCH/FP certificate course for managers and supervisors (mainly Clinical Officers and Registered Nurses).

Over the past several years the MCH/FP Training Programme has become fully institutionalized as the single-most important source of certified MCH/FP manpower in the country. At the time of this evaluation in late 1989, there were 36 trainers engaged full-time in conducting a year-round schedule of MCH/FP courses at eleven Decentralized Training Centres (DTCs). In total, 5,127 health workers have received post-basic (in-service) training in FP and/or MCH/FP since the MOH first began these efforts in 1972. During the past five years alone, 2,752 MCH/FP providers have been trained, indicating tremendous growth in output capacity by the training programme in recent years.

The U.S. Agency for International Development (USAID) has been supporting the DFH's Training Programme since 1982, and currently provides assistance under terms of its bilateral Family Planning Services and Support Project (covering the eight-years, 1985-1993). Thus, 1988-89 (the period during which this evaluation was planned and executed), marked an approximate mid-term in current USAID assistance, and an appropriate juncture for both MOH/DFH and USAID programme managers to take a closer look at the Training Programme.

During the planning stages of this evaluation, the Coordinating Committee first addressed itself to the recommendations of an earlier, limited-scope evaluation of the Programme conducted in 1984 with USAID assistance. The Coordinating Committee analyzed each item of the previous evaluation's recommendations and concluded that an appropriate response had been made to all recommendations with the exception of one to eliminate Clinical Officers from the training in-take. It was felt that the DFH had to continue giving priority to the training of Clinical Officers since many of these officers provide

supervisory and clinical backup, particularly in the handling of complications.

In organizing the evaluation exercise, the full participation and collaboration between MOH and USAID representatives was insisted upon in an effort to ensure that the evaluation report is viewed by its readership as relevant and authoritative. Particular attention was given to the technical design of the evaluation, including involvement of outside expertise and the organization of a ten-person team which engaged in field data gathering and observations in a significant sample of training and service sites over a three-week period.

1.1 Organization of the Report

This report is organized into several sections.

Section 1 summarizes the findings and recommendations, including suggestions on ways in which MOH and USAID programme planners/managers might wish to use the information contained in this report for re-planning and follow-up.

Section 2 gives the objectives of the evaluation and briefly describes methodology used to collect data. A more complete report on methodology is in Appendix A. Appendix B contains the data collection instruments used.

Section 3 is essentially concerned with both the quantitative and qualitative aspects of the training programme, namely, the gross and net numbers of workers trained and the adequacy of the training as indicated by workers' performance in the field.

Section 4 focuses mainly upon technical concerns related to training content and trainer effectiveness. Those decision-makers involved in curriculum design and the instructional elements of the Programme will be most interested in the recommendations of Section 4.

Section 5 addresses structural and administrative issues of critical importance in strengthening the operational capacity and efficiency of the Training Programme. The issues, findings and recommendations discussed in Section 5 will be most relevant to MCH/FP training programme planners and managers.

Section 2

EVALUATION OBJECTIVES AND METHODOLOGY

2.0 Goals and Objectives

The evaluation was undertaken as a joint cooperative effort between the MOH and USAID. Planning, design, and coordination began in July, 1989 with the first meeting of the evaluation Coordinating Committee. The primary goal of the evaluation exercise was to conduct a systematic and comprehensive assessment of the Ministry of Health's Family Health Division in-service family planning training programme. The objectives were:

1. To document the quantity and quality of training output to date;
2. To identify areas needing improvement;
3. To recommend practical, corrective actions as necessary.

2.1 Methodology

Out of 43 districts in Kenya, the evaluation covered 20 districts. The remaining 23 were excluded for reasons ranging from extremely low population density and hence little MOH activity, non-response to the preliminary listing forms, and to inaccessibility. The twenty districts included in the evaluation were divided into five geographical areas labelled A through E as follows:

- A: Western/Nyanza/Western Rift
- B: Mid and Lower Rift Valley
- C: Nairobi/Southern Central and Southern Rift
- D: North Central and Eastern
- E: Coast

From each of the geographical areas, an evaluation was undertaken of:

1. Providers of services at their workplace
2. Trainers at training centers and practical training facilities
3. The training materials used
4. The record keeping system at SDPs
5. The supervision process at SDPs

Field work and data collection activities began 16 October 1989 and continued through 12 November 1989. Several data collection procedures were used including a review of training policies and curriculum, questionnaires, interviews, discussions, and field observations. The battery of field data gathering instruments, and the technical procedures for completing them, are shown in Appendix B. Briefly, the evaluation design and field logistics were developed as described below.

1. Field work covered a maximum of three (3) weeks involving five teams of two officers each (totaling ten officers), represented by seven members from the MOH, and three from USAID and the Population Council.
2. The five teams were given a thorough orientation on data collection procedures, held for 3 days, 19-21 October, 1989 in Nairobi. Following the orientation, the various teams immediately proceeded to the field, most teams departing on Sunday, 23 October.
3. The five teams were divided into the five geographical areas noted above.
4. The geographical areas covered in the study took into consideration such factors as accessibility. Areas covered are shown in the map in Figure 2.1.
5. Field teams included at least one member with extensive FP clinical experience.
6. The field teams were allowed some flexibility in scheduling field work and travel, the details of which were worked out during their orientation week. However, the following basic schedule was followed by all teams:

23-26 October: Observations of one or more days for all Decentralized Training Centres; Trainer, and Supervisory interviews, and; Cluster Post-Post Test and interviews (random sample of 20 subjects, each Team).

27 October Procedural review of field work (all teams), in Nairobi.

30 October to 3 November Additional Supervisory interviews as needed; Complete cluster tests/interviews, and; begin SDP observation visits (random sample of 10 sites each Team).

6-10 November Complete SDP observations, and; Conduct observations at clinical practice sites.

Further details regarding the evaluation design and methodology used are given in Appendix A.

2.2 Study Design and Sample Sizes

The sample design employed for service providers was a stratified random sample. The stratifying factors were geographical area and years 1986/7 and 1988/9. In each of the five geographical areas, between 27 and 32 providers were sampled. The original attempt to include a proportionate number of providers in the categories of KRNs and COs was unsuccessful due to small numbers of these groups in the original frame. Out of the total of 128 sampling units, 100 were ECNs, and 28 were KRNs or COs.

One hundred fifty (150) providers were sampled for the period under consideration. A part of this number (100) was invited to a center in the geographical location where they were located while the rest (50) were observed at their worksite in SDPs. Once sampled for observation, the SDPs where the providers worked automatically became sampled units to provide information on clinic operations. The planned sample is shown in Appendix A in Tables A.1 and A.2 and indicates the actual respondent sample size for various units of study.

At each of the visited SDPs a total of 10 records were selected using a systematic sampling procedure, and relevant data was collected. Out of a total of 500 records expected to provide data, 413 were obtained. Supervisors at each of the selected SDPs also provided information on supervision.

The Division of Family Health has 11 Decentralized Training Centres located in the metropolitan areas of Nairobi, Mombasa, Nyeri, Embu, Meru, Machakos, Murang'a, Nakuru, Kisumu, Homa Bay and Kakamega.

When the trainees attend courses at the DTC they normally go for practical training in hospitals or clinics which are in proximity. Hence for every training centre there exists at least one, and as many as seven practice SDP sites associated with it. The nurse who supervises the students while at the practical site was the sampling unit of interest. The student supervisor (also called "Clinical Instructor"), was expected to provide information about the management of the practical training sessions. A needs assessment test for the students' supervisors was administered to them.

2.3 Data Collection Instruments

A set of thirteen data collection instruments were developed. These are shown in Appendix B. Two methods of data collection were used by each of the field teams: (1) self-administered questionnaires and (2) observation. Most of the 13 instruments were self-administered questionnaires while observation procedures were employed at the training centres and at the work sites of the providers. All the 13 data instruments were administered in English.

2.4 Data Processing

The field interviewers were responsible for field editing of the data and collating their questionnaires before they were submitted for data entry. After office editing, data was keyed into microcomputers using data management software, dBase III+ and standard statistical tabulation and analysis were handled through SPSS/PC+ software.

Section 3

TRAINING PROGRAMME STATUS

3.0 Data on Training

In assessing achievements of the Training Programme to date, the evaluation focussed on answering three questions:

1. How many MOH workers have ever been trained in MCH/FP?
2. How many of these workers are currently providing MCH/FP services?
3. How many workers will need to be trained in the 1990 - 1994 period?

At the outset, it should be noted that the evaluation experienced some difficulty in obtaining accurate information necessary to answer these three questions. The Training Programme currently lacks a management information system that can provide data for accurately assessing current and future MCH/FP manpower requirements. The lack of manpower data was clearly illustrated in connection with attempts to establish a sample frame for this evaluation.

Up to now, the Training Programme's headquarters office has maintained only the type of manual records and files needed for basic administrative purposes, such as a hand-compiled register of all persons trained and pre and post test scores for each trainee certified. The Programme's chronological register lists every person trained from 1972 to the present. The data from this register can be summarized by DTC, year, and qualifications of trainees (KRN/M, ECN, CO).

Unfortunately, there is no way of knowing with certainty which of those persons trained are still active and in service and if active, where they work. It is not possible to track active workers and their locations by taking the Programme's Register and cross-matching it by individual personnel number with the master personnel inventory file maintained by the MOH headquarters Health Information Systems Unit. The master personnel inventory does not currently have the capacity to locate personnel beyond their district pay stations. Plans are now underway to upgrade the capacity of the HIS master personnel inventory. Also, the Division of Nursing plans to undertake an inventory of the nursing cadre to provide accurate data on MCH/FP nurses and their site locations.

In the meantime, the only procedures available to establish even an estimate of how many MCH/FP workers are actually within the

system, where stationed, and if actively engaged in the provision of MCH/FP services, is to request manual returns from the 43 districts, and/or make an estimate through sampling techniques. Both of these procedures were attempted as part of the evaluation design and both were found to have technical limitations.

For long-range planning purposes, the numbers and types of MCH/FP workers required in the national service delivery system are directly related to demand for services and to the number and type of facilities in which these workers might be placed. Unfortunately, neither the demand nor the current or future number and type of facilities available can be determined with accuracy. Many of the same problems that exist with the manpower data also exist with the MCH/FP facilities data. Although a number of offices within the MOH have at one point or another developed facilities files, none of these are comprehensive or totally reliable. Currently, an extensive (and very expensive) field survey would be needed in order to develop composite data on all health facilities by geographical location, by Government, NGO, or private status, by active or non-active MCH/FP clinic status, with or without community extension activities, and by other characteristics.

Given the limitations of existing data, a truly accurate manpower situation analysis is not possible at this time. This represents a serious constraint to effective planning and management of the Training Programme. Improvements in the Programme's ability to document current manpower utilization, to project future requirements with reasonable accuracy, and most importantly, to undertake management decisions which ensure the optimum redeployment and productivity of those persons trained, are strongly needed.

3.1 Workers Ever Trained and Currently Providing Services

Keeping in mind the serious data limitations as described above, this evaluation report nonetheless makes an estimate of the total number of workers who have ever received MCH/FP training, the total number currently providing services, and a projected estimate of future training loads.

Figure 3.1 and Table 3.1 present an analytical sequence for estimating the number of workers engaged in MCH/FP service provision. Between 1972 and 1989, a total of 5,127 persons received MCH/FP training. All of these persons, however, are not currently working with the MOH as client service providers (See Figure 3.1). We estimate that approximately 10 percent (or 513) of those trained work for NGOs. We also estimate that approximately 20 percent of ECNs and ECN/Ms, and 10 percent of KRN and Cos have been lost to attrition, that is, they retire or leave the MOH for other reasons. Another group of persons trained in MCH/FP are now

engaged as supervisors and thus are not directly providing services to clients. Finally, some of those trained have been moved to non-MCH/FP jobs in hospitals or other settings. In short, of the total 5,127 persons who have ever received training in the period 1972-1989, we estimate that only 2,269 or 44 percent are currently working for the MOH and directly providing services to clients. These trained persons represent only 15 percent of all 15,416 workers currently in the MOH (Table 3.2).

Table 3.1 Estimates of Actual MCH/FP Providers By Qualification as of end of 1989

| CATEGORY OF WORKER | NUMBERS TRAINED | | | LOSSES DUE TO | | | | MCH/FP PROVIDERS | |
|--------------------|------------------------|------------------------|------------------------|-------------------------|---------------------------|----------------------|----------------------|-----------------------------------|----------------------------------|
| | Total 1972-1984 (1) | Total 1985-1989 (2) | Total 1972-1989 (3) | NGO Work ers MOH (4) | Attrit' n from MOH (5) | Super- vision (6) | Not In MCH/FP (7) | Currently providing MCH/FP (8) | Percent Ever Trained* (8)/(3) |
| ECN/ECN/M | 1899 | 2335 | 4234 | 423 | 847 | 127 | 596 | 2241 | 53 |
| KRN | 397 | 299 | 696 | 70 | 70 | 418 | 111 | 28 | 4 |
| COs | 79 | 118 | 197 | 20 | 20 | 158 | 0 | 0 | 0 |
| TOTALS | 2375 | 2752 | 5127 | 513 | 936 | 702 | 707 | 2269 | 44 |

* Note: Data rounded to the nearest whole number

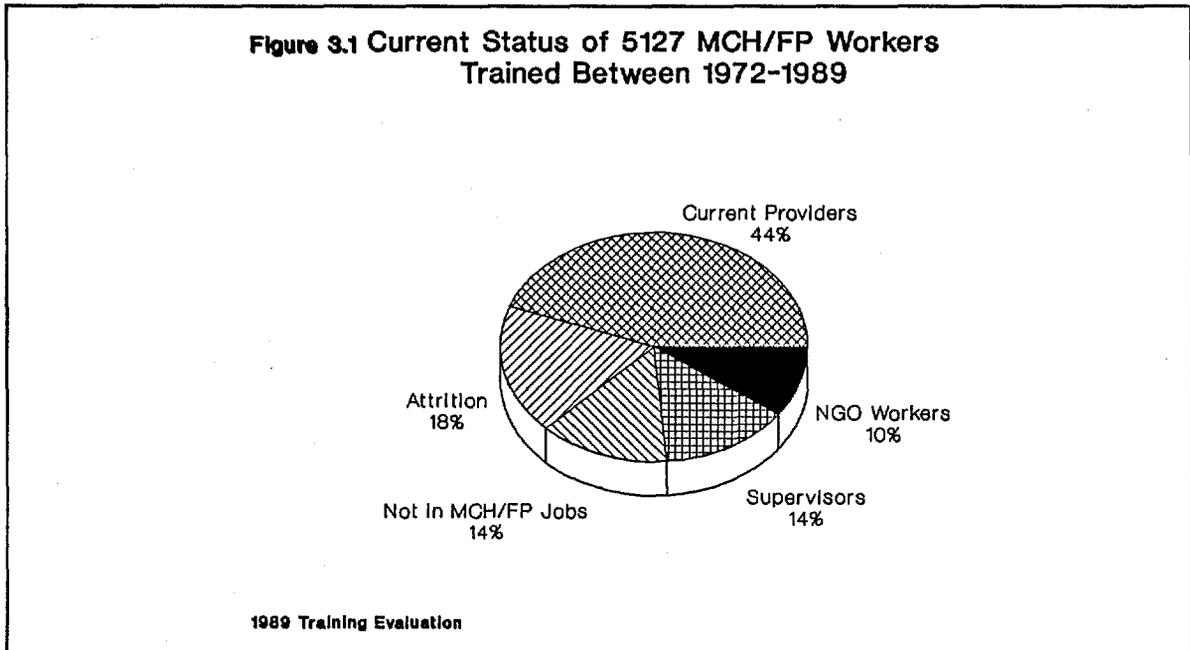


Table 3.2 Estimates of Current Providers As A Percentage of the Total MOH Workforce

| Category of Worker | Total in MOH | Currently providing MCH/FP | Percent of all MOH Currently Providing MCH/FP* |
|--------------------|--------------|----------------------------|--|
| ECN | 11282 | 2241 | 20 |
| KRN | 2493 | 28 | 1 |
| CO | 4639 | 0 | 0 |
| TOTAL | 15416 | 2269 | 15 |

* Note: Data rounded to the nearest whole number

MCH/FP workers trained in the current 7 week (or earlier 9 week) certificate course represent the core group providing day-to-day services throughout the MOH and NGO delivery systems. Table 3.3 shows that the total output of the Training Programme increased from 163 in 1985 to 878 by the end of 1989. This represents a 439 percent increase in the four year period from 1985 through 1989, a growth rate that is due mainly to the energy with which the DFH Training Programme has pursued its mandate and to the levels and consistent availability of finances provided through increased GOK and donor budgetary support since 1985.

Table 3.3 MOH Staff Trained in MCH/FP 1985 Through 1989

| Category of Worker | Year Trained | | | | | Total |
|--------------------|--------------|------------|------------|------------|------------|-------------|
| | 1985 | 1986 | 1987 | 1988 | 1989 | |
| KECNs, KEN/M | 145 | 400 | 420 | 629 | 741 | 2335 |
| Clinic Officers | 8 | 42 | 62 | 93 | 94 | 299 |
| KRNs | 10 | 18 | 19 | 28 | 43 | 118 |
| Totals | 163 | 460 | 501 | 750 | 878 | 2752 |

Table 3.3 also reveals that of all 2,752 persons trained since 1985, Enrolled Nurses (KECNs, KEN/Ms,) accounted for 85 percent, while supervisory training of Registered Nurses (KRN/Ms) and Clinical Officers (COs) accounted for 15 percent.

