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CLINICAL TRAINING SKILLS  
*for* REPRODUCTIVE HEALTH  
PROFESSIONALS

*authors*

Rick Sullivan  
Ron Magarick  
Gary Berghold  
Ann Blouse  
Noel McIntosh

**JHPIEGO**  
CORPORATION

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## *Authors*

Rick Sullivan  
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Ann Blouse  
Noel McIntosh



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This manual is designed to help clinicians (physicians, nurses and midwives) become more effective clinical trainers. To be effective, training in family planning services such as IUD insertion or minilaparotomy should be competency-based, highly participatory and incorporate adult learning principles. In addition, to minimize risk to clients and facilitate learning, it should be "humanistic" (i.e., when possible incorporate the use of anatomic models, such as a pelvic model for IUD insertion, and other training aids as the first step in learning). Finally, clinical skills training should reflect actual conditions in the clinic or operating room and should employ standardized techniques for performing procedures.

Field testing of early versions of this new manual over the past 18 months has led to extensive revisions. The editors gratefully acknowledge the valuable assistance of our international colleagues, representatives from other organizations and JHPIEGO staff (see page *ii* for the list of reviewers). In particular, we are indebted to them for their suggestions, comments, and most importantly, for their time and effort in reading the drafts of the manual.

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# PREFACE

## BACKGROUND

Over the past two decades, use of modern contraceptives has risen rapidly in the developing world. According to recent surveys, however, at least 125 million married couples who want family planning do not have adequate access to contraceptive information, qualified service providers or supplies. Moreover, the need for family planning services will triple to more than 400 million couples during the next 20 years.

As a consequence, the number of reproductive health professionals required to deliver family planning services is increasing dramatically. There is a corresponding need to train clinical trainers and service providers more cost-effectively and in less time. A different approach to clinical training as well as the appropriate use of new, less trainer-intensive educational technologies is required to meet this demand.

For the past 5 years JHPIEGO has been using a **competency-based** approach to clinical training that focuses on **learning by doing**. The objective is to equip clinicians (physicians, nurses and midwives) with the knowledge and skills needed to carry out their clinical duties more safely and efficiently. Field tests of this training approach in selected host country training projects have been highly successful. Participants have learned the required clinical skills and activities **in less time, at less cost and with fewer clients needed for training purposes**.

## USING THIS MANUAL

In order to improve the quality of clinical training as well as to objectively evaluate participant performance, there is a need to standardize the way training is conducted. This manual emphasizes use of **participatory** training techniques based on the principles of adult learning. Because most of the information is transmitted through interactive, “hands-on” learning activities, participants are actively involved in the learning process. Each chapter in this manual describes an area of participatory training for which the clinical trainer is responsible.

**Chapter 1** identifies the **learning principles** used throughout the manual. Also described is how coaching, when combined with other clinical training techniques, is a highly effective mechanism for helping participants master complex skills.

Establishing a **positive training climate (Chapter 2)** before, during and after the course is critical to the success of training. An essential part of this process is understanding how people learn.

Appropriate audiovisual aids are critical to effective training. **Chapter 3** presents guidelines for using audiovisual materials more effectively, not only for presentations but also for classroom and clinical demonstrations.

One of the most commonly used training methods is the **illustrated lecture (Chapter 4)**. The clinical trainer who is able to maintain participant interest with an exciting, dynamic delivery, using a variety of instructional methods, is more likely to be successful in helping participants learn new information.

To measure progress in learning and to evaluate performance (**Chapter 5**), clinical trainers use **competency-based knowledge and skill assessments**. Knowledge questionnaires are used to measure progress in learning new information. Learning guides help participants acquire new skills (**skill acquisition**) and measure progressive learning in small steps as they gain confidence (**skill competency**). Competency-based checklists assist the clinical trainer in evaluating each participant's performance.

**Coaching**, or “behavior modeling” as it is sometimes called, forms the basis for this clinical training strategy. The five elements of the COACH model are fully described in **Chapter 6**. **Combining coaching with other clinical training techniques (Chapter 7)** enables the clinical trainer to more effectively conduct demonstrations, train with anatomic models, guide the participant through each step or task involved in learning the skill and “coach” the participant during practice sessions.

**Chapter 8, Conducting a Clinical Training Course**, describes how to improve the quality of clinical training and what the clinical trainer needs to know in order to organize and conduct a clinical course successfully.

# AN APPROACH TO CLINICAL TRAINING

## INTRODUCTION

The purpose of this manual is to increase the ability of medical and nursing faculty and trainers to conduct clinical training courses. This manual promotes a competency-based training approach based on principles of adult learning. This means the training is **participatory**, **relevant** and **practical**. Adult learning principles are based on the assumption that people participate in clinical training courses because they:

- Are **interested** in the topic
- Wish to **improve** their knowledge or skills, and thus their job performance
- Desire to be **actively involved** in course activities

**WHAT I HEAR, I FORGET;  
WHAT I SEE, I REMEMBER;  
WHAT I DO, I UNDERSTAND.**

*Confucius*

To be effective, clinical trainers must use appropriate training strategies. The participatory, “hands-on” training techniques emphasized in this manual are best reflected in this ancient Chinese proverb.

**Chapter Objective** After completing this chapter, the participant will be able to describe a competency-based clinical training system that incorporates adult learning principles and features mastery learning, coaching and use of humanistic training techniques.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Identify the goal of clinical training
- Describe the principles of clinical skills training
- Define the five elements of coaching
- Describe the key features of competency-based clinical training
- Identify the responsibilities of clinical trainers and participants
- Identify the criteria for selecting and training clinical trainers

## GOAL OF CLINICAL TRAINING

The **goal of clinical training** is to assist health professionals in learning to provide safe, high-quality family planning and reproductive health services to clients through improved work performance. **Training** deals primarily with obtaining the knowledge, attitudes and skills needed to carry out a specific procedure or activity, such as inserting an IUD or providing counseling. Training should be based on the assumption that there will be an immediate application of the physical or mental skill(s) being learned.

**Education**, in contrast, is most often directed toward **future goals**. For example, an individual attends a school or university in order to prepare for a future role as a nurse or doctor. Her or his education provides a broad array of knowledge (and skills) needed to perform that role and from which the student can later select what is needed, according to a given situation.

No matter how effective training is in conveying information or influencing attitudes, if participants are unable to satisfactorily perform the procedure or activity assigned to them, the training will have failed. Therefore, clinical trainers must focus their energies on transferring **skills** as well as on providing the **essential facts** and **attitudinal information** required by participants to perform their jobs.

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Effective clinical training stresses application of knowledge in the performance of skills.

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## PRINCIPLES OF CLINICAL TRAINING

The training techniques and approaches discussed throughout this manual are based on the following eight principles:

- Learning is most productive when the participant is **ready to learn**. Although motivation is internal, it is up to the clinical trainer to create a climate that will nurture motivation in participants.
- Learning is more effective when it **builds** on what the participant already knows or has experienced.