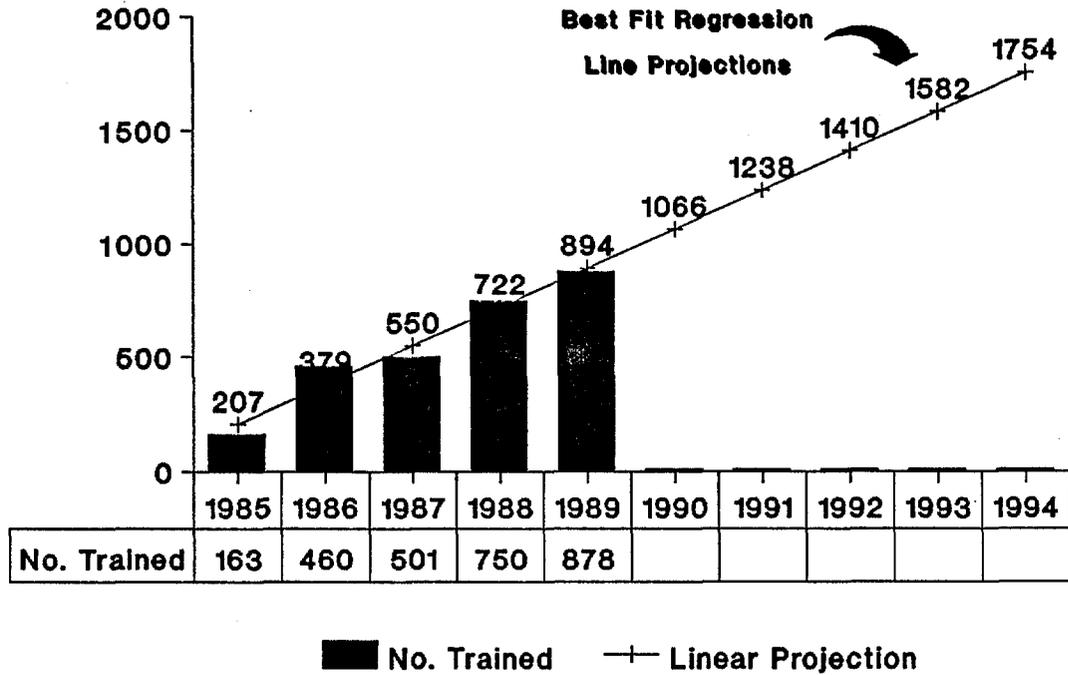
3.2 Estimated Number of Workers Requiring Training Through 1994

Figure 3.2 provides a linear projection of the total estimated number of workers who will be trained between 1990 through 1994 if

current trends in training continue. The projection suggests that over the five year period, an additional 7,050 workers will be trained. Figures 3.3 and 3.4 provide similar linear projections for specific categories of workers and suggest that a total of 5,889 KECNs and KEN/Ms and 1,165 KRN/Ms and Cos will be trained in the five year period.

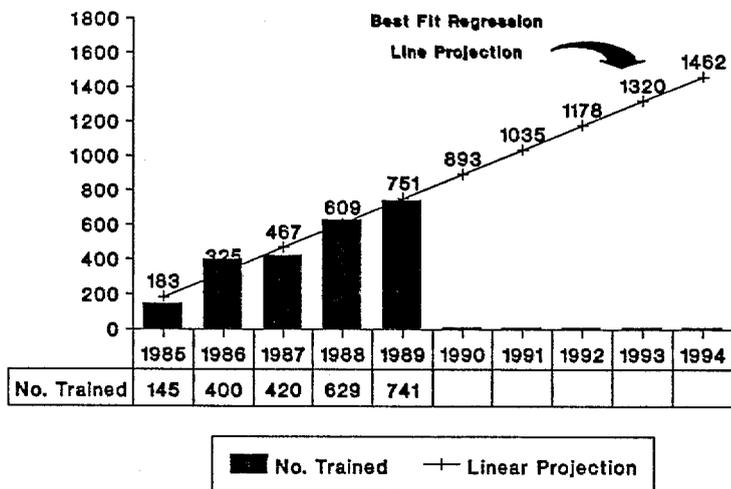
Figure 3.2

**Total MOH Staff Trained 1985-89
and Linear Projection Through 1994**



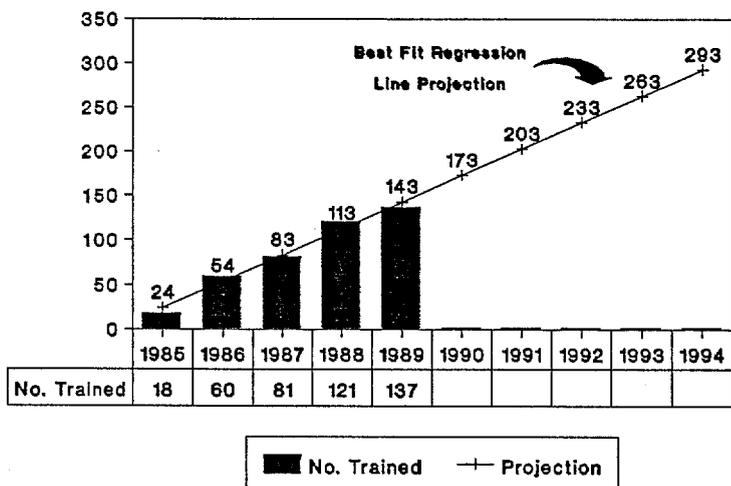
1989 Training Evaluation Report

Figure 3.3 Trained KECNs, KEN/Ms 1985-89 and Linear Projection Through 1994



1989 Training Evaluation Report

Figure 3.4 KRNs and COs Trained 1985-1989 and Linear Projection Through 1994



1989 Training Evaluation Report

The issue of whether or not this output is adequate to cover normal attrition and to meet the growing demand for services is a question of major importance for the Division of Family Health. Although the DFH Training Programme appears to be producing fairly large numbers of certified workers (750 workers in 1988, and 878 by the end of 1989), there is still the general impression among

family planning programme managers that there is a chronic shortage of MCH/FP workers.

In all likelihood, the projections shown in Figures 3.2, 3.3, and 3.4 are probably conservative estimates of the number of trained workers required. The estimates assume a constant and linear percentage increase in the demand for services. If, as is likely, demand for services accelerates on a curvilinear basis, then the need for trained workers will also be curvilinear and far greater than the projections shown. For example, if the private sector (including company/parastatal facilities, Family Planning Association of Kenya, private clinic practices) increases services substantially, then there will be a need for more trained workers. Also, as the cohorts of workers trained in the 1970s reach retirement age in the 1990s, the attrition rate may be greater than expected and thus require an increase in newly trained workers.

Whatever additional factors may increase the need for more trained workers, it seems reasonable to assume that at a minimum, over the next five year period the annual output of trained workers will need to be doubled. This suggests a concomitant doubling of training staff and facilities during the same period, and the need for a substantial increase in training resources.

3.3 Performance of Trained Workers

3.3.1 Profile of Respondents

The evaluation was designed to create a profile of trained family planning workers and to document their performance at Service Delivery Points (SDPs). The evaluators visited 42 SDPs in 20 districts. Information was collected from a sample of providers and their supervisors. The sample included 128 providers, 42 who were interviewed at their SDPs and 86 who were invited to gather at five prearranged locations throughout the country. The data collection instruments are shown in Appendix B.

Table 3.4 indicates that seventy-eight percent of the 128 providers are Enrolled Nurses. The supervisory groups of registered nurses and clinical officers make up 17 and 4 percent respectively. Forty eight percent of the 128 respondents work in health centers, forty percent in hospitals, and about 13 percent in dispensaries (Table 3.5). On average, the 128 respondents have slightly over 4 years of service experience with the MOH, although approximately 35 percent have more than 11 years with the MOH (Table 3.6). As MCH/FP providers they have worked for an average of three years and have been working at the same SDP for an average of four years (Tables 3.7).

(Table 3.6). As MCH/FP providers they have worked for an average of three years and have been working at the same SDP for an average of four years (Tables 3.7).

Table 3.4 Frequency Distribution of Respondents By Qualification

| Category of Worker | Frequency | Percent |
|--------------------|-----------|---------|
| ECN/M | 100 | 78.1 |
| KRN/M | 22 | 17.2 |
| CO | 5 | 3.9 |
| OTHER | 1 | 0.8 |
| TOTAL | 128 | 100.0 |

Table 3.5 Frequency Distribution of Respondents By Type of Facility

| Facility Type | Frequency | Percent |
|---------------|-----------|---------|
| Dispensary | 16 | 12.5 |
| Health Cente | 61 | 47.7 |
| Hospital | 51 | 39.8 |
| TOTAL | 128 | 100.0 |

Table 3.6 Grouped Frequency Distribution of Respondents By the Number of Years they have Worked as Registered Health Workers

| Years Worked | Frequency | Percent |
|--------------|-----------|---------|
| 1 - 5 | 39 | 30.5 |
| 6 - 10 | 43 | 33.6 |
| 11 -15 | 26 | 20.3 |
| > 15 | 19 | 14.8 |
| Missing | 1 | 0.8 |
| TOTAL | 128 | 100.0 |

Table 3.7 Frequency Distribution of Respondents By Number of years Working as a FP Provider.

| Number of Years | Frequency | Percent |
|-----------------|-----------|---------|
| 0 | 13 | 10.2 |
| 1 | 30 | 23.4 |
| 2 | 15 | 11.7 |
| 3 | 6 | 4.7 |
| 4 | 11 | 8.6 |
| 5 | 26 | 20.3 |
| 6 Or More | 27 | 21.1 |
| TOTAL | 128 | 100.0 |

The sample was intended to include only active providers trained since 1985. However, it was found that 10 percent had been trained before 1985 and 21 percent of the sample reported that they were currently engaged in duties unrelated to MCH/FP services. Since the sample was drawn directly from current records, this variation reflects two incidental but useful pieces of information ; firstly, district records on the training history of MCH/FP workers are not totally accurate and secondly, the actual current assignment of trained workers according to district records is not up to date. Also, since the number of workers expected to be active providers who were incidentally discovered to be inactive (21%), the overall numbers of inactive trained MCH/FP workers currently in the system can be assumed to be much higher.

Of the 128 providers contacted, only 18 percent had received additional update training since being certified (Table 3.8).

Table 3.8 Distribution of the Number of providers that have had a Family Planning Update Course

| Response | Frequency | Percent |
|------------|-----------|---------|
| NO Update | 102 | 79.7 |
| YES Update | 24 | 18.8 |
| Missing | 2 | 1.6 |
| TOTAL | 128 | 100.0 |

The data in Table 3.9 show that prior to certification as MCH/FP workers, 43 percent of the group were previously assigned as ward nurses, 35 percent were from health centres, 11 percent were pediatric nurses, and about 10 percent came from other areas.

Table 3.9 Distribution of Respondents By Previous Work Assignment Before MCH/FP Training

| Previous Work Assignment | Frequency | Percent |
|--------------------------|-----------|---------|
| Pediatric Nurse | 14 | 10.9 |
| Operating Theatre | 1 | .8 |
| Health Centre | 45 | 35.2 |
| Ward Nurse | 55 | 43.0 |
| Other | 12 | 9.4 |
| Missing | 1 | .8 |
| TOTAL | 128 | 100.0 |

Among those who reported themselves as nonproviders of MCH/FP services, 70 percent were drawn from and returned to service at hospitals. This suggests that a decrease in the proportion of trainees drawn from hospital wards would increase the overall proportion of trained providers who use their skills most productively after training. Because the staffing patterns in hospitals require flexibility for rotational assignments, MCH/FP certified workers are less likely to have substantial opportunities to utilize their MCH/FP skills.

3.3.2 Adherence to Standard Operating Procedures

The evaluators observed trained workers in the actual process of interaction with FP clients. The checklist used to collect data requested evaluators to observe as many of the following procedures as possible: counseling and interviewing, client's first visit and revisit, pelvic examination and IUCD insertion. For each of these procedures the observer was to check yes or no if a particular procedure was completed. In order to reduce observer bias, the checklist was constructed to document adherence to accepted and established procedures rather than to elicit the evaluator's judgement of the procedure. In forty-two (42) SDP visits the evaluators observed 29 counseling interviews, 24 revisits, 21 pelvic examinations, and 3 IUCD insertions.

MCH/FP workers appear to obtain adequate historical information from their clients to safely prescribe hormonal contraceptives and other methods. Physical examination routinely includes blood pressure measurement; pelvic examination is routinely performed for all new clients and for revisits whenever necessary, and pregnancy is routinely ruled out prior to prescribing contraceptives.

A summary of the counselling interview results are shown in Tables 3.10 and 3.11. Counselling interview results indicate that the great majority of interviews were conducted in private and clients were asked important historical information about the age of the woman, previous contraceptive use and the number of pregnancies. Of the 39 cases observed, 86 percent or more had inquiries about previous contraceptive use, pregnancy history, parity and the age of the client. Further details from Table 3.11 show that providers are more likely to counsel clients on hormonal methods (pills 100 percent and Depo-Provera 92 percent), IUCDs (100 percent), and condoms (100 percent) than they are to explain surgical contraception (39 percent), natural family planning (68 percent), diaphragms (50 percent), and foaming tablets (88 percent) during the client's initial visit. This point should be noted since surgical contraception is among the fastest growing methods of preference for couples who have completed their family sizes, but VSC is being under-promoted in SDPs. Also, while counselling in the use of diaphragms continues to be highlighted, actual demand for this method has been declining tremendously. The observed pattern of counselling new clients suggests the need for greater emphasis on surgical options and is a great reminder that providers need continuing refresher and update courses on new technologies and generally changing demand as various methods emerge. Currently, the programme does not currently address these continuing training needs.

Table 3.10 Distribution of Providers for Selected Performance Indicators in Counselling Interviews

| Procedure | Percent | | Missing Cases | Tot. N |
|--|-----------|---------------|---------------|--------|
| | Performed | Not Performed | | |
| Inquired on Previous Contraceptive Use | 86 | 14 | 10 | 39 |
| Inquired About Parity & Previous Pregnancies | 93 | 7 | 10 | 39 |
| Privacy | 87 | 13 | 9 | 39 |
| Age | 85 | 15 | 11 | 39 |

Note: The total number of cases is 39. Percentages are calculated on valid number of cases (excluding missing cases).

Table 3.11 Distribution of Providers following Standard Procedures during Method Counselling for New Clients

| Method Explained | Yes | NO | Missing Cases | Total No. of Valid Cases |
|----------------------------------|-----|----|---------------|--------------------------|
| Orals | 100 | 0 | 13 | 26 |
| IUCD | 100 | 0 | 14 | 25 |
| Condoms | 100 | 0 | 15 | 24 |
| Depo-Provera | 92 | 8 | 13 | 26 |
| Foaming Tablets | 88 | 12 | 14 | 25 |
| Natural Family Planning | 68 | 32 | 17 | 22 |
| Diaphragms | 50 | 50 | 15 | 24 |
| Voluntary Surgical Contraception | 39 | 61 | 16 | 23 |

Note: Percentages are calculated out of the total number of valid cases observed and exclude missing cases.

Providers appear to be performing very well in following standard operating procedures for revisit clients. Table 3.12 summarizes the providers' performance as observed during 24 client revisits. In all 24 revisits, arrangements were made for a follow-up visit, blood pressure was taken in 96 percent of the revisits, privacy was provided in 83 percent, and a resupply was given in 82 percent of the revisits. The one possible problem area is with side effects. In only 68 percent of the revisits did the provider inquire about side effects. This is an important issue for future consideration in training since client continuation is directly linked to side effect issues.

Table 3.12 Distribution of Providers following Standard Procedures During Client Revisits

| Aspect of Procedure | Yes | No | Missing Cases | Total Valid Cases |
|--------------------------|-----|----|---------------|-------------------|
| Arranged Follow Up | 100 | 0 | 15 | 24 |
| Blood Pressure Taken | 96 | 4 | 15 | 24 |
| Privacy Observed | 83 | 17 | 15 | 24 |
| Supply Given | 82 | 18 | 15 | 24 |
| Enquired On Side Effects | 68 | 32 | 17 | 22 |

Note: Percentages are calculated from valid total number of cases which exclude missing cases.

The checklist for observing pelvic examinations included attention to privacy, explanation of the procedure and use of sterile techniques. The majority of providers attended to these items reasonably well during the examination. Only three IUCD insertions were performed during the clinic observations and in each case the providers adhered to all the items on the checklist. However, in at least one of the three procedures, the provider took close to three hours (counseling time included), suggesting a lack of confidence (and probably proficiency as well). The presence of an observer may have served to aggravate the uncertainty of the provider.

Because clinic observations conducted during the evaluation were done in cameo, it was not possible to gather objective data on the handling of complications and emergencies. The adequacy of provider preparation to meet these situations needs further, separate study.

3.3.3 The Management of Clients at SDPs

At each of 42 service delivery points, ten first visit client records were selected and information from these records was transcribed onto the Evaluator's Clinic Observation instrument. This process resulted in the compilation of a sample of 413 client records which served as a basis for reviewing the type of services delivered as well as some basic quality of care indicators. For each of the 413 records the following information was recorded: method prescribed, blood pressure, age, and parity of the client, and; documentation of whether the provider taught self-breast exam, conducted general and pelvic exam and, provided an appointment for follow-up visit.

Table 3.13 below shows the frequency of methods prescribed as derived from the clinic records.

Table 3.13 Contraceptive Prescription Patterns Among the Providers

| Method | Frequency | Percentage |
|------------------|-----------|------------|
| Combined Pills | 172 | 41.6 |
| Triphasic Pills | 6 | 1.5 |
| Mini Pill | 48 | 11.6 |
| Nova T | 2 | .5 |
| Copper T | 44 | 10.7 |
| Depo Provera | 113 | 27.4 |
| Condoms/Foam Tab | 16 | 3.9 |
| Tubal Ligation | 2 | .5 |
| Missing | 10 | 2.4 |
| TOTAL | 413 | 100.0 |

In the sample of 413, pills were prescribed for 54.7 percent of the clients. Depo-provera was prescribed for 27.4 percent of the clients. Depo-provera is of special interest since it is a method of growing popularity and demand. Since it is also a method reserved for women of proven parity, clinic records were checked for age and parity of those receiving Depo to identify possible evidence of either too lenient or too restrictive prescriptive patterns.

The mean age of Depo users was 27 years and their average parity was 4.6 although 36 percent of the Depo users had three or fewer children. It would appear that most providers are adhering to the MOH standards for prescribing Depo-provera, but tend to direct this method almost exclusively toward older women of multiple parity. This pattern of prescription is clearly illustrated in Tables 3.14 and 3.15 for ages and parity respectively. Informal indications suggest that some service providers are concerned about prescribing Depo to younger women because of the possibility that fertility may be delayed after the method is discontinued. The age and parity of Depo users differs from the general population of clients whose average age is 25 years and average parity is three.