- Learning is more effective when participants are **aware** of what they need to learn.
- Learning is made easier by using a **variety** of training methods and techniques.
- Opportunities for **practicing** skills initially in controlled or simulated situations (e.g., through role play or use of anatomic models) are essential for **skill acquisition** and for development of **skill competency**.
- **Repetition** is necessary to become competent or proficient in a skill.
- The more **realistic** the learning situation, the more effective the learning.
- To be effective, **feedback** should be **immediate, positive and nonjudgmental**.

## COACHING IN CLINICAL TRAINING

Unfortunately, the teaching model with which most health professionals are familiar is the classroom instructor lecturing to a group of students who anxiously take notes so that they can pass a written examination. This approach to teaching, used by a skilled clinical trainer, can be effective in providing basic knowledge. It is, however, a very poor way of imparting clinical skills (such as inserting an IUD), strengthening problem-solving skills or changing clinical practice attitudes.

What is needed is an approach to clinical training that is different from classroom teaching. **Coaching** has been used successfully for technical training by industry for many years. It involves the use of positive feedback, active listening, questioning and problem-solving skills to ensure a positive training climate. Indeed, the characteristics of a skilled clinical trainer are, in many ways, the same as those of a good coach.

The clinical training approach described in this manual is built around the use of coaching. The essential elements of the coaching strategy can be described in five concepts that form the acronym **COACH** which are described below.

- C Clear Performance Model** (behavior modeling). Participants should be shown in a clear and effective manner the skills they are expected to learn.
- O Openness to Learning.** The clinical coach should include activities designed to create readiness to learn and use new skills.
- A Assessment of Performance.** Clinical training should include measures for both assessing competence in the skills being taught and providing feedback on progress toward a satisfactory standard of performance.
- C Communication.** Effective two-way communication between the coach and participant is essential to skill acquisition and attaining skill competency.
- H Help and Followup.** Clinical training should include planning for application of the new skills and help in overcoming obstacles to utilization of the skills.

It should be noted that the COACH elements do not represent a sequence of training or training design. Instead, they describe qualities that should be present in **any** clinical training situation. (See **Chapters 6 and 7** for a complete discussion of how to use coaching in clinical training.)

Finally, when coaching is combined with several other clinical training techniques, it provides a highly effective and efficient system for transferring skills such as performing a minilaparotomy or counseling a client.

## **KEY FEATURES OF THE CLINICAL TRAINING APPROACH**

The **key features** of the clinical training system described in this manual are that it:

- Is **competency-based**
- Employs the concept of **mastery learning**
- Uses a **humanistic training** technique for learning new skills

Each of these components is briefly described in this section.

**Competency-Based Training**

**Competency-based training (CBT)** is distinctly different from traditional educational processes. **CBT is learning by doing.** It is based on a social learning theory which states that when conditions are ideal, a person learns **most rapidly and effectively** from watching someone perform (model) a skill or activity.

Competency-based training provides health workers with those abilities vital to the successful performance of their jobs. It emphasizes how the participant **performs** (i.e., a combination of knowledge, attitudes and, most importantly, skills) rather than what information the participant has **learned**. Moreover, CBT requires that the clinical trainer facilitate and guide or encourage learning rather than serve in the more traditional role of the **instructor** or **lecturer**.

Finally, CBT has a sound scientific basis. As shown in **Table 1-1**, a person's ability to recall essential information is vastly increased when s/he learns the material through participatory methods as compared to more passive methods such as just listening to a lecture or obtaining new information through reading.

**Table 1-1. Learning Recall Related to Type of Presentation**

TYPE OF PRESENTATION	ABILITY TO RECALL	
	after 3 hours	after 3 days
Verbal (one-way) lecture	25%	10-20%
Written (reading)	72%	10%
Visual and verbal (illustrated lecture)	80%	65%
Participatory (role plays, case studies, practice)	90%	70%

*Adapted from: Dale 1969.*

To successfully accomplish CBT, the clinical skill or activity to be taught first must be broken down into its essential steps. Each step is then analyzed to determine the most efficient and safe way to perform and learn it. This process is called **standardization**. Once a procedure, such as insertion of Norplant® implants, has been standardized, competency-based skill assessment instruments can be designed to make **learning** the necessary steps or tasks **easier** and **evaluating** the participant's performance **more objective** (see **Chapter 5**).



**Mastery Learning** The **mastery learning approach to clinical training** assumes that all participants can master (learn) the required knowledge or skill **provided there is sufficient time and appropriate training methods are used**. The goal of mastery learning is that 100% of those being trained will “master” the knowledge and skills on which the training is based. While some participants are able to master a new skill immediately, others may require additional time or alternate learning methods before they are able to demonstrate mastery of the knowledge or skill. Not only do people vary in their abilities to absorb new material, but individuals learn best in different ways—through written, spoken or visual means. Effective learning strategies take these differences into account and use a variety of learning methods.

The mastery learning approach to training enables the participant to have a **self-directed learning experience**. This is achieved by having the clinical trainer serve as facilitator and by changing the concept of testing and how test results are used. In courses which use traditional testing methods, the trainer administers pre- and post-tests to document an increase in the participants’ knowledge **often without regard to how this change impacts on job performance**.

The philosophy underlying the mastery learning approach, however, is one of a **continuous assessment of participant learning**. It is essential that the clinical trainer regularly inform participants of their progress in learning new information and skills and **not** allow this to remain the trainer’s secret.

With the mastery learning approach, a precourse knowledge assessment (e.g., precourse questionnaire) is used to determine what the participants, individually and as a group, know about the course content. This allows the clinical trainer to identify topics which may need additional emphasis or, in many cases, require less classroom time during the course. Providing the results of the precourse assessment to participants enables them to focus on their individual learning needs. A second knowledge assessment, the midcourse questionnaire, is used to assess the participants’ progress in learning **new** information. Again, results of this assessment are reviewed with participants.

With the mastery learning approach, assessment is:

- **Competency-based**, which means assessment is keyed to the course objectives and emphasizes acquiring the essential knowledge and attitudinal concepts needed to perform a job, not just to acquiring new knowledge.

- **Dynamic**, because it enables clinical trainers to provide participants with continual feedback on how successful they are in meeting the course objectives. (Trainers using pre- and post-tests often do not review the correct answers with the participants. As a consequence, participants may leave the course not knowing important information.)
- **Less stressful**, because from the outset participants, both individually and as a group, know what they are expected to learn, where to find the information and have ample opportunity for discussion with the clinical trainer.

**Humanistic Training Technique**

The use of more humane (**humanistic**) training techniques is essential to improving **how** clinical training is conducted. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other training aids such as slide sets and videotapes. Using models **facilitates learning, shortens training time and minimizes risks to clients**. Therefore, the effective use of models is an important factor in improving the quality of clinical skills training. (The humanistic training approach is discussed more fully in **Chapter 7**.) Finally, by using anatomic models initially, participants more easily reach the performance levels of **skill competency** and beginning **skill proficiency** prior to working in the clinical setting with clients (see **Table 1-2**).

Table 1-2. Levels of Performance

<i>Skill Acquisition</i>	Knows the steps and their sequence (if necessary) to perform the required skill or activity but <b>needs assistance</b>
<i>Skill Competency</i>	Knows the steps and their sequence (if necessary) and <b>can perform</b> the required skill or activity
<i>Skill Proficiency</i>	Knows the steps and their sequence (if necessary) and <b>efficiently performs</b> the required skill or activity

Before a participant attempts a clinical procedure with a client, **two learning activities** should occur:

- The clinical trainer should **demonstrate** the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g., training slide sets or videotapes).

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- While being supervised, the participant should **practice** the required skills and client interactions using the model and actual instruments in a simulated setting which is as similar as possible to the real situation.

The number of procedures the participant needs to observe, assist in and perform using models will vary depending on her/his background. Only when **skill competency** and some degree of **skill proficiency** have been demonstrated with **models**, however, should the participant first have contact with a client.

As shown in a study from Thailand (see below), incorporating the use of anatomic models and other training aids **can significantly reduce training time and the number of cases needed for skill competency**. Moreover, practicing with models helps participants correct mistakes in technique which could hurt the client.

#### **Using Anatomic Models in IUD Training**

In a study conducted in Thailand in 1991, the traditional method of IUD training was compared to one using the humanistic approach. When models were used, 70% of participants were judged to be competent after just two insertions in actual clients and 100% by six. In contrast, of the 150 participants taught without the use of models, 50% obtained competency only after an average of 6.5 insertions and 10% did not achieve competency even after 15!

Incorporating this more humane training approach is a key step in improving the quality of IUD training. Moreover, this approach can improve the cost-effectiveness of clinical training programs. Where there is a lack of potential clients, some clinical training programs can take 6 to 8 weeks! If shorter, they may not provide adequate training. On the other hand, when anatomic models are used appropriately for IUD training—not simply for demonstration purposes—training can be cut to 2 weeks or less, a considerable time and cost savings.

## **RESPONSIBILITIES OF THE CLINICAL TRAINER AND COURSE PARTICIPANTS**

In clinical training, the responsibility for meeting learning objectives is **shared** by the **clinical trainer** and each **participant**. The clinical trainer's goal is to help each participant attain full competence in a skill or activity, not just to earn a high grade on a test of knowledge. If a participant does not reach full competence, the clinical trainer should **not** attribute failure simply to the participant's inability but should look for ways to provide additional assistance or coaching as well as ways to improve training methods.

**The role of the clinical trainer is to facilitate learning.** The clinical trainer guides participants toward the discovery of new knowledge and the acquisition of new or improved skills. The clinical trainer also seeks to influence participant attitudes by serving as a role model. For example, the trainer always should demonstrate the skill completely and accurately—poor performance is never acceptable.

**Participants** are actively involved in the learning process and are encouraged to contribute what they know about the topic being discussed. The knowledge participants bring to the training situation is considered as essential to the total training process as is the knowledge of the clinical trainer. **The success of this approach is based on the willingness of participants to take an active part in the training and to share their experiences and knowledge with other participants in the group.**

## SELECTING AND TRAINING CLINICAL TRAINERS

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The key to successful clinical training is **transference**. This involves assisting health professionals who are experts in their field in learning **how to transfer** their knowledge and skills to others.

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In the highly specialized fields of health and industry, organizations are finding that **it is better to select outstanding technical (content) experts and teach them training skills rather than to use training professionals who are not proficient in the technical skills being taught.**

Perhaps the most crucial decision in designing a clinical training course is the **selection of the trainer(s)**. It often has been assumed that anyone with strong academic credentials and good clinical skills could be a trainer, but experience in many parts of the world has shown that **performing and teaching** clinical skills are two very different things.

Until recently, trainers had few ways to learn training skills. To some it came “naturally,” but usually only after many years of trial and error. A fortunate few had the opportunity of being taught by good clinical trainers whose style they could copy. For most, however, little training in these skills was available.

In selecting potential clinical trainers, the following criteria should be considered:

- **Demonstrated proficiency.** S/he must first be an expert service provider in the clinical skill(s) to be taught.
- **Interest in training.** A health professional who is genuinely interested in training will be more likely take the time necessary to learn and practice clinical training skills.
- **Humility.** A good clinical trainer is able to admit when s/he makes mistakes and does not try to prove that participants will never attain her/his skill level.

**Process for  
Becoming a  
Clinical Trainer**

It is recommended that a series of steps be used to assist clinicians in making the transition from **service provider** to **clinical trainer**. First, the clinician may need to acquire service delivery skills, such as counseling or IUD insertion, through training and experience. Over a period of time, usually months (or even years) of repeated practice, the clinician becomes expert (proficient) in providing the clinical skill or activity.

Once proficient, the clinician who wants to become a clinical trainer may attend a clinical training skills course which focuses on learning the skills necessary to effectively transfer her/his expertise to others. During this course, s/he will learn **coaching** and **humanistic** training techniques which are based on adult learning principles. In addition, the clinician will learn a **standardized approach** to performing the clinical procedure and how to use **competency-based skills assessments** to evaluate participant performance. S/he also learns how to:

- present information more effectively (illustrated lectures, demonstrations, role plays, case studies and group discussions), and
- incorporate the use of audiovisuals and other training aids into classroom sessions.

Following this, the new clinical trainer should serve as a cotrainer for one or more clinical training courses for service providers. If possible, cotraining should be done with the advanced trainer who taught the clinical training skills course. In subsequent courses, as the new clinical trainer becomes more skilled in training, s/he will be assisted by an advanced trainer only as needed.

**Table 1-3** summarizes the steps to becoming a qualified IUD service provider and clinical trainer.

**Table 1-3. Process for Becoming an IUD Clinical Trainer**

ACTIVITY	QUALIFICATION
<b>Step 1</b> Clinician attends clinical skills course for service providers to gain skill competence and become qualified in providing IUD services.	<b>Service Provider</b>
<b>Step 2</b> Clinician gains experience and becomes proficient in providing IUD services to clients.	
<b>Step 3</b> Clinician expresses interest in becoming a clinical trainer of IUD service providers and is selected to become a clinical trainer.	
<b>Step 4</b> Clinician attends a clinical training skills course conducted by an advanced trainer to standardize IUD clinical skills, update knowledge and achieve competency in clinical training skills.	
<b>Step 5</b> New clinical trainer conducts service provider training in IUD skills with the assistance of an advanced trainer until s/he becomes proficient and is qualified as a clinical trainer.	<b>Clinical Trainer</b>

**SUMMARY**

Clinical training courses in family planning assist health care workers in performing their jobs more effectively. Such training should be competency-based, use humanistic training techniques and be designed and conducted according to adult learning principles—it should be interactive, relevant and practical.