Table 3.14 Grouped Age Frequency Distribution for all Clients Compared to Depo Provera Users

| Age In Years | ALL SAMPLE | | DEPO USES | |
|--------------|------------|---------|-----------|---------|
| | Frequency | Percent | Frequency | Percent |
| less 20 | 31 | 7.5 | 2 | 1.8 |
| 20 - 24 | 173 | 41.9 | 29 | 25.7 |
| 25 - 29 | 121 | 29.3 | 32 | 28.3 |
| 30 - 34 | 53 | 12.8 | 29 | 25.7 |
| 35 - 39 | 17 | 4.1 | 11 | 9.7 |
| 40 - 49 | 5 | 1.2 | 5 | 4.4 |
| Missing | 13 | 3.1 | 5 | 4.4 |
| TOTAL | 413 | 100.0 | 113 | 100.0 |

Table 3.15 Distribution of The Clients Selected From Records By Parity.

| Number of children | ALL CASES | | DEPO ONLY | |
|--------------------|-----------|---------|-----------|---------|
| | Frequency | Percent | Frequency | Percent |
| 0 | 11 | 2.7 | 1 | 0.9 |
| 1 | 86 | 20.8 | 5 | 4.4 |
| 2 | 89 | 21.5 | 10 | 8.8 |
| 3 | 75 | 18.2 | 25 | 22.1 |
| 4 | 55 | 13.3 | 19 | 16.8 |
| 5 | 31 | 7.5 | 15 | 13.3 |
| 6 | 37 | 9.0 | 18 | 15.9 |
| 7 | 12 | 2.9 | 7 | 6.2 |
| 8 | 8 | 1.9 | 5 | 4.4 |
| 9 | 4 | 1.0 | 4 | 3.5 |
| 10 | 3 | .7 | 3 | 2.7 |
| 11 | 1 | .2 | 0 | 0.0 |
| 13 | 1 | .2 | 1 | 0.9 |
| TOTAL | 413 | 100.0 | 113 | 100.0 |

In Isiolo District with a mainly Muslim population, it was interesting to note that Depo is preferred above all other methods, and that the acceptor population also averages 21 years with parity of one to two children. Service providers report a noticeable increase in contraceptive awareness and preference for a discrete and unobtrusive method such as injectables, suggesting a demand pattern that could develop in other traditionally low-acceptor areas of the country.

3.3.4 Management of Clinic Supplies

During the forty-two clinic visits, contraceptive supply management was also assessed by documenting the physical count and comparing the count to the stock record (Bin Card or supply log, etc.). In 59 percent of the clinics no specific stock control records were being maintained, and where records did exist, the physical count and the recorded supply varied widely. The majority of the clinics had a variation of between 100-150 percent between observed and recorded contraceptive supplies. It should be pointed out that a substantial number had percentage variations of above 200 percent.

Stock-outs of certain contraceptives were also observed in many of the clinics. Table 3.16 documents the frequency of stock-outs for specific contraceptive supplies.

Table 3.16 Instances of Contraceptive Supply Stock-Outs in 42 SDPs

| Method | Instances | As A Percent |
|--------------|-----------|--------------|
| Microlut | 2 | 4.8 |
| Microgynon | 4 | 9.5 |
| Eugynon | 15 | 35.7 |
| Copper T200 | 35 | 83.3 |
| Copper T380 | 6 | 14.3 |
| Lippes Loop | 18 | 42.9 |
| Depo Provera | 16 | 38.1 |

Products sampled were selective and do not provide a complete picture of all stock levels in the SDPs visited. However, certain observations can be made from the limited data generated. The stock patterns in the facilities sampled suggest that the national phase-out policies established for Copper T 200A and Lippes Loop are working. Most facilities were adequately stocked with Copper T 380As. However, provider preference for other products was in evidence. One facility was observed to have no less than twenty-five Lippes Loops in solution and ready for use (their IUCD insertion rates were about 3 per month), while all Copper T 380A devices on-hand had been stored for discard as they were considered to be "unusable" because of tarnishing. If a client had specifically requested a Copper T 380A, it would have been unavailable at this particular facility.

The stock-out rate for Depo-provera at 19 percent of the SDPs visited is notable since this method is in high demand.

The evaluation was able to conclude that the stock-out phenomena in facilities was due more to poor record-keeping and control at the clinic level and less to absolute shortages in the supply system. Quite a few of the sampled facilities were using the newly introduced Contraceptives Logistics Management Information System (CLMIS). The Daily Activity Registers were observed to be well maintained, and the intended supply information available. However the monthly data were underutilized for stock control purposes.

Even in large provincial/district facilities, contraceptive supplies are not necessarily treated as part of the overall stock control system. There is a tendency to maintain all of the available supplies in the facility somewhere in the MCH/FP clinic area (loosely stored in drawers and cupboards), thus consumption rates and supplies-on-hand are not sufficiently monitored. This is in contravention of existing guidelines which have previously established that bulk supplies should be stored and controlled along with all other materials by the facility supplies officer or the pharmacist, and internally requisitioned by the MCH/FP clinic on an as-needed basis. Apparently supply officers/pharmacists still do not view maintenance of contraceptive supplies as their concern, and MCH/FP service providers simply find it more convenient to maintain their own stocks. This might work well if MCH/FP workers were additionally maintaining acceptable stock control procedures -- which they are not in most instances. As an alternative to integrating contraceptive supplies into the general stores at the facility, MCH/FP workers need much better instruction on how to use data from the Daily Activity Register for stock control purposes, and when to initiate actions to ensure replenishment. In addition, since the new contraceptive logistics system provides a mechanism for supplies to be "pushed" to facilities based on off-take data extracted and reported quarterly from the Daily Activity Registers, implementation of these new procedures should also eventually assist in improving the basic contraceptive supply situation in most SDPs.

At each SDP the numbers of specula, tenacula and uterine sounds were counted. In the analysis this count was compared to the daily client visits with the expectation that busy clinics would require more equipment, and where equipment is limited, the chance of inadequate sterilization is increased.

The analysis indicates that busy clinics have more equipment and that for the majority of clinics, inventory is sufficient to ensure that clients need not be exposed to contamination. Equipment shortages in MOH facilities were not alarming overall, but some routine assessment and monitoring is indicated to ensure replenishment as needed. Such information on equipment/supply requirements could easily be introduced as a supplement to the new contraceptive logistics information system. Furthermore, there are limited (if any) buffer stocks of basic contraceptive examining instruments being maintained at the Central Medical Supplies Coordinating Unit or the Division of Family Health Stores Annex. This is very likely hindering the opening of new SDPs -- particularly for private practices that might wish to officially register with the MOH as SDPs. A separate assessment needs to be undertaken to determine these current and future needs.

Since the evaluation only undertook a "spot check" on selected essential equipment items, the findings discussed above are indicative, but incomplete. Aside from these essential items, it was determined from observation and through anecdotal reports from providers that there is a complete absence of visual counseling aids such as demonstration models and wall charts. In addition, there is an almost universal short supply of consumable supplies such as detergents, disinfectants, sterile examining gloves (both reusable and disposable, cotton wool, lotion, etc.

3.3.5 Aseptic Techniques

Data collectors were asked to observe and report on the methods used for sterilizing family planning equipment and supplies. The reports are inconclusive but suggest that accepted procedures for disinfection and sterilization are generally followed but not always up to acceptable standards. Procedures are frequently resource-constrained: some facilities do not have clear water, thus cloth materials used in the examination room, although washed, appear to be dirty; autoclaves are frequently found to be in disrepair; disinfectant and sterile gloves are in short supply. Problems of cleanliness were observed to be incidental rather than universal and where these existed, the observation was that in the absence of resources, awareness and innovation were also lacking.

Presumably, the need for flexibility, initiative and creativity is built into the training curriculum. However, at the permanent work site such initiative appears to be soon overcome and frustrated by day-to-day resource constraints. More information regarding appropriate, alternative techniques for maintaining sterile conditions needs to be built into the Training Programme (as for example, techniques for within-package loading of Cooper T 380A). In addition, increased supervision in this area would likely serve to reinforce acceptable practices.

3.4 Effects of Supervision on Quality of Care

Data about the pattern of supervision for trained MCH/FP workers was gathered through questionnaires, observations and interviews with supervisors. Trained MCH/FP workers were also questioned about their experiences with supervisors. Supervisors were asked for information about their qualifications, training and experience as well as their supervision routines. They also completed the knowledge assessment questionnaire.

A total of 36 supervisors were identified as being associated with the sample. It is assumed that the concentration of supervisors found in the study is higher than national averages because of the relatively large number of urban sites included in the sample relative to the country as a whole. Out of the 36 supervisors identified and responding to questionnaires during the evaluation, Table 3.17 shows their levels of qualification.

Table: 3.17 Qualifications of Supervisors

| Qualification | Frequency | Percent |
|---------------|-----------|---------|
| KRN/M | 12 | 33.3 |
| CO | 2 | 5.6 |
| PHN | 13 | 36.1 |
| ECN | 8 | 22.2 |
| Missing | 1 | 2.8 |
| TOTAL | 36 | 100.0 |

The descriptions of qualifications are simplified for presentation purposes. Many of the supervisors have additional qualifications such as "midwife" and all have had family planning training. As expected, Public Health Nurses (PHNs) are most frequently identified as supervisors of family planning workers, and along with KRN/MS they provide almost 70 percent of supervision.

Somewhat surprising is the relatively large percent of ECNs identified as supervisors. The increase in ECN who are functioning as supervisors is apparently a response to the larger number of trained ECN/MCH/FP workers per facility. As the number of trained ECN/MCH/FP workers in a given facility increases, the individual who is most senior tends to be appointed by the District Public Health Nurse as the MCH/FP supervisor. This appointment is informal and is not accompanied by salary increase or increased training. The importance of this point is relevant when weighed against the vast experience that supervisors are bringing into the public health sector (Table 3.18). Sixty one percent of the

supervisors report an experience of 5 years or above. Of this group, 45 percent have at least 10 years experience.

Table 3.18 Number of Years Acting as a Supervisor

| Value Label | Frequency | Percent |
|-------------|-----------|---------|
| < 1 YR | 3 | 8.3 |
| 1 YEAR | 6 | 16.7 |
| 2 YEARS | 1 | 2.8 |
| 3 YEARS | 3 | 8.3 |
| 4 YEARS | 1 | 2.8 |
| 5 YEARS | 7 | 19.4 |
| 6 YEARS | 5 | 13.9 |
| 10 YEARS | 10 | 27.8 |
| TOTAL | 36 | 100.0 |

The responsibilities of MCH/FP supervisors in MCH/FP clinics are difficult to define especially since 90 percent of supervisors report that they have no standard supervisory guidelines. This failure to use guidelines or checklists does not pass unobserved by the providers who also report that 80 percent of their supervisors do not use these aids for supervisory purposes. The data collected, however, do provide some insight into supervisory problems and therefore responsibilities. Administration is a major aspect of the supervisory role as suggested by the host of administrative problems reported by the 36 supervisors. These include: transport, shortage of MCH/FP instruments and supplies such as gloves, lotions and stationery as well as shortages of contraceptive supplies, particularly certain pills and Depo-provera. (Although problems of transport are undoubtedly chronically severe throughout, the perceptions of equipment/supply shortages tend to be somewhat more exaggerated than actual findings as discussed in Section 3.2.5 of this report).

Although one third of those sampled report no problems in monitoring the performance of MCH/FP providers, another third of the sample report lack of transport for supervision as a problem. This could explain the irregular and infrequent supervisory visits received at some locations. Other supervisors report shortage of KRCHNs to assist with staff supervision.

The supervisor's responsibilities are diverse and to some extent reflect their position in the system. For example, some DPHNs surveyed in this study supervise as many as 104 staff and have responsibility for the entire operation of multiple SDPs, a work load that would be difficult to manage even if transportation were available. In contrast, 56 percent of supervisors are

responsible for six or less workers and 83 percent of the sample supervise 16 or less.

The study also gathered information about frequency of supervision. Table 3.19 provides a summary of responses.

Table 3.19 Frequency of Supervision as Reported by supervisors and providers

| | <u>SUPERVISORS</u> (#36) | <u>MCH/FP WORKERS</u> (#128) |
|-----------------------|-----------------------------|---------------------------------|
| NO ACTIVE SUPERVISION | 27.8 | 43.0 |
| DAILY | 27.8 | 14.8 |
| WEEKLY | 19.4 | 10.2 |
| MONTHLY | 13.9 | 18.0 |
| QUARTERLY | 1.1 | 10.2 |
| SEMI-ANNUALLY+ | 0 | 3.9 |

The differences in perception of supervision suggest that although the supervisors say they are actively supervising the SDPs, a substantial number of workers are apparently not aware that they are being supervised. Of course, one could argue that monitoring can take place without the worker being aware but supervision should be a positive, supportive act which contributes to the workers performance and creates a bond between the worker and his/her service system. Of the 43 percent of workers reporting no supervision or no routine supervision, more than 60 percent were unable to identify their supervisor. This suggests that many workers experience a sense of isolation or lack of support from their own management structures. These perceptions may have a negative effect on provider performance.

The data from this evaluation suggests a profile of supervisors which emphasizes their need for additional development and support. Only 25 percent of the supervisors report having received a contraceptive technology update course. Anecdotal findings suggests that many supervisors do not provide the type of support to MCH/FP that they might otherwise provide because they feel technically inadequate. Furthermore, 60 percent of MCH/FP supervisors have not received any formal preparation in supervising others. The lack of attention to development of a supervisor cadre for MCH/FP workers is further validated by the low scores of supervisors on the evaluation's Needs Assessment (Knowledge Test) Questionnaire.

Section 4

TRAINING CONTENT AND PROCESS

4.0 General

The Training Programme is concerned with several different types of courses including:

1. The 7-week MCH/FP Certificate Course for Enrolled Community Nurses;
2. A similar 7-week MCH/FP Certificate Course offered separately to Kenya Registered Nurse/Midwives and Clinical Officers;
3. A 5-day Contraceptive Technology Update Course for Enrolled Community Nurses; MCH/FP Course Content and Structure
4. A similar one-week Update Course for MCH/FP supervisors and trainer/tutors;
5. A special course to train MCH/FP trainers, and;
6. Other specialized subject workshops for selected audiences which might be scheduled by DFH headquarters from time-to-time.

The 7-week Certificate Course for ECNs is offered four times per year at each of eleven DTCs. Beginning in 1989, each centre also offered one Technology Update course for ECNs. Schedules for the Nairobi and Nyeri centres are slightly different since they also provide the 7-week course for KRNs/COs. Nairobi is the only centre providing Training of Trainers, usually one 3-week course per year, and is the main centre that will organize any other specialized workshops on an as-needed basis.

There is little difference in the content and instructional procedures for the 7-week certificate training for ECNs as compared to the one offered for KRNs/Ms and COs. The two courses are separated mainly because of differences in entry-level qualifications, and for protocol reasons. In general, the 7-week certificate courses form the core of the Training Programme, requiring the major portion of the Programme's efforts and resources, and representing the single-most important Programme output.

A syllabus, or detailed outline of the MCH/FP course, was last revised and published in 1986. This syllabus serves as the basic guideline for all MCH/FP training and certification by the MOH (or any other training institution in the country that might undertake such efforts).

4.1 Course Content

In general, the Training Programme is endeavoring to impart knowledge and skills of high technical quality based on international standards. As shown from the basically acceptable performance of workers in the field (discussed in Section 3.3 of this report), with some noted exceptions much of the essential learning gained during training is being applied in actual practice.

In the 7-week curriculum the following subjects are covered in approximately 70 hours of classroom instruction: all approved contraceptive methods, contraceptive actions, prescription protocols, management of side effects, anatomy and physiology of male and female reproductive systems, general physical, breast, and pelvic examinations, history taking, interviewing and counseling, adolescent fertility, infertility management, IUCD insertion and diaphragm fitting. Clinic management topics include sterilization of FP equipment and record keeping. Non-FP topics such as immunizations, cold chain management, and ORT are also included in the list of recommended subjects for the 7-week course. These non-FP topic areas are only being covered in overview. However, since the MOH not only covers these subjects in specialized, separate in-service training courses, but also in the post-basic Continuing Education curriculum, it may not be necessary to spend as much time on these subjects as is currently being provided.

The 7-week course essentially covers the subjects normally appropriate for MCH/FP providers with an emphasis on the FP aspect. Additional attention needs to be given to counselling in new contraceptive technologies such as NORPLANT. Certain areas in client case management such as IUCD management, and possibly, management of complications and side effects need further attention. (See also Section 3.2 of this report). More specific information on MOH policies, particularly related to handling of adolescents and young, low-parity clients, is needed. Additional emphasis should also be given to natural family planning, management of contraceptive stocks, and maintenance of sterile conditions. All of these subjects are currently touched upon rather superficially (if at all), in classroom training, and have no specific linkages during the practical phase.

4.2 Course Materials

Generally, the Training Programme is using good quality training/reference documents. These include:

- The MCH/FP Certificate Course Curriculum, 1986;
- Africa Family Planning Methods and Practices;
- Contraceptive Technology: 14th Revised Edition;
- "Blue Book", or Standard Operational Procedures Manual for FP service provider, published by the MOH, 1988.

The MCH/FP Curriculum published in 1986 is well-known and used in all DTCs. The MCH/FP Curriculum has been widely distributed to Trainers and training centers; 53 percent of Trainers have a personal copy, and 91 percent of DTCs have a reference copy. The "Blue Book" is also widely available as 97 percent of Trainers report having access to a copy. However, even this wide distribution can be assessed as insufficient.

The MCH/FP Curriculum is a good outline of course objectives and content, but could be more useful if it were to include or be supplemented by more specific instructional guidelines and test questions. Each and every Trainer should have a working copy of the curriculum since it is the Trainer's single-most important teaching aid. The Curriculum should also routinely be made available to consultants and other resource people as they plan lectures since it defines the minimum level of content that should be taught about each topic.

Trainers report using the Curriculum in the following manner:

- | | | |
|------------|---|---|
| 96 percent | - | To assist in preparation of lesson plans; |
| 71 percent | - | To identify content materials needed; |
| 52 percent | - | To assist in preparation of evaluation questions. |

There remains some confusion among Trainers about the purpose and limits of the MCH/FP curriculum as indicated by the responses where one third of Trainers who report using the curriculum to, "describe procedures". In fact, the Curriculum only provides standards, but does not contain sufficient details for instruction. Instead, this is provided by the Standard Operating Procedures Manual (frequently referred to in the field as the "Blue Book", or the "SOP"). The Blue Book is an enormously useful document for

trainers, students, and practitioners alike. It is accurate, comprehensive, readable, well laid out and contains helpful diagrams. With the exception of reproductive anatomy and physiology, this manual contains all the basic technical information a student will need to know to provide family planning services.