**Competency-based training** focuses on the specific knowledge, attitudes and skills needed to carry out a procedure or activity. Competency is objectively assessed by **evaluating overall performance**, not by measuring only the knowledge and skills needed to perform the procedure or activity.

Additional key features of effective clinical training are that it:

- Employs **mastery learning** which enables the participant to have a self-directed learning experience with the clinical trainer serving as facilitator

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- Is built around the use of **coaching** which involves the use of positive feedback, active listening, questioning and problem-solving techniques to assist participants in learning new skills
- Uses **humanistic** training techniques which facilitate learning new skills

Because the **goal** of clinical training is to help health care workers learn to provide safe, high-quality services, the responsibility for achieving the training objectives is **shared** by the **clinical trainer** and **each participant**. If a participant does not meet the course objectives, the clinical trainer should **not** simply attribute failure to the participant's lack of ability, but should look for additional ways to assist the participant and to improve training methods.

Finally, not every expert service provider can become a good clinical trainer. Therefore, the criteria for selecting potential candidates should include humility and a sincere interest in training in addition to proficiency in a clinical skill or activity.

# CREATING A POSITIVE TRAINING CLIMATE

## INTRODUCTION

The following case studies illustrate the importance of good planning, communication and establishment of a good learning environment—from the participant's and clinical trainer's points of view.

### CASE STUDIES

#### Training from a participant's viewpoint:

*You have been informed by your supervisor that you have been selected to participate in a 2-week course in the management of genital tract infections in family planning clients. You were advised of this a week before the course was to start and were told that you had been nominated for participation by someone in authority at the Ministry of Health. You are unsure whether the fact that your name was selected is a positive or negative reflection on your work. Does it mean that you may be in line for a promotion, or does someone think that you haven't been doing a good job and need additional training? No information is provided about the training other than the dates, location and starting time.*

*The first session is about to begin and you are a little nervous about what to expect. You find a place to sit towards the back of the classroom and then glance around the room. You know only one of the other ten participants. Five minutes after the session is scheduled to start, the clinical trainer comes hurrying through the door with a stack of papers. Turning to the first person in sight, he says, "Please pass these out"! The trainer then begins the first session on "Screening for Genital Tract Infections in Family Planning Clients." You exchange glances with the other participants and wonder whether they, like you, are hoping that the end of the course comes soon.*

#### Training from a clinical trainer's viewpoint:

*You have been informed that you are to conduct a 2-week service providers' course on the management of genital tract infections in family planning clients. You are given the course syllabus, outline and schedule. You pack up all of your course materials and travel to the training site. Upon arrival you find:*

- *The people who are there do not have the background and skills you had expected.*
- *The training room is too small and there is poor ventilation.*
- *There is no writing board or overhead projector.*
- *The room contains chairs lined up in rows.*
- *You planned for 15 participants—30 show up!*

Have either of these situations ever happened to you? How would you feel if they did? Would this situation affect your attitude toward the clinical trainer or the course? Unfortunately, from either the participant's or the clinical trainer's point of view, the training course is off to a poor start. Given the circumstances, the clinical trainer will

have a difficult time creating an appropriate and positive climate for learning.

**A positive training climate** is one which:

- Acknowledges how people learn
- Encourages and is conducive to learning
- Creates an atmosphere of safety in which participants can ask questions
- Gives responsibility for accomplishing the course objectives to everyone participating, not just the clinical trainer

**Chapter Objective** After completing this chapter, the participant will be able to create a positive training climate.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Consider how people learn
- Plan for a positive training climate **before** the training course
- Establish and maintain a positive training climate **during** the course
- Continue a positive training climate **after** the course

## **HOW PEOPLE LEARN**

Establishing a positive training climate hinges on understanding how adults learn, especially service providers attending a clinical training course. The dynamics of the training process are very much dependent on the clinical trainer having a clear understanding of the participants' expectations and needs, and the participants having an understanding of why they are there. Adults who attend courses to acquire new knowledge, attitudes and skills:

- Require training to be **relevant**
- Are highly **motivated** if they see the training as relevant
- Need **participation** and **active involvement** in the training process
- Desire a **variety** of learning experiences
- Desire **positive feedback**

- Have **personal concerns** and need an atmosphere of safety
- Need to be recognized as **individuals** with unique backgrounds, experiences and learning needs
- Must maintain their **self-esteem**
- Have **high expectations** for themselves and their trainer
- Have **personal needs** that must be taken into consideration

These ten characteristics are described in more detail below.

**Relevance** The clinical trainer should design learning experiences that **relate directly to the job responsibilities of the participants**. The objectives of the course should be stated clearly and linked to job performance at the beginning of the training. Time should be taken to explain how each learning experience relates to the successful accomplishment of the course objectives.

**Motivation** People bring **high levels of motivation and interest** to training. Family planning workers, for example, may wish to learn new knowledge and skills to improve client services. Motivation can be increased and channeled by the clinical trainer who provides clear training goals and objectives. To make best use of a high level of participant interest, it is important to explore ways to incorporate the needs of each participant into the training sessions. This means that the clinical trainer needs to know quite a bit about the participants, either from background information or by allowing participants to talk about their experience and learning needs early in the course.

**Involvement** Few individuals prefer just to sit back and listen. The effective clinical trainer will design learning experiences that **actively involve the participants in the training process**. Examples of how the clinical trainer may involve participants include:

- Allowing them to provide input regarding schedules, activities and other events
- Questioning and feedback
- Brainstorming and discussions
- Hands-on work
- Group and individual projects
- Classroom activities

**Variety** Participants attending training **desire variety**. The clinical trainer should use a variety of training methods including:

- Audiovisual aids
  - writing boards
  - flipcharts
  - overhead transparencies
  - slides
  - videotapes
  - anatomic models and real items (e.g., instruments)
- Illustrated lectures
- Demonstrations
- Brainstorming
- Small group activities
- Group discussions
- Role plays and case studies
- Guest speakers

**Positive Feedback** Participants need to know **how they are doing**, particularly in light of the objectives and expectations of the training course. Is their progress in learning clinical skills meeting the trainer's expectations? Is their level of clinical performance meeting the standards established for the procedure? **Positive feedback provides this information.**

Learning experiences should be designed to move from the known to the unknown, or from simple activities to complex ones. This progression provides positive experiences and feedback for the participant. To maintain positive feedback, the clinical trainer can:

- Give verbal praise either in front of other participants or individually
- Use positive responses during questioning:
  - "That's correct!"
  - "Good answer!"
  - "That was an excellent response!"