The Blue Book should be able to replace many of the duplicated handouts now in use, and the information in the Blue Book is more accurate as well as having a much better presentation. Trainers could be relieved of the burden to duplicate handouts, and students could be better able to manage their materials if the Manual replaced the handouts currently being given out during training. Unfortunately, while most Trainers have a personal copy of the Blue Book, not all DTCs are able to provide each student a copy, and at any rate, students are not allowed to take a copy with them back to their work sites. For some centres, a copy already exists at the SDP. Other supplementary materials on AIDS (HIV), STDs, and IUCD insertion, for example, could be identified or developed and given to students. A modulized series of booklets prepared by International Development Training (IDT), the University of North Carolina (INTRAH) and Johns Hopkins University (JHPIEGO), this latter specifically on use of the Copper T 380A, were reviewed and found to be potentially quite appropriate and useful augmentations to the SOP.

Other than the Blue Book, other reference documents listed above were reported to be available by about one-third of the Trainers. "Africa Family Planning Methods and Practices " has been in use for over ten years in Kenya, and is a document that is familiar to most health workers and readily associated with the MCH/FP Training Programme. A few Trainers felt that the book was gradually becoming outdated in some areas and they certainly preferred the Blue Book as a procedures guide, but still viewed the Africa FP Methods document as "useful". It was also observed that these books are in critical short supply in DTCs -- sometimes as few as one or two for 15 students -- and many of those found were extremely worn (torn bindings, loose pages, etc.). The publication, "Contraceptive Technology" is much less well known, but coveted where it is found. Attempts need to be made to make this and other books available on a very wide scale.

Aside from the MCH/FP Curriculum and other reference materials used in the course, Trainers do not have a standard instructional workbook or manual. This type of workbook would serve a different purpose than other types of materials used. For example, the Curriculum and Standard Operating Procedures Manual describe what is to be taught. In contrast, an instructional manual would provide steps and procedures for how the subject matter should be presented to students. One advantage of having an instructional manual for Trainers is that competency-based and adult learning/teaching approaches could become more structured and

reinforced. Such learning principles as: motivation, social relationship, physical environment, clarity, relevance to the future, relevance to previous experience, structure, active learning, feedback, and speed in teaching could be introduced and used competently by even inexperienced Trainers (so long as they had a grasp of the technical content). This type of instructional manual would offer an alternative to the current dependency on lecture methods, would introduce minimum teaching standards into the Programme, and would reduce the burden on Trainers in both preparing for and delivering instruction. Such a manual would also serve as a "text book" for the Training of Trainers course.

4.3 Instructional Approaches

Apart from Nairobi and Nyeri DTCs (which have slightly different schedules), each of the other DTCs routinely train 15-20 certificate students four times per year. Usually two or three Trainers take responsibility for organizing and conducting the courses. An analysis of DTC course schedules indicates that less time is allocated to both classroom and practice experience phases than has been designated by the DFH. The average number of classroom hours at DTCs is 70, with 130 hours for clinical practice, (compared with the standard guideline of 88 and 160 hours, respectively). During the classroom phase of training, instruction is provided by the Trainers and selected resource people. Approximately half of the subjects are taught by Trainers whose teaching responsibilities usually include introduction of contraceptive methods.

The classroom teaching load varies among DTCs depending upon the number of Trainers present and the number of resource people available in the area. For example, at Nyeri each of the six Trainers teaches approximately eight hours during the three week classroom phase, while in Embu where there are fewer Trainers, the teaching load is greater and more resource people assist with training. At the Nairobi DTC where there are many Trainers, only 30 percent of subjects are assigned to resource people. Subject assignment for resource people depends upon their availability and interest as well as the interests and expertise of Trainers.

In addition to preparing for teaching sessions, a substantial amount of Trainer time is allocated to administrative arrangement which include: duplicating materials, arranging student housing, scheduling resource people, arranging transport, communicating with DFH and district officials regarding finances, and dealing with financial and social problems of students. Problems reported by Trainers in the classroom phase were mainly administrative and much of these concerns are directly related to the temporary and ad hoc nature of training arrangements (such as use of hotels). The Trainers express all manner of frustrations with such items as long delays in payment of bills and lack of authority over course

finances; lack of transportation, lack of administrative support from relevant district MOH offices, and; inadequate supplies.

All DTC Trainers are generally familiar with the subject matter of the MCH/FP Curriculum, but also routinely identify areas in which consultants are better prepared to cover a specific subject area than they are, for instances, reproductive mechanisms, breast-feeding practices, treatment of diarrheas, nutrition, hormonal actions and contraceptive logistics management. Although use of consultants is one way of enriching the course, their over-use has a somewhat opposite effect in that it tends to make for unevenness of coverage in the required subjects. Nurse-trainers appear to be most comfortable with procedures directly related to client contact, but shy away from many of the technical/medical topics, and clinic management areas.

4.4 Duration of the Course

The MCH/FP Course is organized into a three week block of classroom training, followed immediately by a four week block of practical training carried-out full-time in an operating MCH/FP clinic. Prior to 1989 the classroom phase was 4 weeks in duration and the practical phase 5 weeks. Starting in 1988-89 the course length was reduced by two weeks. In the current 7-week course there is greater emphasis on practical experience. The course outline increases the number of practice hours by 10, while decreasing the overall course duration by two weeks and the course hours by 22. Time allocations for the 7-week course compared with the previous 9-week course are shown in Table 4-1.

It should be re-stated that most DTCs are not managing to provide more than 70 classroom instructional hours compared to the prescribed 88 hours. The remaining 18 hours of classroom time is allocated to administration and testing.

Table 4.1 Comparison of 7 and 9 week Courses

| | <u>9-WEEK COURSE*</u> | <u>7-WEEK COURSE**</u> |
|-----------------|-----------------------|------------------------|
| PRACTICAL PHASE | 150 HOURS | 160 HOURS |
| CLASSROOM PHASE | 120 HOURS | 88 HOURS |

* 30 hours of instruction per week

** 35 hours of instruction per week

The change in duration of training from 9 to 7 weeks is not favored by most DFH Trainers who feel that the longer course should be re-established. Their discomfort with the shorter course arises because of their belief that the students learn more and perform better after receiving the 9-week course and because they report not having sufficient time to cover the material in the shorter course, despite a memorandum from the DFH directing DTC Trainers to eliminate certain topics and reallocate the time among remaining topics.

However, this opinion or perception about adequacy of time for the certificate course does not appear to be well founded. Indeed, results of the knowledge test administered to a sample of service providers trained in the longer 9-week course during 1986-87, compared to a sample trained in the shorter 7-week course during 1988-89 indicated that there was no appreciable difference in knowledge performance between the two groups. Review of the scores indicates a 7 percent improved score for those trained in the

seven-week course in 1988/89, over those trained in the longer nine-week course in 1986/87. This difference can likely be explained by knowledge decay which is to be expected, particularly when exposure to regular supervision and Contraceptive Technology Update training is limited. Beyond this, there does not appear to be any significant difference in the scores of the two groups. This suggests that the shorter seven-week course is not transferring less knowledge than the previous longer nine-week course.

4.5 Approaches to Practical Training

The length of the training course is directly tied to the required length of the practical/clinical phase, and this is more specifically related to the need for flexible time in which a determined number of client contacts and proficiency in IUCD insertion and removals can be offered. Consequently, the current 7-week course and in particular, the practical phase of the curriculum, is not defined by instructional content per se, but rather driven by logistical issues of finding sufficiently high-volume SDPs in which to place trainees where they can also travel from and return to a central location where housing is available. SDPs qualified to provide practical training are considered to be very limited in number. Because of this, it is also difficult for the MOH/DFH to encourage other outside training institutions to become involved in training since they would, in essence, also have to "compete" for these same limited practice facilities. In the meantime, a considerable amount of time during the four-week practical is occupied with traveling to and from the practice site, and once there, waiting for the required types of client-acceptors to present themselves. Furthermore, the Training Programme finds it necessary to rotate students between several sites in proximity to the DTC, usually about four sites, to ensure that all students will eventually have adequate opportunities for practice (mainly with IUCD insertions).

Under this arrangement, and working alone, the resident service provider in the SDP would likely have 3-4 students one week and a different group the next, making it difficult to establish instructor rapport or assess student proficiency and progress. This is compensated for by the practice of most DTC Trainers travelling almost daily along with the students to their practice sites and most often taking over the FP client load while providing instruction in place of the resident service provider. It should be noted also that many of the practice sites do not currently have staff who are actually qualified as Clinical Instructors, thus the resident service provider views student instruction as an additional burden and is disinclined to be involved.

On the other hand, at least one site visited had found ways of productively using students to ease the work load, and both providers and clients eagerly looked forward to having the students. It is unclear why this particular site was more receptive to receiving students than was found generally. However, it does suggest that improved practical learning environments are possible. In the case in point, the service provider in-charge had received the ToT course, and had basically turned over many clinic services to the students so that she functioned much more as a supervisor rather than a "demonstrator".

More than half of the Clinical Instructors (SDP service providers at the practice sites) are ECNs who are well experienced in FP; they average 5 years of FP service. A large percent of this group (65 percent) received FP training before 1985 and only 27 percent have participated in a Technology Update Course. They supervise an average of 3 students at a time and 46 percent report that they submit written reports of student performance to DTC Trainers. Those that do not (more than half) represent a group of service provider/instructors that do not feel themselves to be directly involved in the instructional process or responsible for students.

The general constrained practical learning situation is further handicapped by the fact that many potential practice sites in the country (such as many district and sub-district hospitals and large health centres in districts other than the one in which the DTC is based), are not currently a part of the training/teaching network. This is because these facilities probably do not have qualified Clinical Instructors in place, and even if they did, ways and means would need to be found to ensure that DTC Trainers could maintain acceptable levels of contact with students during practical training. The Nairobi DTC is the only centre that currently out-places students to other district sites for the duration of the practical training phase.

Although these are all well-established patterns within the Training Programme, many aspects appear to have evolved overtime based on operational constraints and a rationale that requires further close re-examination at this time. It is possible that if more qualified and specifically designated Clinical Instructors could be placed in a wider network of facilities, and if students could be out-placed for the duration of their practical training, the practical training phase could be made more efficient and possibly shorter, thus streamlining the course.

4.6 Trainers' Performance

Performance of an individual Trainer, his/her knowledge, skills, and ability to teach, is directly related to the trainer's background, credentials, and natural talents. To acquire the best caliber of Trainers, the Programme needs to be able to carefully identify the best suited training staff, and ensure that they receive additional training as Trainers. Currently, many Trainers are recruited into the Programme without much consideration of their qualifications (or even interest) to work in this specialized field of service.

Although selection, or rather, designation of nurses assigned as MCH/FP Trainers is managed by the Division of Nursing (and based on a variety of factors), the Training Programme should nonetheless have some input into the selection and placement of trainers. It could also perhaps be argued that because of the critical importance of MCH/FP services to the MOH's policies and priorities on primary/preventive health care, similar priority should also be given to selecting the highest caliber of workers possible for the in-service MCH/FP certificate Training programme.

Because of the relatively high turnover of Training staff (out of 28 positions during 1986-88, 12 were replaced), the DFH has found it difficult to meet the demand for training Trainers for its internal needs and to supply other institutions.

Thirty-four trainers representing all of the DTCs and the DFH contributed information to this survey. The following profile of trainer characteristics has emerged from the data analysis. Over 90 percent of trainers sampled are KRN/Ms, one CO completed the survey form and two records did not have qualifications listed. Twenty five percent of training staff have been training for one year or less and the average length of training service is three years. All trainers are qualified MCH/FP providers; more than half received MCH/FP training prior to 1985. Less than half have participated in a Contraceptive Technology Update and only 60 percent have participated in a Training of Trainers course.

The trainers who were observed during classroom performance presented a wide range of topics. They all presented the session objectives, 75 percent used lecture as the major method of instruction while discussion was included in 66 percent of the presentations. The average session was one and a half hours in length. As part of this survey, the trainer's knowledge of teaching methods and contraceptive technology was assessed and their classroom performance observed. The knowledge assessment contained two questions requesting the trainer to construct learning objective for a specific situation. The average percent correct on these two questions was 54 percent. The trainers were asked to prepare a test question for a specific situation; 58 percent of the trainers responded correctly. The last two

questions measured knowledge of IUCD insertion procedure and client counseling about method selection. The average percent correct for the two questions was 37.5 percent. The relatively low scores among the trainers are a source of concern.

4.7 Training Outcomes -- Technical Knowledge of Retrained Certified Workers

The regular assessment DFH procedures include knowledge and performance reviews. The DFH's 40 question knowledge test is standardized and administered as both a pretest and posttest. The DTC also develops and administers a mid-term knowledge test. The performance evaluation is based upon a checklist that requires final observation and scoring of specific procedures. In addition, the participant must submit the required number of satisfactory performance reports for each of the skills identified in the curriculum. The final results of knowledge and performance tests as well as the documentation of procedures completed are submitted for review at the DFH where grades are compiled and certificates of completion are prepared. On rare occasions when a participant receives a grade below 50 percent or is unable to achieve the requisite number of completed procedures s/he is given additional time to complete the requirements. Although the DFH procedures include participant follow-up after training, the division reports being unable to follow-up due to work load and transportation difficulties. The division has therefore welcomed this evaluation as an opportunity to establish current levels of performance among trained providers. For these purposes a "knowledge test" (most commonly referred to during the evaluation as a "needs assessment"), was administered to sampled units.

It would have been useful to compare the scores made by subjects in the evaluation with the scores they achieved during and at the end of the course. This turned out not to be practical since the sample included large numbers of workers trained in DTCs other than Nairobi (where records on original post-test results were probably available, but difficult to key into the sample).

The test used in this evaluation was drawn from previous DFH tests and curriculum content and contained questions about anatomy and physiology, mechanisms of action of various contraceptives, decision making about prescription, management of side-effects and new contraceptive technology. The 15-item test was developed with the assistance of DFH Trainers and the correct answers were provided by the DFH Trainers. Ninety-two providers who had received MCH/FP training from 1985-1989 completed the knowledge assessment.

The average scores by qualification and designation are given in Table 4.2, below.

Table 4.2 KNOWLEDGE ASSESSMENT BY QUALIFICATION AND DESIGNATION OF RESPONDENTS

| | <u>SCORE AS A % OF CORRECT ANSWERS</u> | <u>NUMBER OF RESPONDENTS</u> |
|--------------------------|--|----------------------------------|
| (A) <u>QUALIFICATION</u> | | |
| ECNs | 43 | 82 |
| KRNs | 49 | 41 |
| COs | 61 | 5 |
| OTHER | 42 | 11 |
| TOTAL | | 139 |
| (B) <u>DESIGNATION</u> | | |
| STUDENT SUPERVISOR | 56 | 24 |
| WORKPLACE SUPERVISOR | 44 | 34 |
| FP PROVIDER | 44 | 81 |
| TOTAL | | 139 |

It is important to note from the outset that knowledge assessments of this nature are at best indicators of how much knowledge someone has gained or retained and if they can organize this knowledge to solve written problems; these results do not necessarily translate into clinic-based competencies.

In contrast to the knowledge assessment results, the clinic performance observations indicate that trained providers are competently implementing many of the standard operating procedures for which they have been trained. It has also become apparent since reviewing the evaluation results that there are differences of opinion among various professionals about MOH policy on the handling of certain situations (particularly related to services to adolescents and young, low-parity clients). Since at least three of the test items related to clinical judgement as might be applied to typical cases, confusions about MOH guidelines was highlighted, and also reduced overall scores.

Having said this, the uniformly low scores on the knowledge assessment suggests that the current training system is not sufficiently transferring basic theoretical knowledge. An analysis of test items suggests that the biggest confusion rests in the areas where providers must make independent decisions on non-routine cases. Underlying this was evidence of uncertainty about various contraceptive actions -- particularly related to hormonals. The curriculum does not appear to be adequately preparing workers in important areas related to independent case management. The problematic levels of technical knowledge acquired by providers as demonstrated from test scores in this evaluation, raise a variety of issues and unanswered questions regarding the efficiency of instruction. In the meantime, what should be done in the in-service curriculum to improve the knowledge base of ECNs and other supervisory categories who will be trained during the next 2-3 years? Could practical instruction be made more efficient with more extensive and systematic use of training models? Can better and more efficient use of DTC Trainers and Clinical Instructors be made during practical training?

These questions and related issues raised throughout this Section 4 of the report lead to the recommendation that a separate and more specific assessment of these areas be undertaken with a view toward establishing more efficient instructional sequencing and logistical arrangements for the certificate course. Clearly some improvements and revisions to the course as it is currently constituted, are indicated. However, any such curriculum revisions should not be undertaken before a more thorough and detailed assessment of course content and process is carried out.

4.8 Family Planning Technology Updates

The DFH identified the need to update the knowledge and skills of family planning providers, supervisors and tutors in 1985 and has conducted a number of update training sessions in the intervening years (a total of 435 to date). In 1989 DFH decided to conduct updates on a more systematic basis and each DTC was asked to conduct one update during the year in addition to the four MCH/FP courses already scheduled.

The objective of Update workshops for the Principal Tutor and the Provincial Midwives conducted in 1987 was to promote integration of family planning into the ECN courses. The objective of the Update for clinical supervisors and ECNs has been to improve their knowledge of contraceptive technology and their ability to manage FP clients. Typically a contraceptive update workshop takes place over five days and has approximately 20 hours of classroom lectures and discussions.

It is difficult to evaluate the impact of existing contraceptive update workshops since our evaluation procedures could not differentiate between the knowledge and skill acquired during update and that learned at some other time. In general, the updates appear to be a review of the MCH/FP course material. This may be appropriate but could be supplemented with current research, management and ethical issues related to the use of modern contraception, and practical problems encountered in Kenya. Since contraceptive technology updates are to receive renewed emphasis, it is probably time to review the objectives, teaching methods, exercises, and availability of supplemental materials.

To date only a small fraction of the practicing family planning providers, tutors and supervisors have received contraceptive updates. Evaluation data provide the following information based upon the sample:

Table 4.3 Percentage Distribution of Respondents That Received Update Courses By Category

| <u>Worker Category</u> | <u>Percent Having Received Update</u> |
|------------------------|---------------------------------------|
| MCH/FP Provider | 18 |
| DFH Trainers | 46 |
| Clinic Instructors | 27 |
| Supervisors | 25 |

Although the DFH recognizes the importance of providing contraceptive updates they have yet to develop a comprehensive training plan. This evaluation has provided some insight into the magnitude of the need for contraceptive update training among family planning providers and it has also highlighted an important subset of MOH personnel who require special attention if the quality of service is to be expanded, improved and maintained. This group includes nurse tutors, DFH Trainers, Clinic Instructors, and supervisors of service providers.

Section 5

PROGRAMME STRUCTURE AND ADMINISTRATION

5.0 General

As of November 1989, the Programme included 36 designated training officers, 14 of whom were assigned to DFH headquarters and 22 of whom were stationed at an additional ten sites.

The eleven sites (including Nairobi) are referred to as, "Decentralized Training Centres" (DTCs). However the term "centre" is somewhat misleading. In most locations both the residential accommodation for trainees as well as classroom space, and even sometimes training office space are commercially hired venues (which could change from one year to the next).

Each DTC conducts a full rotational schedule of courses for certification and updating of ECNs; the centres in Nairobi and Nyeri additionally handle at least three courses per year for certification of KRNs and COs (those mainly designated for MCH/FP training and/or supervisory roles). The 36 trainers are assigned full time to MCH/FP training activities.

5.1 The Programme's Operational Mandate

Up to now the Programme has not been viewed (internally or within the MOH/DFH, in general), as having the mandate to set its own training priorities and targets. Instead, the Programme has tended to be viewed as a "training shop", with little or no say or concern with trainee selection, deployment, or determination of future manpower/training needs.

Although the Programme does screen applications and makes some judgements about the intake of KRNs and COs, ECNs, who are the largest and most critical group in terms of service provision, they are mainly selected by district management personnel, usually the District Public Health Nurse. The DFH has an established criteria checklist to be used by managers in selecting candidates for training, and these criteria are applied with reasonable consistency. Nevertheless, close to half of all ECNs ever trained are not actively engaged as MCH/FP service providers in the MOH system due to such factors as attrition, re-assignment to supervision, or assignment to non-MCH/FP jobs. (See also Section 3.1 of this Report). It is the position of MOH management that not much can be done to cut these loses. However, in addition to recommendations that targets be increased to provide a buffer against underutilization of trained ECNs and other workers, this

evaluation also recommends that the underlying causative factors related to loss and under-utilization of trained manpower be re-examined.

The current procedures and criteria for selection remain suspect. It is possible that more sensitive, individually reported application forms could be developed to better screen nominees. However, it is the feeling of those closest to the situation that this would not provide particularly reliable or improved information on which to base decisions. It is the general impression that even though a candidate may not be particularly interested in MCH/FP work, he/she would be eager to attend the course for many other reasons including just getting a break from the regular routine or perhaps preparing for a time when skills might come in handy in the future. While this may be true, the possibility of improving retention of trained workers through more appropriate selection, should not be abandoned altogether. Instead, this evaluation recommends that the issue be further explored by the Training Programme through an operations research study.

In addition to selection problems, there currently are no reliable mechanisms in the MOH for tracking workers in the system once they are certified, thus the Programme does not have a basis for routinely measuring attrition or estimating manpower/training needs or replacement requirements. Historically the Programme's operational mandate has mainly been seen as one of training "as many as possible" MCH/FP workers. Management priorities within the Training Programme have been guided by impressions of need (which does not necessarily suggest that priorities are that far afield, but that they could be more rational), and; annual targets have been defined in terms of operational capacity rather than on the basis of objectively defined need.

Underlying the "training shop" perception of the DFH Training Programme is the implicit MOH policy that as many Nurses and Clinical Officers as possible should eventually become certified in MCH/FP practice since they will always have opportunities to use these skills no matter where they may be working in the system. This open-end approach was clearly more relevant in the earlier days of the national MCH/FP Programme when manpower requirements were virtually limitless. While there is no real argument with the concept that it is desirable for the maximum numbers of health workers to be conversant with MCH/FP technology and services, the evaluators feel there are more practical ways of accomplishing this objective, and question the efficiency of this open-end policy as applied to the certificate Programme at this time. The evaluators instead would argue for a more systematic approach to determining the numbers of workers to be certified, and a more rational, data-based approach to determining alternative ways of accelerating the output and augmenting the net supply of trained MCH/FP manpower.

5.2 Headquarters Organizational Structure

Currently the organizational structure of the Training Programme at headquarters is extremely flat, consisting of a unit head and deputy, and several senior officers who carry out various management functions and tasks. Almost all of the trainers are, on occasion, called upon for direct involvement in teaching or follow-up of students in the clinical practice phase. Given the current and emerging scope of responsibilities of the Training Programme, it appears absolutely necessary for headquarters personnel to be reorganized so that there is a more hierarchical and functionally-defined management structure.

The unit first needs to re-articulate its current mandate at the goal/purpose levels. Secondly, the unit must determine the objective functions that will make this mandate possible, and assign individuals to carry out these specified objectives. Also, the unit must define the additional management training and staff development that will be needed to strengthen the managerial and technical/administrative skills of designated staff.

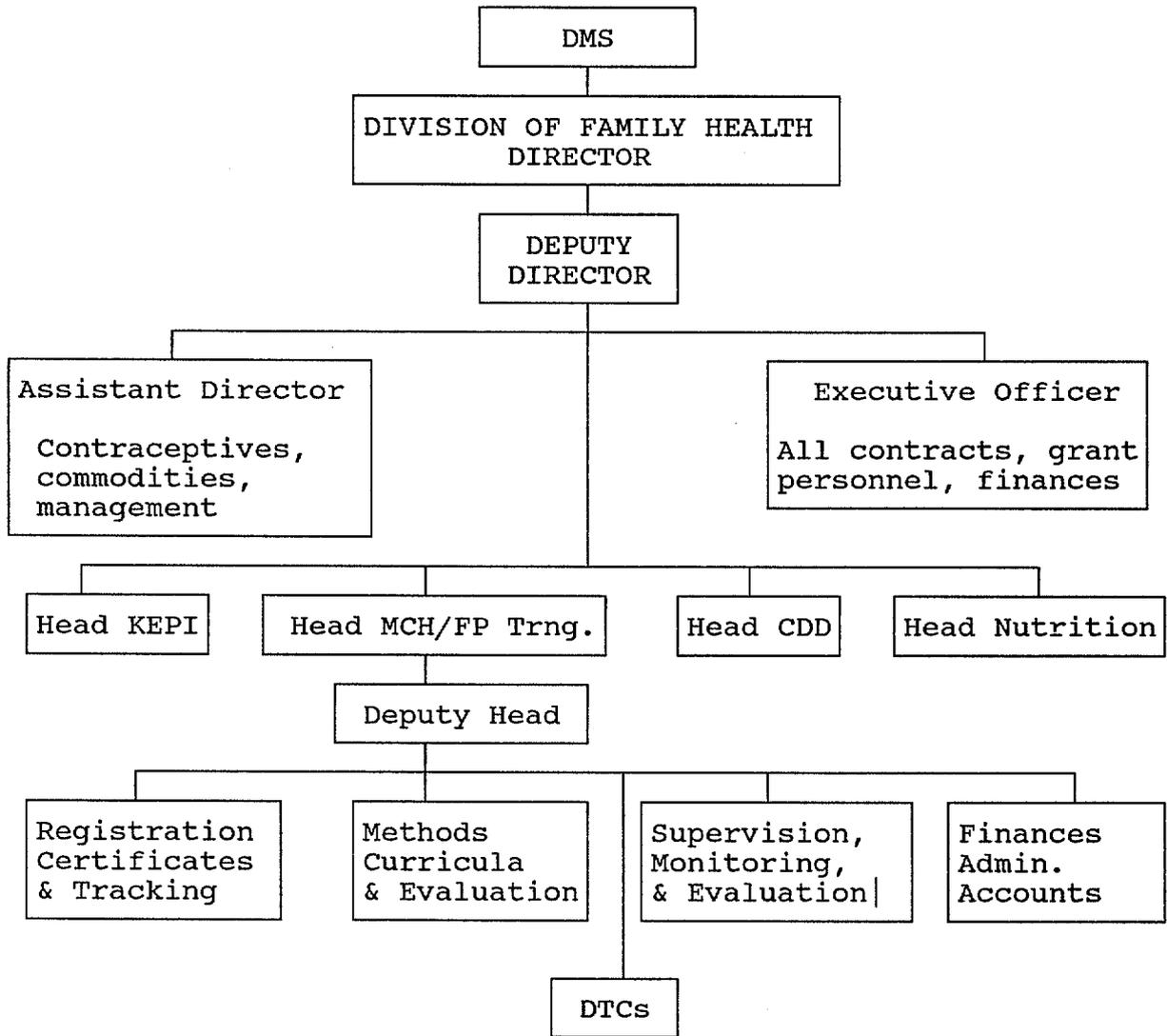
The unit clearly requires both line and staff functions including officers-in-charge of specific technical areas such as:

- registration/certification;
- instructional methods, curricula and materials development;
- supervision and programme monitoring/evaluation;
- finances and administration.

Particularly on the finance/administration side, it can be argued that these services and functions are provided for elsewhere in the MOH/DFH structure. However, in reality resource management both at headquarters and DTCs is extremely problematic and require special attention -- at least in the near term -- to ensure that other improvements needed in management of the Programme are facilitated.

Figure 5.1 below, is suggestive of the manner in which the Family Planning Training unit might be set up. The illustrative organogram assumes that the MCH/FP Training unit will be closely integrated with and dependent upon other administrative support functions within the Division of Family Health management structure. The figure also shows a possible overall structure of the Division that might best accommodate the administrative support requirements of the Training Unit as well as those of other technical units within the Division.

FIGURE 5.1 ILLUSTRATIVE HEADQUARTERS ORGANIZATIONAL STRUCTURE



For KEPI and CDD, all training, data, and commodities management functions could remain decentralized within the technical departments as currently exists.

5.3 Staff Development

5.3.1 Headquarters Managers and Technical Staff

It will be necessary for Ministry of Health/Division of Family Health management to develop a specific organizational structure for the Training unit complete with designated officers to be in charge of various functional areas similar to those shown in Figure 5.1, above. Job descriptions for all workers to be assigned to a particular area will also need to be developed. Once decisions are made about staff assignments, the Training unit will then be able to specify what additional knowledge/skills each staff person will need in order to carry out a particular job competently. On this basis, an immediate and long range plan for staff development can be established.

Beyond this, the evaluation cannot specify managerial staff development requirements. It can only be stressed here that the Training unit cannot hope to move forward with optimizing its operations unless both improved structures and a systematic plan for staff development are implemented.

5.3.2 Trainers

In 1985 the University of North Carolina, Program for International Training in Health (INTRAH) began assisting the DFH in the training of trainers. Each year the DFH and INTRAH have reviewed training needs and agreed upon the training objectives for an annual Training of Trainers (ToT) course. ToTs have included: training methods, curriculum development, and case and clinical management. INTRAH also conducted one Preceptor Skills Training course for 12 Clinical Instructors. A total of 63 DFH trainers and Clinical Instructors have attended one or more of the workshops. Approximately thirty-five (56 percent) of those trained are still trainers or provide training support as Clinical Instructors or consultant resources during the certificate training.

One major intent of the Memorandum of Agreement between the DFH and INTRAH was to strengthen the capacity of the DFH to be able to independently train MCH/FP trainers. However, as of September, 1989, when the last ToT was conducted with INTRAH assistance, a specific ToT curriculum was not left in place, and the DFH is not self-sufficient in being able to undertake this type of training without outside assistance.

In retrospect, the main approach of co-training DFH with INTRAH consultants in conducting the ToTs was an important but insufficient intervention to ensure the level of self-sufficiency originally envisioned. Insufficient provision was made for INTRAH

consultants to assist their DFH co-trainers in developing a standardized ToT curriculum and related instructional materials.

The DFH is therefore currently faced with a situation where it must now go back and redesign and develop the entire ToT course from the beginning. There is some urgency in doing so since there is an extremely high and growing demand for trained MCH/FP trainers in nurse training institutions, and if the Training Programme is going to successfully encourage other training institutions to become involved in MCH/FP training.

In redesigning the ToT course, it should be noted that the majority of trainers are clinicians with limited, if any teaching background or experience (currently there are only 3 trainers out of 36 with formal teaching credentials). This is common in many in-service training organizations, where trainers tend to be drawn from the ranks of technically qualified staff who must then expand their skills to learn how to teach others. Although the DFH's ToT course as it has been provided up to now has assisted in developing these teaching skills to a certain extent, it is unrealistic to expect that solid competencies in instructional design, classroom methods, evaluation, etc., can be transferred in a three week workshop. Instead, far more attention should be given to providing trainers with a well laid out classroom instructional manual that would provide steps and details on instructional procedures (prepared resource materials, training exercises, key-point lecture outlines, etc.). In this way the ToT course could focus more on how to use a set of teaching aids, rather than attempting to impart a wide and complex range of adult learning/teaching principles in a very limited time with the expectation that trainers will be able to confidently and independently apply these concepts.

Once a Trainer has received a basic ToT course and gained teaching experience with the assistance of standardized teaching aids (such as an instructional manual), other more advanced trainers' courses could be offered in a progressive sequence. It is also possible that establishing a skills development track for trainers would offer new professional challenges interests and incentives to trainers.

5.4 Decentralized Training Centres

All eleven of the Decentralized Training Centres (DTCs) were found to be operational, but most were seriously deficient in terms of physical set-up and permanency of their locations. For example, in Meru during 1988, the DTC used a church-related conference facility to house their trainees, offices, materials, records, etc. For 1989, the entire operation moved to a commercial venue (a small hotel). The Meru staff were hopeful that they would be able to remain at their current venue for next year, but strongly suspected that they would be required by the District Tender Board

to solicit an alternative venue for 1990. Most DTCs also find it routinely necessary to shuttle between their training site and the district hospital for administrative concerns (typing, photocopying, finances, transport arrangements). Table 5.2 shows the various combinations of sites used by each "centre" to carry out its training activities.

Table 5.2 Organizational Configuration of the 11 DTCs

| TC Location | Residential Site | Classroom Site | Administrative Office Site | Numbers/ Clinic Sites | GENERAL COMMENTS ABOUT FACILITY ARRANGEMENT |
|-------------|-------------------------------------|-------------------------------------|-------------------------------------|-----------------------|---|
| Homa Bay | Nyanza Hotel | Nyanza Hotel | Nyanza Hotel | 5 | |
| Kisumu | Casonova Hotel | Medical Training | Medical Training | 4 | |
| Kakamega | Western Hotel | Provincial General Hospital | Provincial General Hospital | 5 | |
| Nakuru | National Christian Council of Kenya | National Christian Council of Kenya | National Christian Council of Kenya | 4 | |
| Nairobi | Methodist Guest House | Methodist Guest House | Division of Family Health, Hdqtrs | 4+Several Districts | |
| Murang'a | Rural Health Trng Centre - Muranga | Rural Health Trng Centre - Maragua | Rural Health Trng Centre - Maragua | 6 | RHTC is 8 Km from Murang'a Town |
| Nyeri | Central Hotel & Thingira Hotel | Provincial General Hospital | Provincial General Hospital | 7 | Classroom space adequate |
| Meru | 3 Steers Hotel | 3 Steers Hotel | 3 Steers & Rm. at District Hospital | 4 | |
| Embu | Tel Aviv Hotel | Tel Aviv Hotel | Tel Aviv Hotel | 5 | |
| Mombasa | Government Trng Institute | Government Trng Institute | Coast Prov. Gen. Hospital | 6 | Facilities adequate |
| Machakos | Five Hill Lodge | Medical Training College | Medical Training College | 5 | |

* This venue has since changed beginning in 1990.

Most of the DTCs are situated in provincial headquarters (exceptions are Meru, Machakos, Muranga and Homa Bay). All are located at provincial/ district headquarters because of proximity to administrative infrastructure as well as providing relatively high SDPs to be used as clinical practice sites.

It should be noted that the concern for positioning DTCs in proximity to high-volume MCH/FP SDPs is substantially influenced by the related concern to ensure that all trainees certified in the

Programme can be exposed to their required number of client procedures, particularly IUCD practice insertions, within the given 4-week practical period.

A number of problems with arrangements and operations of the DTCs were identified during the evaluation. Notably, most DTCs were found to be directly dependent on the district administrative offices in their locations, including depending on the district tendering procedures to identify commercial venues for residential accommodations; and dependency on district health administrators (District Medical Offices, Public Health Nurse, and Hospital Secretary) to facilitate cash flow and transport to meet their requirements. Where a degree of cooperation and support was forthcoming from district health management, the arrangement could be seen to work reasonably well; where cooperation and support were unsatisfactory, administration of the DTC becomes chronically frustrating and a logistics nightmare. These observations raise immediate questions about whether there may not be more efficient ways of setting up these decentralized centres.

In summary, the evaluation found the facilities arrangements for DTC to be generally unsatisfactory. The current situation has a negative impact both on the efficiency and effectiveness of training and furthermore also lowers the morale of both students and trainers. In the long term, the MOH needs to consider establishment of additional free-standing training facilities (similar to the concept of Rural Health Training Centres, but based closer to urban centres). In the interim, a careful and more indepth survey and feasibility study is indicated, and should be undertaken at the earliest possible date as a matter of urgency.

5.5 Fiscal Administration

A critical aspect of the Programme relates to the actual cost and the flow of cash available to carry out scheduled activities. A major portion of operational financing is provided by the United States Agency for International Development on a reimbursable basis to the Government of Kenya. During each donor and GOK budgeting periods, a specified (usually more than adequate amount) is formally committed to the Programme.

The MOH/DFH then is free to draw against these allocations for its authorized operations. However, this arrangement has a myriad of attendant problems:

1. The technical office (DFH) frequently has difficulty in securing and drawing down funds, and experiences the normal delays of Government machinery. In any event, some portion of annually allocated funds do flow, as planned, from July to June of each GOK fiscal year.