- Recognize appropriate skills while coaching in a clinical setting:
  - “Very good work! Ilka is holding the scalpel in a way that provides excellent control.”
  - “I would like everyone to notice the incision that Jean Robert just made. He did an excellent job, and your incisions should look like this one.”
- Let the participants know how they are progressing toward achieving course objectives

**Personal Concerns**

The clinical trainer must recognize that many participants have a number of **concerns about themselves** when it comes to training, such as:

- A fear of failure or embarrassment
- Fitting in with the other participants
- Getting along with the trainer
- Understanding the content
- Being able to perform the skills being taught

The clinical trainer must be aware of these concerns and open the training course with an introductory activity that will place participants at ease. It should communicate an **atmosphere of safety** so that participants do not become involved in judging each other or themselves. For example, a good introductory activity is one which acquaints participants and helps them to connect faces with names. This opening activity can be followed by learning experiences that support and encourage the participants. Suggested warmup activities are presented in this chapter.

**Being Treated as an Individual**

People prefer to be **treated as individuals**, each of whom has a unique background, experience and learning need(s). Past experiences are good foundations upon which to base new learning.

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Each person is the best judge of what ideas and skills are relevant to her or his particular work situation.

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To ensure that participants feel like individuals, the clinical trainer should:

- Use participant names as often as possible
- Involve all participants as often as possible
- Treat participants with respect
- Allow participants to share information with others during classroom and clinical instruction

**Self-Esteem** Participants need to **maintain high self-esteem** to deal with the demands of a clinical training course. Respect on the part of the clinical trainer, which includes avoiding negative feedback, is essential to maintaining participant self-esteem and confidence while learning.

Health professionals attending a course:

- Require training which adds to rather than subtracts from their sense of competence and self-esteem
- Need to have their own career accomplishments recognized

**High Expectations** People attending training courses tend to set **high expectations both for the trainers and for themselves**. Getting to know their clinical trainer(s) is a real and important need. Clinical trainers should be prepared to talk modestly, and within limits, about themselves, their abilities and their backgrounds.

**Personal Needs** All participants have **personal needs** during training. Taking timely breaks and providing the best possible ventilation, proper lighting and an environment as free from distraction as possible are among the ways of reducing tension and contributing to a positive training atmosphere.

## **PLANNING FOR A POSITIVE TRAINING CLIMATE BEFORE THE COURSE**

A positive training environment does not come about by accident, but through **careful planning**. This planning takes thought, time, preparation and often some study on the part of the clinical trainer. In most cases, **designing** the clinical course will be the responsibility of an advanced clinical trainer while **conducting** the course will be the role of the clinical trainer. Course design requires special knowledge and experience in order to write primary and enabling objectives and

select appropriate training methods and materials. These topics are beyond the scope of this manual.

During the planning phase of the course, the clinical trainer should:

- Obtain basic **information about the participants**
- Review the existing **course materials** (e.g., reference manual, course handbook and training aids)
- Organize the **physical resources** of the training site
- Anticipate the **needs of the participants**
- **Prepare her/himself** for the course

Although no one can anticipate everything that will happen during a clinical training course, the objective is to minimize the unexpected and then deal with any unplanned events as gracefully as possible.

### **Information About Participants**

It is important for the clinical trainer to know basic information about participants such as:

- **How many** participants will be attending the course

For the clinical trainer to plan for seating arrangements, course materials, clinical activities, etc., it is critical to know how many will be attending the course. Some training methods such as coaching and clinical demonstrations work best with small groups, while other methods, including illustrated lectures, are better suited to larger groups.

- **Why** the participants enrolled in the course

Sometimes this can be found out in advance, although often one has to ask participants on the first day of training. Knowing why they are attending and how they feel about coming to the course is important for the clinical trainer.

- **The experience and educational background** of the participants

The clinical trainer should attempt to gather as much information about participants as possible prior to training. An effective way to do this is to meet the participants **before** the course begins and talk with them about their background and expectations. When this is not

possible, the clinical trainer should do this during the first day of the course.

- The types of **clinical activities** the participants will perform in their daily work after training

Knowing the exact nature of the work that participants must perform after training is critical for the clinical trainer. It is important to use appropriate, job-specific examples throughout the course so that participants can draw connections between what is being taught and what they will need to do. This is an excellent way to reinforce the importance of what is being learned.

- The **sociocultural background** of the participants

Beliefs and values are a critical part of acceptance or rejection of family planning and of specific contraceptive methods. Thus, they must be considered when planning the training course.

### **Course Materials**

In some cases, the clinical trainer may be responsible for selecting the training methods and activities to be used in the course. Increasingly, however, clinical trainers are given a training package consisting of a reference manual, course schedule and outline, audiovisual aids and competency-based knowledge and skill assessment instruments.

In other instances, the clinical trainer may be asked to participate in a course that has been planned and developed by an organization or agency (e.g., Ministry of Health) or a medical or nursing school. In either case, the clinical trainer will not have any responsibility for **developing** the course, although there may be situations when s/he may have to **adapt** the course to the local setting. The task then is to make the best use of available course materials. In addition, any supplemental or new materials needed to customize or localize the course must be developed in advance of the training.

Even if most of the training activities and methods (e.g., case studies, group discussion, brainstorming, use of assessment instruments) are specified in a training package, considerable thought and planning are needed to determine the **timing**, **sequence** and **progression** from one activity to another.

### **Physical Resources**

The clinical trainer must consider the **physical resources** at the training site. Such facilities planning is vital. There are, of course, times when training courses will be scheduled in remote places which cannot be

visited beforehand. In such cases, it is important to consult with someone who knows the facility well in order not to leave things to chance. Regardless of the course location, the clinical trainer must be innovative and flexible in dealing with the unexpected events that invariably occur during a course.

The first aspect of facilities planning deals with the physical resources of the training site:

- Is the size of the space appropriate for the size of the participant group? Is there a need for smaller “breakout” rooms for participants? Is proper furniture available such as tables, chairs and desks?
- Is the room properly heated/cooled and ventilated?
- Is there a writing board with chalk or marking pens? Is there an information board available for posting notes and messages for participants?
- Is the lighting adequate? Can the room be darkened in order to show audiovisuals and still permit participants to take notes or follow along in their training materials?
- Is there proper audiovisual and demonstration equipment? Is it in working order, with spare parts, such as bulbs and electrical extension cords, readily available?

The **physical arrangement of the furniture and participants** within the room will affect the interaction and communication that occurs during the course. Plan the physical arrangement of the room to accommodate the selected training strategies. For example, a session using anatomic models will need an arrangement that allows one or more participants to work on each model comfortably. A group discussion, however, will require participants to be able to see and talk to each other easily. The most common arrangements for classroom tables and chairs are:

- **U-shaped.** This arrangement allows the trainer to move about the room and maintain eye contact. It works well with audiovisuals such as projectors, videotapes or flipcharts.

- **Rectangular or circular.** This arrangement is excellent when training uses primarily group discussion and brainstorming; it is not well-suited to using audiovisuals.
- **Small group arrangement.** Several groups of tables and chairs arranged in separate workstations provides space for small groups to work together.