2. Funds for decentralized operation are transmitted to district accounts and can be drawn by the MOH cognizant officer. However, there are indications that funds are sometimes "integrated", and perhaps not used for the MCH/FP training purposes intended. Decentralized Training Centres frequently find themselves in a "cash flow" bind during the periods when trainees are on-site. This makes for a particularly unpleasant and demoralizing administrative experience when routinely faced with threatening venue operations and 15 to 20 destitute health professionals
3. Once expenses have been incurred and accounted for through the normal district-national Government Accounting system, these expenditures are apparently very difficult for the MOH headquarters accounting office to trace and segregate. Consequently, GOK invoicing and donor reimbursements are extremely sluggish. Due to delayed or unacceptable billing, no reimbursements to Treasury on behalf of the DFH Training Programme were made during calendar year 1989.

If all data for the period September 1985 to December 1988 are complete, it appears that far more operational resources are being allocated to the DFH Training Programme than can possibly be absorbed. Not only does the GOK/MOH need to better account for expenditures, but also to better determine actual financial requirements and budgets. An internal or independent audit review of the programme's financial history and accounting procedures is indicated.

The fiscal data additionally suggest a useful gross integer to use in calculating the average direct cost of training one MCH/FP worker in the DFH Training Programme. The figure of Kshs 8,780 (U.S. \$400) per person trained/certified, (regardless of rank -- KRN, CO, or ECN), can reasonably be used for future planning and budgeting purposes.

This rough integer of Kshs. 8,780 (U.S. \$ 400) per person should also be used as a current baseline in evaluating the appropriate costs quoted by non-Government training institutions should they propose similar certificate training. Even if the more expeditious non-Government certification equalled to four times the DFH direct costs, the suggested per capita cost including overhead should not exceed Kshs. 36,800 (U.S. \$ 1,600) per trainee for a seven-week residential course including training staff, materials, and transport.

APPENDICES

Appendix A

METHODOLOGY

A.1 Sample Frames

The population included several categories of subjects: (1) trainers at their training locations; (2) clinical instructors at their teaching facilities; (3) supervisors of MCH/FP services wherever they could be found; (4) service providers brought to a central location, and; (5) service providers visited at their work sites.

One hundred percent of all trainers (total of 34 present at that time), and all Decentralized Training Centers were contacted during field visits. A specified number of classroom and clinical instructors, and an unspecified number of supervisors were automatically keyed to a particular DTC, and thus did not need to be identified through a sample. The population which required creation of a sample frame was service providers identified by year certified in MCH/FP, whether currently engaged in MCH/FP services, and if so, the current work site locations.

For the population to be identified through sampling an attempt was made to create an exhaustive frame that would allow for a representative selection of sampling units. The first step toward this objective was to create a list of qualified family planning providers trained in the years 1986 to 1989. To obtain this list a letter and proforma were sent from the Division of Nursing to District Public Health Nurses (DPHN) in all 43 districts. Information requested was: the full name, station, qualification, year of MCH/FP certification, and year of MCH/FP update course, if any.

Out of the 43 districts in Kenya, the original design excluded 9 for reasons of security or accessibility. Originally 275 service providers were to be selected in the years under consideration (1986 and 1989). 1986 was important since it was the first year the course was being implemented throughout the year in all Decentralized Training Centres. Changes in the duration of the course and implementation procedures made it important to sample also from 1989. If insufficient sampling units were available for 1986, they were supplemented by a random list of units from 1987. 1989 units were supplemented by 1988 units whenever necessary.

Modifications to the final sample were completed after receiving the inventory information from the districts. Necessary data on the years of training and whether the institution was providing services was missing from several field returns. The responses coming to the office were also slow and yet field work

had to commence by the 16th of October. Finally, out of the 31 districts absolutely required to submit a list of MCH/FP service providers, 20 provided the list and the rest had to be excluded due to non-response.

A.2 Study Design and Sample Sizes

The sample design employed for service providers was a stratified random sample. The stratifying factors were geographical area and years 1986/7 and 1988/9. In each of the five geographical areas, between 27 and 32 providers were sampled. The original attempt to include a proportionate number of providers in the categories of KRN's and CO's was unsuccessful due to small numbers of these groups in the original frame. Out of the total of 128 sampling units, 100 were ECN's, and 28 were KRN's or CO's.

One hundred fifty (150) providers were sampled for the period under consideration. A part of this number (100) was invited to a center in the geographical location where they were located while the rest (50) were observed at their worksite in SDP's. Once sampled for observation, the SDP's where the providers worked automatically became sampled units to provide information on clinic operations. The planned sample is shown in Table A.1. Table A.2 shows the actual respondent sample size for various units of study.

At each of the visited SDP's a total of 10 records were selected using a systematic sampling procedure, and relevant data was collected. Out of a total of 500 records expected to provide data, 413 were obtained. Supervisors at each of the selected SDP's also provided information on supervision.

Table A.1 Distribution of Sample Units According to Size of Population and By Region

| A R E A | | | | | | | |
|-------------------------------------|---|-----|-----|-----|-------|----|-------|
| A | B | C | D | E | TOTAL | | |
| POP SIZE BY YEAR AND TEAM | | | | | | | |
| AREA 1986/9 | | 144 | 46 | 146 | 120 | 39 | 503 |
| 1987/8 | | 143 | 57 | 168 | 145 | 50 | 563 |
| TOTAL | | 287 | 103 | 314 | 273 | 89 | 1,066 |
| SAMPLE SIZE | | | | | | | |
| Providers at District Centres | | | | | | | |
| | | 20 | 20 | 20 | 20 | 20 | 100 |
| Providers in SDPs | | | | | | | |
| | | 10 | 10 | 10 | 10 | 10 | 50 |
| TOTAL | | 30 | 30 | 30 | 30 | 30 | 150 |

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Table A.2 Units of Study and Sample Sizes

| INSTRUMENT | DESCRIPTION | SAMPLE SIZE | POPULATION SIZE N | METHOD OF DATA COLLECTION | |
|------------|----------------------------------|-------------|-------------------|------------------------------------|--------------------|
| 1.1.1 | Trainers Questionnaire | 36 | 36 | Self-administered | |
| 1.1.2 | Trainers Assessment | 36 | 36 | Self-administered (Knowledge Test) | |
| 1.1.3 | Trainers Performance Checklist | 12 | 36 | Observation | |
| 1.1.4 | Training Centre | 11 | 11 | Self-administered Questionnaire | |
| 2.1.1 | Providers Questionnaire | 84 | 100 | Self-administered | |
| 2.1.2 | Providers Assessment | 84 | 100 | Self-administered | (Knowledge Test) |
| 3.1.1 | Supervisors | 26 | 26 | Self-administered | Questionnaire |
| 3.1.2 | Supervisors Assessment | 26 | 26 | Self-administered | (Knowledge Test) |
| 4.1.1 | Providers Questionnaire | 47 | 50 | Self-administered | |
| 4.1.2 | Providers Performance | 47 | 50 | Observation | Checklist |
| 4.2.1 | Clinic Observations Desk Reviews | 420 | 500 | Inventories and | and Records Review |
| 4.3.1 | Supervisors | 36 | 50 | Self-administered | Questionnaire |
| 4.3.2 | Supervisors Assessment | 37 | 50 | Self-administered | (Knowledge Test) |

The Division of Family Health has 11 Decentralized Training Centres located in the metropolitan areas of Nairobi, Mombasa, Nyeri, Embu, Meru, Machakos, Murang'a, Nakuru, Kisumu, Homa Bay and Kakamega.

When the trainees attend courses at the DTC they normally go for practical training in hospitals or clinics which are in proximity. Hence for every training centre there exists at least one, and as many as seven practice SDP sites associated with it. The nurse who supervises the students while at the practical site was the sampling unit of interest. The student supervisor (also called "Clinical Instructor"), was expected to provide information about the management of the practical training sessions. A needs assessment test for students' supervisors and a knowledge test was administered to the students' supervisors.

A.3 Data Collection Instruments

A set of thirteen data collection instruments were developed. These are shown in Appendix B. A brief description of each of the instruments, according to sites, where they were administered (i.e. training centres, district centres, clinic practice sites and Service Delivery Points), follows below:

At training centres the four data collection schedules used were: 1.1.1., 1.1.2, 1.1.3 and 1.1.4. The first schedule, 1.1.1 collected biodata information, training background, the training process, administration and materials. The second schedule referenced 1.1.2, collected information on trainer knowledge with emphasis on update requirements. Observation of trainer performance in the classroom was recorded on 1.1.3. Finally, information on administrative concerns (housing, transportation, finance, students selection and deployment) are recorded on schedule 1.1.4. The set of these questionnaires was designed to provide information about trainers and the environment within which they work.

Clinic practice sites are part of the training system for the training centres. Data on clinical practice sites was collected using two instruments, 3.1.1 and 3.1.2. The first instrument collected data on background, basic and updated training, work experience, type of preparation and support given to the Clinical Instructors by trainers. The second instrument is a needs assessment of knowledge to assist in determining future update courses needs.

At the SDPs data was collected both from the pre-selected providers and observation of clinic operations using instruments 4.1.1, 4.1.2, 4.3.1 and 4.3.2. Collection of information about training background, posting before training, materials received during training, frequency and nature of supervision was gathered from schedule 4.1.1. Instrument 4.1.2 was used to record observation on provider performance.

Data on a random sample of 10 first visit client records was collected in every SDP. The client records provided data on key indicators of FP performance (number of new acceptors and revisits), and this was recorded on instrument 4.2.1.

At the SDPs it was necessary to collect information on supervision of services. Instruments 4.3.1 and 4.3.2 were used for that purpose. Data on supervisory training, experience, documentation of supervisory tasks, frequency and nature of supervision was collected using instrument 4.3.1. A needs assessment of knowledge was conducted using schedule 4.3.2.

The 100 trained family planning providers who were invited to a district centre filled two instruments; a knowledge needs assessment and a schedule on the background experience and training information using instruments 2.1.1 and 2.1.2.

A.4 Data Collection

Two methods of data collection were used by each of the field teams: (1) self-administered questionnaires, and; (2) observation. Most of the 13 instruments were self-administered questionnaires while observation procedures were employed at the training centres and at the work sites of the providers. All the 13 data instruments were administered in English.

A.5 Data Processing

The field interviewers were responsible for field editing of the data and collating their questionnaires before they were submitted for data entry. After office editing, data was keyed into microcomputers using data management software, dBase III+. Standard statistical tabulation and analysis utilized was done using the available statistical software, SPSS/PC+

A.6 Design Biases and the Quality of Data

Two kinds of bias can be expected in this type of survey. The first results from an exclusion of peripheral areas and the second from non-responses. Areas that were intentionally excluded from the study were out-lying and difficult to access. It might be argued that these areas were selectively excluded, thus reducing the representativeness of the districts that were included in the sample. However, the exclusion criteria was mainly based on considerations of security and travel logistics as viewed from Nairobi. There is no inherent reason to suspect that site findings in excluded areas would differ substantially from those included in the sample. Thus the bias for variables of inquiry resulting from these exclusions is expected to be minimal. However, one effect was noted: the concentration of supervisors (a total of 36 contacted), is probably much higher than national or regional averages due to urban bias in the sample.

The second type of bias, non-response, is known to be notoriously bad when samples are drawn from postal surveys. In this case the construction of the sampling frame was based on postal responses from the field. In order to minimize this type of problem, two provisions were made:

1. A reply paid envelope was enclosed along with a letter encouraging District Public Health Nurses to complete the proforma.
2. When responses were still not forthcoming from some districts a postal reminder and telephone recalls were administered.

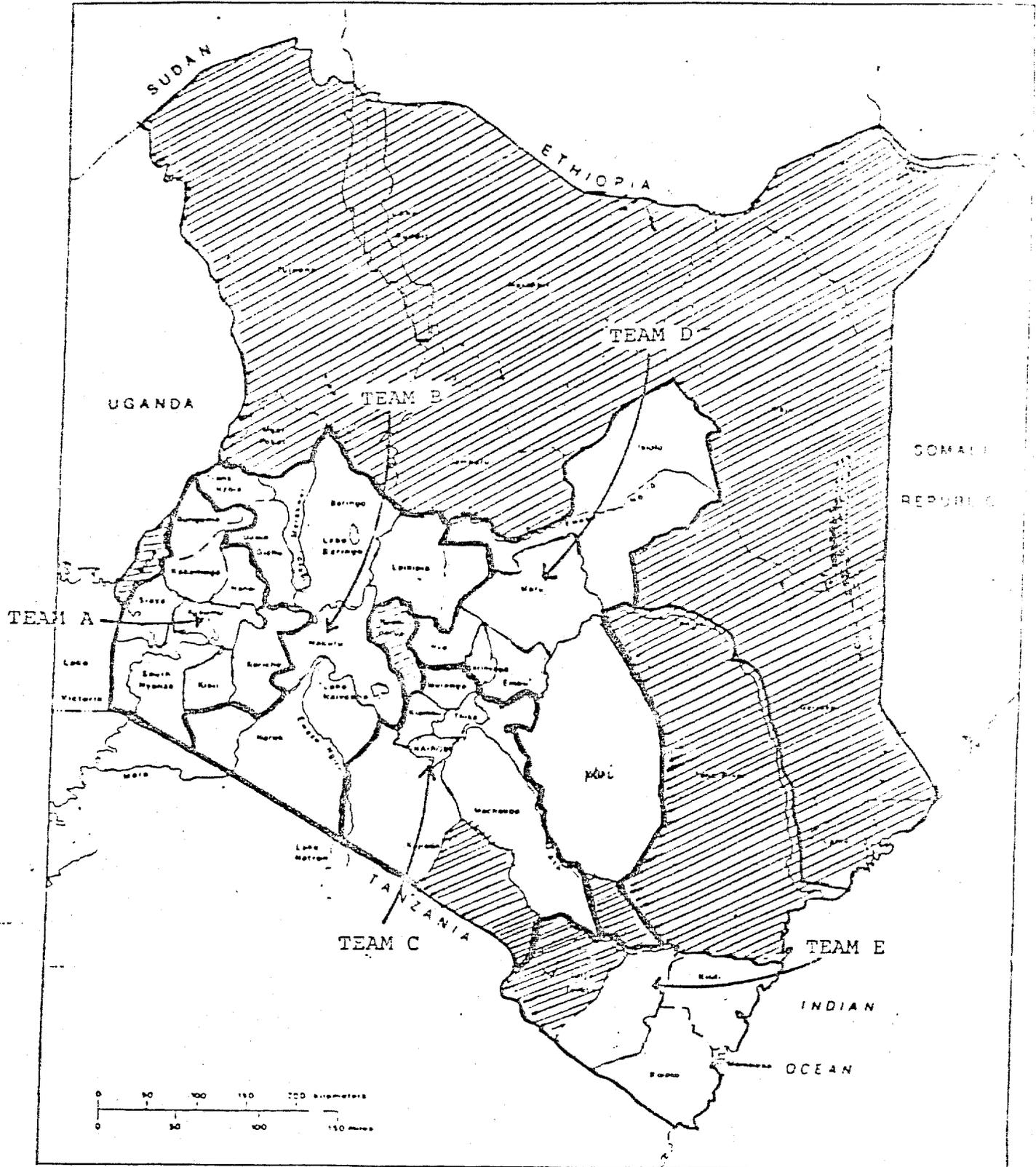
As a result of these provisions, the final district response rate was 65 percent. Another aspect of bias that was identified in the design phase was a result of inaccuracies of the data provided in the district responses. This reduced the number of the originally sampled units, and the enumerators found it necessary to make several on-the-spot substitutions of subjects that were erroneously captured in the sample because of inaccurate information.

The field enumerators who participated in the field work were all trained in various areas of public health. Half of the members of the team had been part of the study from the initial stages. Training in the use of the data collection instruments was conducted for three days. Mid-way after field work started, the 5 teams met in Nairobi to discuss field experiences and solve problems that may have arisen. The uniformly well-organized packets submitted by field teams, and the ease of interpretation during data entry attested to a high degree of quality in data collected.

APPENDIX B

Figure 2.1

Map of Kenya Showing Areas of Sample



APPENDIX C

INSTRUCTIONS FOR DATA COLLECTION INSTRUMENTS

1.0 TRAINING CENTERS

The data collection instruments for Training Centers consist of:

- 1.1.1 Trainers Questionnaire
- 1.1.2 Trainers Needs Assessment
- 1.1.3 Performance Checklist: Trainers
- 1.1.4 Training Center Questionnaire

PROCEDURES:

A. The data collection team will visit each of the 11 training sites during the current session of MCH/FP training. During that visit the Trainers Instruments will be completed.

B. The 1.1.1 Trainers Questionnaire and 1.1.2 Trainers Needs Assessment are to be completed by each trainer assigned to the 11 decentralized training centers. Each center has at least two trainers, some have more. The trainers of the Division of Family Health Nairobi have completed these two instruments. It should take approximately 1 hour and one half for these two instruments to be completed.

C. The 1.1.3 Performance Checklist: Trainers, is to be completed while observing a trainer conducting a training session. The data collector should observe the entire training session. In each training center it is desirable to observe each trainer as he or she teaches. The DFH trainers should also be observed.

D. The 1.1.4 Training Center questionnaire is to be completed by senior trainer at a decentralized training center. The time for this will depend upon the availability of records.

1.1.1 DFH: INSERVICE TRAINING EVALUATION, TRAINERS
QUESTIONNAIRE

Qualification: KRN----- CO----- Questionnaire #-----

Work Station ----- Number of years as a trainer -----

Number of Trainers who also work at your training center -----

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. The person who gave you this questionnaire will answer any questions you may have about the meaning of individual questions.

1. Please list all MCH/FP training centers where you have been posted and indicate how long you were posted in each center.

PLACE DURATION OF POSTING

2. Enter the dates that you received training in family planning.

Basic MCH/FP ----- Family Planning Update -----

Training of Trainers ----- Other -----

3. Enter the number of basic MCH/FP courses for which you have been a TRAINER from 1985 until present. -----

4. Enter number of Family Planning Update courses for which you have been a TRAINER from 1985 until present. -----

5. a) Do you have a personal copy of the MCH/FP Curriculum?
Yes --- No ----

b) Does the Training Center have a copy of the Curriculum?
Yes --- No -----

6. In which of the following ways do you use the MCH/FP Curriculum during the training course?

- a) To assist in the preparation of lesson plans
- b) To identify content areas to be included in the timetable
- c) To describe the procedure e.g. for pelvic examination
- d) To assist in preparation of evaluation questions

7. List the titles of the FP reference books and handouts that students receive during training.

8. How frequently do you use lesson plans for training sessions?

Always ----- Most times ----- Seldom ----- Never ----

9. Do you have a copy of the Family Planning Procedure Manual.

Yes --- No ---

10. In which of the following ways do you use the Family Planning Procedure Manual?

- a) As a student reference manual
- b) As a tutor reference manual
- c) As a self instructional manual for students
- d) To assist in the preparation of lesson plans
- e) To assist in the development of test questions
- f) To assist in the evaluation of student performance

11. Read the list of activities below and circle those that you undertake to prepare for the classroom phase of training.

- a. Selection of Students
- b. Needs Assessment
- c. Preparation of a timetable
- d. Preparation of session plans
- e. Duplicating handouts
- f. Contact and Schedule outside lecturers

Other Activities? -----

12. Read the list of activities below and CIRCLE those that you do to PREPARE for the 4 week practical experience program.

- a. Notify student supervisors of dates and names of students
- b. Meet with supervisors to discuss your expectations of students
- c. Provide performance checklists to supervisors
- d. Make transportation arrangements for students
- e. Make housing and meal arrangements for students
- f. Orient students to the 4 week practical experience
- g. Selection of clinical practice sites.

Other Activities -----

13. Read the list of activities below and CIRCLE those that you do to EVALUATE the CLASSROOM phase of training.

- a. Written pretest of knowledge
- b. Written weekly tests of knowledge
- c. Written post test of knowledge at conclusion of 3 weeks

- d. Observation of skills such as: pelvic exam, IUCD insertion

Other Activities -----

14. Read the list of activities below and CIRCLE those that you undertake to EVALUATE the PRACTICAL EXPERIENCE program.

- a. Weekly evaluation of skills such as client counselling, general and pelvic exam, IUCD insertion
- b. Evaluation of skills at conclusion of 4 weeks
- c. Discussion of performance with students

Other activities -----

15. Read the list of activities below and CIRCLE those that you do during the practical experience program.

- a. Observe student performance at clinical practice sites
- b. Meet with student supervisors to discuss student progress
- c. Stay at clinical site with students
- d. Provide assistance to students with learning problems
- e. Provide assistance to students with social problems

16. Please describe how you select family planning clinics to send students for practical experience.

17. Please describe how you select student supervisors for the practical experience.

1.1.2 TRAINER: NEEDS ASSESSMENT QUESTIONNAIRE

Questionnaire # -- Qualifications: KRN --- CO ---

Location of Training Center -----

1. What is your recommendation for subjects to be included in the next contraceptive technology update that you will receive.

2. What subjects would you like included in the next Training of Trainers course?

3. What is your assessment of the following training materials?

a. Maternal Child Health/Family Planning Curriculum

Very Useful ---- Somewhat Useful ---- Not Useful ----

b. Family Planning Methods and Practice: Africa

Very Useful ---- Somewhat Useful ----- Not Useful ----

c. Family Planning Procedure Manual

Very Useful ---- Somewhat Useful ---- Not Useful ----

d. List other materials that you use to prepare teaching sessions

4. Fill in the designation of the person who assists you when you have training problems related to:

a) Transportation -----

b) Teaching Methods -----

c) Curriculum Content -----

d) Finance -----

e) Student Performance -----

f) Clinical Practice Experience -----

5. Give examples of administrative problems you have experienced when planning and conducting training programs.

6. In this question you are asked to write two different learning objectives for a specific training situation.

Situation: You are preparing a classroom session on the topic of management of side effects of oral contraceptives.

a) Write a learning objective that measures the student's knowledge of the side effects of oral contraceptives.

b) Write a learning objective that measures the student's ability to manage the side effects of oral contraceptives.

7. Please write a test question that will measure the students' ability to apply her knowledge about the management of side effects of oral contraceptives to a real life situation.

8. Describe the main difference between the insertion technique for Copper T and Lippes Loop.

9. A mother of a 6 week old child has come to the FP clinic for advice about contraceptives. She is breastfeeding her child and wishes to continue breastfeeding. Indicate the advice you would give her by circling the appropriate letter or letters below.

- a) Contraceptives are not advised at this time
- b) Mini pill
- c) Combined or triphasic pill
- d) IUCD
- e) Condom or foaming tablet

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

1.1.3 DFH PERFORMANCE CHECKLIST: TRAINERS

NAME OF TRAINER ----- LOCATION OF DTC -----
TOPIC OF SESSION ----- NAME OF OBSERVER -----

1. What teaching method or methods did the trainer use for this session?

---- Lecture ----- Demonstration
---- Discussion ----- Role Play
---- Case Study Other -----

2. How long was the session? (minutes or hours) -----

3. What visuals were used?

---- Chalkboard ----- Anatomical models
---- Posters ----- Photographs
---- Newsprint Other -----

4. Describe the learning materials given to the participants to assist them during this session.

5. Did the trainer present the objectives of the session to the participants?

Yes ----- No -----

6. Check off any of the following evaluation methods that the trainer used during the session.

---Checklist ---Return demonstration
---Oral Question and answer ---Written question and answer
---Written assignment Other -----

7. What did the participants do during the session? Please circle the student behaviors during the session and estimate the percentage of the session that the students were engaged in these behaviors. The total percent should equal 100.

a) listen ---percent
b) ask questions ---percent
c) discuss issues ---percent
d) demonstrate ---percent
e) read hand-outs ---percent
f) other ---percent

1.1.4 DFH QUESTIONNAIRE: TRAINING CENTER

LOCATION OF CENTER: ----- NUMBER OF TRAINERS: -----

Date of Establishment: ----- Name of Data Collector-----

1. List the dates of the MCH FP Training Courses conducted at the center:

| YEAR | MONTH | NUMBER OF STUDENTS | QUALIFICATIONS OF STUDENTS |
|------|-------|--------------------|----------------------------|
|------|-------|--------------------|----------------------------|

1985

1986

1987

1988

1989

2. List the dates of the Family Planning Updates conducted at the center:

1986

1987

1988

1989

3. List the titles of books, manuals and other training materials that are available for reference in the training center.

4. Describe problems you have encountered in the following areas while planning and conducting training programs.

a) Supervision of Students:

b) Evaluation of Students:

c) Transportation and Living Arrangements for Students:

d) Selection of Participants

e) Arrangements for Practical Experience sites:

f) Finance:

g) Other

INSTRUCTIONS FOR DATA COLLECTION INSTRUMENTS

2.0 DISTRICT CENTERS

The data collection instruments to be used at the district centers include:

2.1.1 Questionnaire: Trained Family Planning Providers

2.1.2 Needs Assessment for Family Planning Workers

PROCEDURES FOR DATA COLLECTION:

- A. Twenty family planning providers will be invited to selected district centers in each of the five areas.
- B. All twenty family planning providers will complete instruments 2.1.1 and 2.1.2. The data collector should review each completed instrument for missing data or misunderstanding of questions before the FP providers depart from the center. The data collectors should hand out 2.1.1. first and allow up to one hour for completion. Collect 2.1.1. and review this instrument for omissions and misunderstandings while the group is completing 2.1.2. Allow one hour and one half for completion of 2.1.2. After both instruments are completed, please assist any provider who has incorrectly completed the information on 2.1.1. Do not assist the providers to complete 2.1.2.
- C. Be sure that you allocate a different number to each provider i.e. 1-20 and that the same number appears on each of the two questionnaires. (provider # 1 receives two questionnaires numbered with 1). This will allow the data analysis process to correlate the background of each provider with the results of the needs assessment. It is not necessary to have the name of the provider but it is essential to keep both instruments together as a set.

2.1.1. DFH QUESTIONNAIRE: TRAINED FAMILY PLANNING PROVIDERS

QUESTIONNAIRE # ----- QUALIFICATION ECN-----KRN-----CO---- OTHER----

LOCATION OF SDP ----- NAME OF DATA COLLECTOR -----

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. The person who gave you this questionnaire will answer any questions you may have about the meaning of individual questions.

1. How many years have you been working as a registered health worker _____
2. How many years have you been providing services in family planning? _____
3. How long have you worked in your present location? _____
4. What was your work assignment before you received MCH/FP Training? i.e. pediatric nurse, operating theatre, health center, ward nurse. _____
5. At what Training Center did you receive MCH/FP Training?

6. What year did you receive the basic MCH/FP Training? _____
7. Have you attended a Family Planning Update? Yes ____ No ____
If yes, indicate the year and place of training _____
8. If you have attended a Family Planning Update please check off the subjects that were taught.

- IUCD insertion technique for Copper T
- IUCD insertion technique for Lippes Loop
- Counselling clients to select contraceptive method
- Counselling clients about side effects
- Management of side effects
- Use of the low dose pills
- Natural Family Planning Methods
- Methods for client follow-up

9. Please indicate any other topics that you wish to be included in Family Planning Updates in the future.

10. Please provide the following information about the supervision you receive.

Qualification of Supervisor -----

Frequency of Supervision -----

Date of your last evaluation by a supervisor -----

11. Does your supervisor use any checklist or guidelines while supervising your work?

If yes, please describe: -----

12. On average, how many family planning clients do you provide services to:

Every day -----

Every week

13. On average, how many hours each day do you see family planning clients? _____

14. On average, how many hours each week do you see family planning clients? _____

15. How many other workers at your service delivery point have received training in family planning? _____

2.1.2 DHF QUESTIONNAIRE: NEEDS ASSESSMENT FOR FAMILY PLANNING WORKERS

QUESTIONNAIRE # --- QUALIFICATION ECN --- KRN ---- CO--- LOCATION

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. If you do not understand any of the questions ask the person who gave you this paper for assistance.

Directions: Select the correct answer or answers for the following questions:

1. Oestrogen is produced by:
 - a) Corpus Luteum only
 - b) Ovarian Follicle only
 - c) Both corpus luteum and ovarian follicle

2. Progesterones act as contraceptives by:
 - a) Producing hostile cervical mucus
 - b) inhibiting capacitation
 - c) Speeding ovum transport if given prior to fertilization
 - d) All of the above
 - e) A and B

3. The Mechanism of action of combined oral contraceptives is:
 - a) Inhibition of implantation
 - b) Inhibition of ovulation
 - c) Inhibition of capacitation

4. The Minipill consists of:
 - a) Oestrogen only
 - b) Progesterone only
 - c) Oestrogen and progesterone combined
 - d) Oestrogen and progesterone in sequence

5. List 5 absolute contraindications of IUCD.
 - a)
 - b)
 - c)
 - d)
 - e)

6. A mother of a 6 week old child has come to the FP clinic for advise about contraceptives. She is breastfeeding her child and wishes to continue breastfeeding. Indicate the advise you would give her by circling the appropriate letter or letters below.

- a) Contraceptives are not advised at this time
- b) Mini pill
- c) Combined or triphasic pill
- d) IUCD
- e) Condom or foaming tablet

Explain the reason for your advise.

7. An unmarried mother of three children comes to your family planning clinic for advise. She explains that she has several sex partners, her blood pressure is 130/90, she requests to have an IUCD inserted. Select the appropriate advise from the list below.

- a) low dose pill
- b) mini pill
- c) IUCD and advise her to stay with one man
- d) refer for tubal ligation counselling

8. A woman arrives at the clinic requesting IUCD insertion. She is menstruating and her history and physical examination reveal no contraindication to the IUCD. You have all the necessary sterile equipment but no clean non sterile gloves available. What would you do?

9. Select the correct answer from the list below. Describe the main difference between the insertion technique for Copper T and Lippes Loop IUCDs.

- a) there is no difference
- b) for lippes loop place the inserter int he uterine cavity and push the plunger to release the loop. For Copper T use the Push or withdraw technique.
- c) For Copper T use the withdraw technique . For Lippes Loop place the inserter in the uterine cavity and pull the plunger to release the loop.

- d) For Lippes Loop place the inserter in the uterine cavity and push the plunger to release the loop; when inserting the Copper T use the withdraw technique.

10. The most common side effects of Depo Provera during the first year of use are:

- a) Chloasma and headaches
- b) Irregular senses and amenorrhoea
- c) Depression and anxiety
- d) Acne and hirsutism

11. List 5 absolute contraindications of hormonal contraceptives.

12. A client who has been using an IUCD for six months arrives at the clinic explaining that she had her period five or six weeks ago and she insists on removing the IUCD. What would you do for this client.

- a) Remove the IUCD if the threads are visible
- b) Explain to the women that it will not harm the baby and do not remove the IUCD
- c) Do a pregnancy test and if positive refer to the doctor

13. A 30 year old breastfeeding mother with 4 children who has used mini pills for six months comes to the clinic for a routine checkup. She reports that she has not side effects from the pills, her blood pressure is 120/80, she has returned to work and is no longer breastfeeding on demand although she continues to breastfeed her child. What advise would you give this mother.

- a) Continues the minipills as long as she breastfeeds
- b) Stop minipills and give low dose combined pill
- c) Give a triphasic pill
- d) Give depo provera

14. How many years after insertion of a Norplant implant type 1, would you expect this contraceptive to be effected.

- a) 1 years
- b) 5 years
- c) 3 years
- d) 7 years

15. What is the active contraceptive agent in a Norplant implant?

- a) Norgesterel acetate
- b) Ethynodiol diacetate
- c) Norethisterone
- d) Medroxy Progesterone

INSTRUCTIONS FOR DATA COLLECTION INSTRUMENTS

3.0 CLINICAL PRACTICE SITES

The data collection instruments to be used at the clinical practice sites include:

- 3.1.1 Questionnaire: Student Supervisors
- 3.1.2 Needs Assessment for Student Supervisors

PROCEDURES FOR DATA COLLECTION:

A. The data collection team will visit 2 clinical training sites associated with each Decentralized Training Centre. At these training sites the family planning worker who is supervising the student will complete the questionnaires.

B. The student supervisors complete 3.1.1. Questionnaire: Student Supervisors and 3.1.2 Needs Assessment for Student Supervisors. The total number of student supervisors who will complete questionnaires during the data collection exercise is 22. Time allocated for completion is the same as that set aside for the providers. Again, please remember to allocate a different number to each student supervisor and place that number on both instruments.

3.1.1. DFH QUESTIONNAIRE: STUDENT SUPERVISORS

Questionnaire # Qualification: ECN ... KRN ... CO ...
OTHER

Location of SDP..... Name of Data Collector

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. The person who gave you this questionnaire will answer any questions you may have about the meaning of individual questions.

1. How many years have you been providing services in family planning? Please place an X in the appropriate place below.

1... 2... 3.... 4.... 5.... 6-9..... more than 10.....

2. How long have you worked in your present location?

3. What year and month did you receive the basic MCH/PH training?

4. Have you attended a Family Planning Update? Yes... No....

If yes, indicate the year and place of training

5. Please list any other training that has prepared you for your role as a student supervisor.

6. If you have attended a family planning update please check off the subjects that were taught.

- ... IUCD insertion technique for Copper T
- ... IUCD insertion technique for Lippes Loop
- ... Counselling clients to select contraceptive methods
- ... Counselling clients about side effects
- ... Management of side effects
- ... Use of low dose pills
- ... Natural family planning methods
- ... Methods for client follow-up

7. On average how many students do you supervise for the practical phase of their training?

8. How much time per day do you devote to supervision of students?

.... 1 hour 2 hours 3 hours4-6 hours6-8 hours

9. Please describe the activities of trainers from the training center during the practical phase of training.

10. Please describe below any guidelines that you receive from the training centre to assist you in supervision of students?

11. List t absolute contraindications of hormonal contraceptives.

- a)
- b)
- c)
- d)
- e)

12. Please describe any problems you have encountered while you supervise students during the clinical practice phase of training.

- a) Supervision of Students
- b) Evaluation of Students
- c) Housing and transportation for students
- d) Student Practice Experience

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3.1.2. DFH QUESTIONNAIRE: NEEDS ASSESSMENT FOR STUDENT SUPERVISORS

QUESTIONNAIRE #... QUESTIONNAIRE ECN... CO.... OTHER

LOCATION NAME OF COLLECTOR

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. If you do not understand any of the questions ask the person who gave you this paper for assistance.

Direction: Select the correct answer or answers for the following questions:

1. Oestrogen is produced by:
 - a) Corpus Luteum only
 - b) Ovarian Follicle only
 - c) Both corpus luteum and ovarian follicle
2. Progesterone acts as a contraceptive by:
 - a) Producing hostile cervical mucus
 - b) Inhibiting capacitation
 - c) Speeding ovum transport if given prior to fertilization
 - d) All of the above
 - e) A and B
3. The mechanism of action of combined oral contraceptives is:
 - a) Inhibition of implantation
 - b) Inhibition of ovulation
 - c) Inhibition of capacitation
4. The Minipill consists of:
 - a) Oestrogen only
 - b) Progesterone only
 - c) Oestrogen and Progesterone combined
 - d) Oestrogen and Progesterone in sequence

5. List 5 absolute contraindications of IUCD.

- a)
- b)
- c)
- d)
- e)

6. A mother of a 6 week old child has come to the FP clinic for advice about contraceptives. She is breastfeeding her child and wishes to continue breastfeeding. Indicate the advice you would give her by circling the appropriate letter or letters below.

- a) Contraceptives are not advised at this time
- b) Mini Pill
- c) Combined or triphasic pill
- d) IUCD
- c) Condom or foaming tablet

Explain the reason for your advice

.....
.....

7. An unmarried mother of three children comes to your family planning clinic for advice. She explains that she has several sex partners, her blood pressure is 130/90, she requests to have an IUCD inserted. Select the appropriate method or advice from the list below.

- a) low dose pill
- b) mini pill
- c) IUCD and advise her to stay with one man
- d) refer for tubal ligation on counselling

8. A woman arrives at the clinic requesting IUCD insertion. She is menstruating and her history and physical examination reveal no contraindication to the IUCD. You have all the necessary sterile equipment but only clean not sterile gloves available. What would you do?