**Participant Needs**

Planning to meet the **needs of participants** is essential. Some of the questions that must be addressed include:

- Are there physical barriers?
- Will participants be able to see the audiovisuals? Is the projection screen well placed? Is the video monitor big enough?
- Will there be adequate electric power throughout the course? What will happen if the power fails?
- What plans need to be made for meals? Will refreshments such as tea, coffee, soft drinks or water be provided during breaks?
- Does the facility have a policy regarding smoking?
- Are there toilet facilities and are they adequately maintained?
- Are telephones accessible and working? Can emergency messages be taken?
- What arrangements have been made for emergencies, such as accidents or sudden illnesses?

**Self-Preparation**

A variety of activities is important to the clinical trainer's **self-preparation**. Before the course, the clinical trainer should:

- Update her/his knowledge about the course topics (e.g., contraceptive technology, infection prevention, sexually transmitted diseases)
- Assure that her/his clinical training skills are up to standard (e.g., training with models, conducting demonstrations and role plays)
- Revise training aids such as slide sets and transparencies to be sure they are up-to-date
- Prepare and personalize a set of trainer's notes. Colored pens or markers can be used to:

- Highlight key points
- Add key questions
- Insert reminders to conduct the activities presented in the course outline (case studies, role plays, discussions, demonstrations, problem-solving activities, etc.)

Trainer’s notes, such as key content points or questions for the participants, can be outlined on the writing board, flipcharts or in transparencies. Notes and reminders also can be written directly on the reference manual pages. Adding notes to a full page of text, however, can make the page crowded and difficult to glance at while presenting information.

To provide more room for notes, create a copy of the pertinent text from the reference manual with text on only one side of each page. As shown in the example below (Figure 2-1), this provides a blank page opposite each page of text which can be used for writing the clinical trainer’s notes.

Figure 2-1. Trainer’s Notes

<p><b>COMPETENCY-BASED TRAINING</b></p> <p>Competency-based training (CBT) is distinctly different from traditional educational processes. <b>CBT is learning by doing.</b> It is based on social learning theory which states that when conditions are ideal, a person learns <b>most rapidly and effectively</b> from watching someone perform (inodel) a skill or activity.</p>	<p><i>Blank page available for clinical trainer’s notes</i></p>
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Each of the activities needed for planning a positive training environment is covered in more detail in subsequent chapters.

One final element is the clinical trainer’s **mental** preparation. It is natural for the trainer to be somewhat anxious before beginning a course. Setting unrealistic expectations (e.g., expecting to begin a course free from anxiety and with total self-confidence) increases a clinical trainer’s sense of strain. A better strategy is to anticipate and accept a certain amount of anxiety, reflect on successful past experiences, focus on the careful planning that has been completed and

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then launch into the training process. In addition, the clinical trainer who recognizes these feelings of initial anxiety often makes a better connection with participants who may be feeling the same or a higher level of concern.

## **ESTABLISHING AND MAINTAINING A POSITIVE TRAINING CLIMATE DURING THE COURSE**

Good planning helps to assure a positive training climate before training begins. Establishing and maintaining a positive training climate during training depends on how the clinical trainer delivers information because the **trainer sets the tone** for the course. In any course, **how** something is said may be just as important as **what** is said. To help create and maintain an atmosphere that is conducive to learning, use an introductory course overview, warmup activities, effective verbal and nonverbal communication, and humor, as well as informal activities outside the course.

**Overview** An introductory course overview may be used to:

- Allow participants to become acquainted with each other
- Review course goals and participant learning objectives
- Describe activities that will occur during the course
- Review participant expectations for the course
- Examine the course schedule and course materials
- Indicate the location of telephones and other services
- Answer any questions participants might have

**Warmup Activities** These activities encourage participant involvement and interaction and can be helpful in diminishing any personal concerns the participants may have. They can be used at the beginning of the course and periodically throughout training, for instance, at the start of each day. **Clinical trainers should participate in these activities.** Examples of warmup activities include:

- On the first day of training it is important that participants get to know each other. Even when they already know each other, the clinical trainer needs to become acquainted with participants. Instead of the usual “tell us your name” option, divide the group into pairs. Give participants a few minutes to interview each other.

Each participant is then given a minute to introduce her/his partner by name and to share at least two unique characteristics about her/him.

- Divide the group into pairs and ask participants to tell each other their favorite food or to name the animal they feel best describes them and why. This information is shared with the group when participants introduce their partners.
- Give participants slips of paper and ask them to write down at least three things they would like to learn during the course of that day's activities. Ask them to attach their slips to a poster board or piece of flipchart paper which is posted in the classroom. The clinical trainer can then review these expectations with the group and tell them which topics will and will not be covered. This activity also can help the clinical trainer focus the course on individual or group learning needs and interests.
- Participants and the clinical trainer form a circle. Using a soft ball, toss the ball around the circle. Participants state their names as they catch the ball. After a few minutes, when catching the ball, they call out the name of the person who tossed the ball to them.

This activity also can be used throughout the course by substituting a quick information exchange for people's names. For example, the clinical trainer may ask "What are the indications for IUD use?" The ball is tossed around the circle and participants call out a different indication as they catch the ball.

- Participants write down three questions and find someone in the room they know as little about as possible. Each asks the other her/his questions. The participants then introduce their partners by sharing both the questions and the answers.
- Prepare a name tag for each participant. Place the tags in a box and have each participant draw a name tag. Participants locate the person whose name tag they drew and introduce themselves. (This is especially useful for larger groups—20 or more.)

**Verbal  
Communication**

Verbal communication refers to how something is said. In order to capture and maintain participants' interest, clinical trainers should:

- Vary the **pitch, tone and volume of their voice** to emphasize important points. Avoid monotone speech which will cause boredom no matter how important the content.
- Begin each session and each topic with a **strong introduction** to capture interest and draw attention to important points.
- **Communicate on a personal level** with each of the participants by using their names; however, be sensitive to cultural norms. In some settings using first names may make the participants more comfortable; in other settings, use of first names may be inappropriate.
- Try to **incorporate participants' ideas and examples** into the training. Remembering a participant's comments, either from a previous session or from outside the training environment, will encourage participant interest and further participation.
- **Avoid repeating words or phrases** such as "Do you know what I mean?," "...you know?" and "Do you understand?" These can be extremely annoying after a short time.
- **Vary the pace and delivery.** Make important points slowly and cover less important material more quickly. Use terms that are familiar or easily understood by the participants.
- Try to make **logical and smooth transitions** between topics. Where possible, link topics so that the concluding review or summary of one presentation introduces the next topic. In any case, clearly state the beginning of a new topic and use audiovisual aids (chalk or writing board, flipchart, projection screen) to show it. **Abrupt transitions between topics can cause confusion.**
- Take the time to **give clear directions for all classroom and clinical activities** so that participants will not be confused and lose interest. Participants should not have to wonder what will come next, what they are supposed to do or how activities will be conducted.
- Remember that family planning involves consideration of intimate issues. Sexual matters may be difficult to talk about because they

involve strongly held views, taboos and religious beliefs. **Using words that are acceptable to participants** will encourage them to do the same when they work with clients and fellow staff members.