JP

9. Select the correct answer from the list below. Describe the main difference between the insertion technique for Copper T and Lippes Loop IUCDs.

- a) There is no difference
- b) For Lippes Loop place the inserter in the uterine cavity and push the plunger to release the loop. For Copper T use the push or withdraw technique.
- c) For Copper T use the withdraw technique. For Lippes Loop place the inserter in the uterine cavity and pull the plunger to release the loop.
- d) For Lippes Loop place the inserter in the uterine cavity and push the plunger to release the loop; when inserting the Copper T use the withdraw technique.

10. The most common side effects of Depo Provera during the first year of use are:

- a) Chloasma and headaches
- b) Irregular menses and amenorrhoea
- c) Depression and anxiety
- d) Acne and hirsutism

11. List 5 absolute contraindications of hormonal contraceptives.

- a)
- b)
- c)
- d)
- e)

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12. A client who has been using an IUCD for six months arrives at the clinic explaining that she had her period five or six weeks ago. She insists that you remove the IUCD. What would you do for this client.

- a) Remove the IUCD if the threads are visible
- b) Explain to the woman that it will not harm the baby and do not remove the IUCD
- c) Do a pregnancy test and if positive refer to the doctor

13. A 30 year old breastfeeding mother with 4 children who has used mini pills for six months comes to the clinic for a routine checkup. She reports that she has no side effects from the pills. Her blood pressure is 120/80. She has returned to work and is no longer breastfeeding on demand although she continues to breastfeed her child. What advise would you give this mother.

- a) continue the minipills as long as she breastfeeds
- b) stop minipills and give low dose combined pill
- c) give a triphasic pill
- d) give Depo Provera

14. How many years after insertion of a Norplant Implant Type 1, would you expect this contraceptive to be effective.

- a) 1 year
- b) 5 years
- c) 3 years
- d) 7 years

15. What is the active contraceptive agent in a Norplant implant?

- a) Norgesterel Acetate
- b) Ethynodiol Diacetate
- c) Norethisterone
- d) Medroxy Progesterone

INSTRUCTIONS FOR DATA COLLECTION INSTRUMENTS

4.0 SERVICE DELIVERY POINTS

The data collection instruments to be used at the service delivery points include:

4.1. Provider Instruments:

- 4.1.1 Questionnaire: Trained Family Planning Providers
- 4.1.2 Performance Checklist: FP Providers

4.2. Clinic Observation:

- 4.2.1 Observations and Record Review

4.2 Clinical Supervisors:

- 4.3.1 Questionnaire: Supervisors of FP Providers
- 4.3.2 Needs Assessment for Supervisors

PROCEDURES FOR DATA COLLECTION:

A. The data collection teams will visit 10 randomly selected service delivery points in each of the five geographical areas. Each SDP a preselected FP service provider will be asked to complete the data collection instrument; 4.1.1. Questionnaire: Trained Family Planning Providers.

B. At each SDP a member of the team will observe the FP provider with clients and complete 4.1.2 Performance Checklist: FP Providers.

C. A member of the team will complete 4.2.1 Observations and Record Review during the SDP visit.

D. At every SDP, the supervisor of the designated FP provider will be asked to complete 4.3.1 Questionnaire: Supervisors of FP Providers.

E. Since each data collection team will be visiting 10 different service delivery points please remember to place the location of the SDP on each of the data collection instruments. This will allow the data analysis process to draw conclusions about the relationship between the worker's (provider or supervisor) training background and his or her current performance.

4.1.1 DFH QUESTIONNAIRE: TRAINED FAMILY PLANNING PROVIDERS

QUESTIONNAIRE #.... QUALIFICATION ECN..... CO.....
OTHER.....

LOCATION OF SDP NAME OF DATA COLLECTOR
.....

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. The person who gave you this questionnaire will answer any questions you may have about the meaning of individual questions.

1. How many years have you been working as a registered health worker?
2. How many years have you been providing services in family planning?
3. How long have you worked in your present location?
4. What was your work assignment before you received MCH/FP training?
5. At what training center did you receive MCH/FP training?
6. What year and month did you receive the basic MCH/FP training?
7. Have you attended a Family Planning Update? Yes
- No

If yes, indicate the year and place of training
.....

8. If you have attended a Family Planning Update please check off the subjects that were taught.

- ... IUCD insertion technique for Copper T
- ... IUCD insertion technique for Lippes Loop
- ... Counselling clients to select contraceptive method
- ... Counselling clients about side effects
- ... Management of side effects
- ... Use of the low dose pill
- ... Natural family planning methods
- ... Methods for client follow-up

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9. Please indicate any other topics that you wish to be included in family planning updates in the future.

10. Please provide the following information about the supervision you receive.

- a) Qualification of Supervisor
- b) Frequency of Supervisor
- c) The date of your last evaluation by a supervisor

11. Does your supervisor use any checklists or guidelines while supervising your work?

If yes, please describe

.....
.....

12. On average, how many family planning clients do you provide services to:

In one day In one week

13. On average, how many hours each day do you see family planning clients?

14. On average, how many hours each week do you see family planning clients?

15. How many other workers in your service delivery point have received training in family planning?

fm

4.1.2 PERFORMANCE CHECKLIST: FAMILY PLANNING PROVIDERS

QUESTIONNAIRE # NAME OF DATA COLLECTOR

SDP Location

Instructions: During the visit to the service delivery point use this instrument while you observe the performance of the preselected family planning worker. Observe this worker while she attends to a client. Observe as many of the following procedures as possible. Review the checklist during the procedure and indicate what you see by placing a tick in column YES or NO.

| 1.0 COUNSELLING INTERVIEW | YES | NO |
|---|-------|-------|
| a. Was the interview conducted in an area that provided privacy | | |
| b. Did the service provider ask the client the following questions before introducing the range of methods? | | |
| Previous use of contraceptive methods | | |
| IUCD | | |
| Condoms | | |
| Diaphragm | | |
| Foaming Tablets | | |
| Natural Methods | | |
| Depo-Provera | | |
| Voluntary Surgical Contraception | | |
| 2.0 CLIENT REVISIT | | |
| a. Was the interview conducted in an area that provided privacy? | | |
| b. Did the worker ask the client about side effects? | | |
| c. Did the worker take the client's blood pressure? | | |
| d. Did the client receive a date for follow-up visit? | | |
| e. Did the client receive a supply of contraceptives? | | |

3.0 PELVIC EXAMINATION

- a. Was an the examination conducted in a private area?
- b. Did the worker explain the procedure to the client?
- c. Did the worker use properly sterilized gloves and speculum?

4.0 IUCD INSERTION

- a. Was the examination conducted in a private area?
- b. Did the worker explain the procedure to client?
- c. Did the worker use properly sterilized gloves, speculum, tenaculum and uterine sound?
- e. Did the client receive instructions about checking the IUCD string?
- f. Was the client told what normal side effects to expect immediately after insertion?
- g. Was the client given a follow-up appointment?

COMMENTS:

Please write any comments about the worker's performance that you think will assist evaluators when this checklist is reviewed.

4.2.1 CLINIC OBSERVATIONS AND RECORD REVIEW

QUESTIONNAIRE #..... NAME OF DATA COLLECTOR
.....

SDP Location Number of trained FP Workers
.....

1. Directions: Select 10 client records from the SDP files. Select records that are dated within the last month. Review these records and answer the following questions pertaining to the information contained on the client records.

RECORD #1 Clinic Record Number

a. Note the method prescribed for the patient

.....minipillNova TCopper TDepo-Provera
.....Condoms/Foaming TabletsCombined Pills
.....Triphasic Pills

b. Record the blood pressure written on the record

BP BP is not recorded

c. Note the age of the client

d. The parity of the client

e. Check below the information recorded in the space on the bottom of the record.

... Taught the client self breast exam
... Completed a pelvic exam
... General physical exam
... Appointment for follow-up visit

RECORD #2 Clinic Record Number

a. Note the method prescribed for the patient

.....MinipillNova TCopper TDepo-Provera
.....Condoms/Foaming TabletsCombined Pills
.....Triphasic Pills

- b. Record the blood pressure written on the record
 BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

RECORD #3 Clinic Record Number

- a. Note the method prescribed for the patient
 - ...Minipill ...Nova T ...Copper TDepo-Provera
 -Condoms/Foaming TabletsCombined Pills
 -Triphasic Pills
- b. Record the blood pressure written on the record
 BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

RECORD #4 Clinic Record Number

- a. Note the method prescribed for the patient
 - ...Minipill ...Nova T ...Copper T ...Depo-Provera
 - ...Condoms/Foaming Tablets ...Combined Pills ..Triphasic Pills

- b. Record the blood pressure written on the record
 BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

RECORD #5 Clinic Record Number

- a. Note the method prescribed for the patient
 - ...Minipill ...Nova T ...Copper T ...Depo-Provera
 -Condoms/Foaming TabletsCombined Pills
 -Triphasic Pills
- b. Record the blood pressure written on the record
 BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

RECORD #6 Clinic Record Number

- a. Note the method prescribed for the patient
 -MinipillNova TCopper TDepo-Provera
 - ...Condoms/Foaming Tablets ...Combined Pills ...Triphasic Pills

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- b. Record the blood pressure written on the record
 BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

RECORD #7 Clinic Record Number

- a. Note the method prescribed for the patient
 - ...Minipill ...Nova T ...Copper T ...Depo-Provera
 -Condoms/Foaming TabletsCombined Pills
 -Triphasic Pills
- b. Record the blood pressure written on the record
 BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

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RECORD #8 Clinic Record Number

- a. Note the method prescribed for the patient
 - ...Mini pill ...Nova T ...Copper T ...Depo-Provera
 -Condoms/Foaming TabletsCombined Pills
 -Triphasic Pills
- b. Record the blood pressure written on the record
 - BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client
- e. Check below the information recorded in the space on the bottom of the record.
 - ... Taught the client self breast exam
 - ... Completed a pelvic exam
 - ... General Physical Exam
 - ... Appointment for follow-up visit

RECORD #9 Clinic Record Number

- a. Note the method prescribed for the patient
 - ...Mini pill ...Nova T ...Copper T ...Depo-Provera
 -Condoms/Foaming TabletsCombined Pills
 -Triphasic Pills
- b. Record the blood pressure written on the record
 - BP BP is not recorded
- c. Note the age of the client
- d. The parity of the client

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e. Check below the information recorded in the space on the bottom of the record.

- ... Taught the client self breast exam
- ... Completed a pelvic exam
- ... General Physical Exam
- ... Appointment for follow-up visit

RECORD #10 Clinic Record Number

a. Note the method prescribed for the patient

- ...Mini pill ...Nova T ...Copper T ...Depo-Provera
-Condoms/Foaming TabletsCombined Pills
-Triphasic Pills

b. Record the blood pressure written on the record

BP BP is not recorded

c. Note the age of the client

d. The parity of the client

e. Check below the information recorded in the space on the bottom of the record.

- ... Taught the client self breast exam
- ... Completed a pelvic exam
- ... General Physical Exam
- ... Appointment for follow-up visit

2a. Enter the FP Register to compare Family Planning client visits for the last two years e.g 1988 and 1989. Compare the family planning services delivered for the months of January, May and September.

2b. For the same week please enter the number of clients who received the following methods.

Pills..... IUCD..... Depo-Provera.....
Condoms.... Foaming Tablets..... Other.....

3. Use the FP Register to compare Family Planning client visits for the last two years e.g. 1989. Compare the Family Planning services delivered for the months of January, May, September.

| | 1988 January | May | September |
|---------------------|--------------|-------|-----------|
| Total Client Visits | | | |
| New Acceptors | | | |
| Revisits | | | |

| | 1989 January | May | September |
|---------------------|--------------|-------|-----------|
| Total Client visits | | | |
| New Acceptors | | | |
| Revisits | | | |

4. Obtain the current stock level of pill and IUCD stocks from the register for contraceptive supplies and compare this figure with the current physical stock on hand for each item.

| | # Listed in Stock Register | Physical Count |
|--------------|----------------------------|----------------|
| Pills | | |
| Microlut | | |
| Microgynon | | |
| Eugynon | | |
| IUCD | | |
| Copper T | | |
| Copper T380A | | |
| Lippes Loop | | |
| Other | | |

5. Count the number of speculum, tenaculum, uterine sounds available in the clinic.

- Speculum
- Tenaculum
- Uterine sounds

6. Describe the methods of sterilizing equipment and FP supplies you observed during the visit.

gb

4.3.1 DFH QUESTIONNAIRE: SUPERVISORS OF FAMILY PLANNING PROVIDERS

QUESTIONNAIRE #.... QUALIFICATION KRN/M.... CO.... PHN.....

Location of SDP NAME OF DATA COLLECTOR

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. The person who gave you the questionnaire will answer any questions you may have.

1. How many years have you been a SUPERVISOR of FP services. Please place an X in the appropriate place below.

1.... 2..... 3... 4... 5.... 6-9.... Other more than 10....

2. At what training centre did you receive the basic family planning training?

3. What year and month did you receive the basic MCH/Family Planning training?

4. Have you attended a Family Planning Update? Yes.... No....

If yes, indicate the year and place of training.....

5. If you attended a Family Planning Update please check off the subjects that were taught.

- ... IUCD insertion technique for Copper T
- ... IUCD insertion technique for Lippes Loop
- ... Counselling clients to select contraceptive method
- ... Counselling clients about side effects
- ... Management of side effects
- ... Use of the low dose pills
- ... Natural family planning methods
- ... Methods for client follow-up

6. Please indicate any topics that you would like included in future family planning updates.

7. How many family planning workers do you supervise?
.....

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8. On average, how frequently do you observe their performance?
.....

9. What improvement would you like to see in the performance of the family planning workers who you supervise?

10. Do you have written guidelines for evaluating the performance of the family planning workers you supervise?

Yes No

If yes, please describe
.....

11. Have you received any training in supervision? Yes
No...

If yes, please indicate the year and place of training
.....

12. Please describe any problems you have as a supervisor of family planning workers in the following areas:

- a) Supplies
- b) Monitoring the performance of workers
- c) Transportation
- d) Other

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN IT TO THE PERSON WHO GAVE IT TO YOU.

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4.3.2 DFH QUESTIONNAIRE: NEEDS ASSESSMENT FOR SUPERVISORS

QUESTIONNAIRE # ... QUALIFICATION ECN... KRN/M OTHER
.....

LOCATION NAME OF DATA COLLECTOR
.....

This questionnaire has been developed to assist the DFH to plan for future training activities. Please answer all questions. If you do not understand any of the questions ask the person who gave you this paper for assistance.

Directions: Select the correct answer or answers for the following questions.

1. Oestrogen is produced by:
 - a) Corpus Luteum only
 - b) Ovarian Follicle only
 - c) Both corpus luteum and ovarian follicle

2. Progesterone acts as a contraceptive by:
 - a) Producing hostile cervical mucus
 - b) Inhibiting capacitation
 - c) Speeding ovum transport if given prior to fertilization
 - d) All of the above
 - e) A and B

3. The mechanism of action of combined oral contraceptives is:
 - a) Inhibition of implantation
 - b) Inhibition of ovulation
 - c) Inhibition of capacitation

4. The Minipill consists of:
 - a) Oestrogen only
 - b) Progesterone only
 - c) Oestrogen and Progesterone combined
 - d) Oestrogen and Progesterone in sequence

5. List 5 absolute contraindications of IUCD.

- a)
- b)
- c)
- d)
- e)

6. A mother of a 6 week old child has come to the FP clinic for advice about contraceptives. She is breastfeeding her child and wishes to continue breastfeeding. Indicate the advice you would give her by circling the appropriate letter or letters below.

- a) Contraceptives are not advised at this time
- b) Mini Pill
- c) Combined or triphasic pill
- d) IUCD
- e) Condom or foaming tablet

Explain the reason for your advice

.....

7. An unmarried mother of three children comes to your family planning clinic for advice. She explains that she has several sex partners, her blood pressure is 130/90, she requests to have an IUCD inserted. Select the appropriate method or advice from the list below.

- a) low dose pill
- b) mini pill
- c) IUCD and advise her to stay with one man
- d) refer for tubal ligation on counselling

8. A woman arrives at the clinic requesting IUCD insertion. She is menstruating and her history and physical examination reveal no contraindication to the IUCD. You have all the necessary sterile equipment but only clean not sterile gloves available. What would you do?

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9. Select the correct answer from the list below. Describe the main difference between the insertion technique for Copper T and Lippes Loop IUCDs.

- a) There is no difference
- b) For Lippes Loop place the inserter in the uterine cavity and push the plunger to release the loop. For Copper T use the push or withdraw technique.
- c) For Copper T use the withdraw technique. For Lippes Loop place the inserter in the uterine cavity and pull the plunger to release the loop.
- d) For Lippes Loop place the inserter in the uterine cavity and push the plunger to release the loop; when inserting the Copper T use the withdraw technique.

10. The most common side effects of Depo Provera during the first year of use are:

- a) Chloasma and headaches
- b) Irregular menses and amenorrhoea
- c) Depression and anxiety
- d) Acne and hirsutism

11. List 5 absolute contraindications of hormonal contraceptives.

- a)
- b)
- c)
- d)
- e)

12. A client who has been using an IUCD for six months arrives at the clinic explaining that she had her period five or six weeks ago. She insists that you remove the IUCD. What would you do for this client.

- a) Remove the IUCD if the threads are visible
- b) Explain to the woman that it will not harm the baby and do not remove the IUCD
- c) Do a pregnancy test and if positive refer to the doctor

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13. A 30 year old breastfeeding mother with 4 children who has used mini pills for six months comes to the clinic for a routine checkup. She reports that she has no side effects from the pills. Her blood pressure is 120/80. She has returned to work and is no longer breastfeeding on demand although she continues to breastfeed her child. What advise would you give this mother.

- a) continue the minipills as long as she breastfeeds
- b) stop minipills and give low dose combined pill
- c) give a triphasic pill
- d) give Depo Provera

14. How many years after insertion of a Norplant Implant Type 1, would you expect this contraceptive to be effective.

- a) 1 year
- b) 5 years
- c) 3 years
- d) 7 years

15. What is the active contraceptive agent in a Norplant implant?

- a) Norgesterel Acetate
- b) Ethynodiol Diacetate
- c) Norethisterone
- d) Medroxy Progesterone