**Nonverbal Communication**

Nonverbal communication is as important as verbal communication. Such things as **dress, eye contact, body language and movement about the room** can have a significant impact on establishing and maintaining a positive training climate. To use nonverbal communication effectively:

- Remember the **importance of a first impression**. How you greet participants and the initial “message” you convey can set the tone of the course.
- Use **eye contact** to “read” faces. This is an excellent technique for establishing rapport, detecting understanding or confusion and getting feedback.
- Use **positive facial expressions** to aid in the process of communication.
- **Walk about the room** as you make your points. A skilled clinical trainer coordinates movements and gestures with instructional delivery. Be energetic!
- **Walk towards participants as they respond** to questions or make comments. A slow nodding of the head while maintaining eye contact demonstrates interest and encourages active participant involvement.
- **Avoid distracting gestures or body language**, such as fidgeting, excessive pacing, jingling keys or coins in pockets, or playing with chalk or marking pens.
- **Limit the use of desks, lecterns or podiums** that establish an artificial barrier between the clinical trainer and participants.
- **Display enthusiasm** about the topic and its importance. Energy and excitement are contagious and directly affect the enthusiasm of participants.

**Use of Humor**

Humor fosters a team environment while enhancing and maintaining a positive training climate. At no time should humor be offensive nor should humor be used or tolerated as a means of attack. The best humor

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in training situations is gentle and directed towards producing an atmosphere of relaxation. Examples of appropriate humor include:

- Cartoons and transparencies related to the topic
- Topic-related puns and stories
- Cartoons integrated into training handouts

**Informal Learning  
Activities**

Activities outside class and conversations during meals and refreshment breaks can be a means of informal learning for both the clinical trainer and the participant as well as a means of creating a relaxed atmosphere. The clinical trainer must remember, however, to maintain professional standards and respect the confidentiality of such informal conversations. Gossip about participants and other clinical trainers is rarely, if ever, helpful. Participants may attempt to gain the favor of trainers by being critical of their peers. It is important to defend the dignity of the training course and the participants by not being drawn into such interactions.

Commitments made by a clinical trainer during informal activities are as valid as those made in the classroom. S/he should follow through on promises made to participants, whether it is for photocopying a topic-related article, arranging an introduction to a colleague or bringing up a participant's point for discussion in the next training session.

Incorporating participants' ideas discussed during informal conversations is a way for the clinical trainer to show that s/he values their contributions. Ask participants to help you remember: "Please remind me to use your experience with a difficult removal of Norplant implants in tomorrow's demonstration."

**CONTINUING THE POSITIVE TRAINING CLIMATE AFTER THE COURSE**

Some situations allow for **providing followup after training**. If so, giving assistance in the workplace can be very valuable and should be discussed before the training course ends. In these instances, there is the possibility for a continuation of the positive training climate established during training. Another possibility which may be considered is an advanced course (i.e., a more formal followup to the course being completed). Clinical trainers should be careful not to be carried away in the enthusiasm which often accompanies the completion of a clinical course and promise more than they have the power to deliver. On the other hand, it may be helpful to hear the participants'

desires for further training and to carry these requests to the appropriate decision-making person or organization. (For more on help and followup after the course, see **Chapter 5.**)

## **SUMMARY**

Effective clinical training depends on **establishing a positive training climate**. The clinical trainer carries the central responsibility for creating and maintaining such a climate.

Creating a **positive training climate before the training course** includes understanding the participants and their social and cultural backgrounds, reviewing existing course materials, considering the needs of the participants, organizing and using the physical facilities to maximum benefit and self-preparation.

Establishing and maintaining a **positive training climate during the course** is influenced by the delivery style of the clinical trainer, including verbal and nonverbal communication and the use of humor. Throughout the course particular emphasis should be placed on working effectively with each participant and maintaining an atmosphere of respect for all participants.

Finally, planning to continue the **positive training climate after the course** is important for the successful transfer of the clinical training to the workplace. The clinical trainer and the service delivery organization should make every effort to assure that each graduate of the course has the opportunity, resources and motivation to apply the learning on the job.

## THREE

# USING AUDIOVISUAL AIDS

## INTRODUCTION

Using appropriate audiovisual aids is a critical step in the training process. Audiovisual materials supplement training activities by highlighting important points or key steps or tasks. Because individuals have different styles of learning, using a variety of audiovisuals allows the participant to receive information in different ways and reinforces the learning process.

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Prior to each training session, test all audiovisual equipment to assure that the equipment is working properly.

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**Chapter Objective** After completing this chapter, the participant will be able to use audiovisuals effectively to present information.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Present information using a writing board
- Present information using a flipchart
- Present information using transparencies
- Present information using slides
- Present information using a videotape

## WRITING BOARD

A writing board can display information written with chalk (chalkboard or blackboard) or special pens (whiteboard). Although there usually are more effective methods of transmitting information, the writing board is still the most commonly used visual aid. It is especially useful for impromptu discussions, brainstorming sessions and note taking.

The **advantages** of using a writing board:

- Available in most training rooms and does not require electricity
- Easy to use and inexpensive

- Suitable for use by both clinical trainers and participants
- Excellent for brainstorming, problem solving, making lists and other participatory activities

There are some **disadvantages** to using a writing board, including:

- The board cannot hold large amounts of material.
- Writing on the board is time consuming.
- It is difficult to write on the board and talk to the participants at the same time.
- The board can get messy.
- There is no permanent record of information presented.

### **Tips for Using a Writing Board**

- Keep the board clean.
- Use chalk or pens that contrast with the background of the board so that participants can see the information clearly.
- Make text and drawings large enough to be seen in the back of the room.
- Prepare complex drawings in advance (if very complex, an overhead transparency or 35 mm slide may be preferable).
- Underline headings and important or unfamiliar words for emphasis.
- Do not talk while facing the board.
- Do not block the participants' view of the board; stand aside when writing or drawing is completed.
- Allow sufficient time for participants to copy the information from the board.

### **FLIPCHART**

A flipchart is a large tablet or pad of paper, usually on a tripod or stand. It can be used to display previously prepared notes or drawings as well as for brainstorming and impromptu discussions.

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**Advantages** of the flipchart:

- Available in most training rooms, easy to move from room to room and does not require electricity
- Small enough that several may be used simultaneously (e.g., for small group work)
- Easy to use and inexpensive
- Suitable for use by both the clinical trainers and participants
- Excellent for brainstorming, problem solving, making lists and other participatory activities
- Pages of information can be prepared in advance and revealed at appropriate points in the presentation
- Pages can be removed from the pad and taped on the walls of the training room

**Disadvantages** of the flipchart are the same as those listed for the writing board except that there is a permanent record of information presented.

**Tips for Using a Flipchart**

- Use wide-tipped pens or markers; markers with narrow tips produce printing that is difficult to read.
- Print in block letters that are large enough to be read easily in the back of the room.
- Use different colored pens to provide contrast; this makes the pages visually attractive and easier to read.
- Use headings, boxes, cartoons and borders to improve the appearance of the page.
- Use bullets (●) to delineate items on the page.
- Leave plenty of “white space” and avoid putting too much information on one page (crowded and poorly arranged information is distracting and difficult to read).

- When pages are prepared in advance, use every other page (if every page is used, colors will show through and make text difficult to read).
- Have masking tape available to put pages up around the room during brainstorming and problem-solving sessions.
- To hide a portion of the page, fold up the lower portion of the page and tape it (when ready to reveal the information, remove the tape and let the page drop).
- Face the participants, not the flipchart, while talking.

## TRANSPARENCIES

The overhead projector is one of the most commonly used and most versatile pieces of audiovisual equipment. This visual aid projects images onto a screen using **transparency** film and silhouettes of opaque objects. A **transparency** is a plastic or acetate sheet (film) containing written or drawn material. An **overlay** is one transparency placed over another to show complex information. For example, in a presentation on female anatomy, the trainer could use one transparency showing the uterus and a second transparency, which is laid over the first, showing the surrounding organs.

The **advantages** of using transparencies are:

- The projector is simple to use, can be used in almost any training room which has electricity and is less sensitive to fluctuations in voltage than film and slide projectors.
- The projector can be used with the classroom lights on, allowing participants to take notes.
- Use of transparencies saves time (writing on a board is slower than talking) and allows the trainer more time for discussion with participants.
- They are inexpensive and can be prepared quickly and easily.
- They can be used repeatedly.

The primary **disadvantage** of transparencies is that the clinical trainer cannot project directly from the printed page. Also, the clinical trainer must be careful not to block the participants' view of the screen.

### **Making Transparencies**

There are **four** ways to produce transparencies:

- Use permanent or non-permanent (water soluble) pens to create text or drawings on plastic or acetate sheets.
- Use a copy machine with transparency film designed for copiers. Any original that produces a copy of acceptable quality on paper will produce an equivalent copy on transparency film. The transparencies are loaded in the appropriate copier paper tray and the transparency master is placed on the glass copy surface and copied onto the transparency film.
- Use a thermal transparency machine with specially designed transparency film. The transparency master is placed under the film and inserted into the machine. Within a few seconds, a transparency is produced.
- Use a computer and laser printer. The information to appear on the transparency is produced on the computer using word processing or graphics software. The page is then printed on special transparency film.

### **Guidelines for Preparing Transparencies**

- Limit the information on each transparency to one main idea and about five to six lines of large type.
- Use large lettering (at least 5 mm tall, preferably larger, if printing or 18 point or larger if using a computer). Ordinary typed materials or a page from a book are not suitable for transparencies unless they are enlarged, which can be done on many photocopy machines.
- Print text. It is easier to read than script handwriting.
- Make graphics and drawings large enough to be seen easily in the back of the room.
- Mount transparencies in standard mounting frames or insert them in plastic pockets with frames. These provide a more professional finish, make the transparencies easier to handle and also protect them.

- Number the transparencies to keep them in the correct order (numbers can be written on the transparency itself or on its outside frame).
- Store the transparencies in a box with a lid, in an envelope or a “pocket” made from manila folders or sheets of clear plastic to protect them from dust and scratches.

**Tips for Using the Overhead Projector**

- Before the presentation begins, locate and check the operation of the on/off switch.
- Be sure that there is an extra projector bulb and that it is working. Some overhead projectors have two bulbs so that if one burns out, a second is available at the flick of a switch.
- Focus the projector and check the position of the image on the screen using a transparency **before** beginning the session.
- Turn the projector on after the transparency is placed on the glass and turn it off before removing the transparency.
- Face the participants, **not** the screen, while talking.
- Show one point at a time and control the pace of the discussion by covering selected information with a piece of paper. (The paper can be placed either on top of or beneath the transparency and moved down to reveal the next item.)
- Use a pointer or pencil directly on the transparency to focus attention on a specific area; this allows the trainer to maintain direct eye contact with the participants.
- Allow plenty of time for the participants to read what is on the screen and take notes.
- Turn the projector off when you are finished using the transparencies.

## **SLIDES**

The 35 mm slide projector is a commonly used audiovisual aid which offers many of the same advantages of the overhead projector. One important difference is that full color images are easier to create using slides. Slides can be prepared by the clinical trainer or purchased commercially. Increasingly, slide sets covering specific topics or procedures are provided as part of a clinical training package.

The **advantages** of using slides are that they:

- Are relatively inexpensive and easy to produce—can be made locally by the trainer
- Are good for showing individual (detailed) steps of a clinical procedure or close-ups of equipment
- Can be shown in a fairly light room which allows the participants to take notes
- Can be used with audiotapes to produce a slide show with narration

The **disadvantages** of using slides are:

- The slide projectors are much more expensive than overhead projectors.
- The slide projectors are more fragile than and do not tolerate voltage fluctuations as well as overhead projectors.
- They are not updated as easily or produced as inexpensively as transparencies.

### **Guidelines for Preparing Slides**

- Limit each slide to one main idea (detailed information should be put into a handout, not on a slide).
- Text slides should be short and concise. It is recommended that a slide contain no more than 35 words (approximately five lines of text).
- Legibility of the material on the slide is crucial. A good rule is that if a slide can be read by the naked eye—without a projector—it will be legible to participants in the back of the room.

- Number the slides in pencil or pen on the mounting frame.
- It is essential to mark or “spot” slides for projection:
  - Place the slide on a light box (an overhead projector is ideal) so that the image appears as it will on the screen
  - Turn the slide upside down
  - With the slide upside down, mark or number the slide in the upper right-hand corner
  - When inserting in slide tray, place slide upside down (the mark or number should be visible in the upper right-hand corner)

**Tips for Using the Slide Projector**

- Arrange the room so that all participants can see the screen; make sure that there is nothing between the projector and the screen.
- Set up and test the slide projector before the participants arrive.
- Make sure there is an extra projector bulb in working condition; practice replacing the bulb.
- Locate the focus control and check the focus of the projector and position of the image on the screen.
- Run through all the slides in advance to ensure that they are in the correct sequence and inserted properly in the slide tray (with the mark or number in the upper right-hand corner).
- Determine if all or some of the lights can be left on during the slide presentation; this will make note taking easier for the participants.
- During the presentation, avoid rushing through a series of slides. This can be very frustrating for the participants. Take time to view and discuss each slide. Where appropriate, ask participants questions regarding what they are seeing on a slide.

## **VIDEOTAPES**

Videotapes are creative audiovisual aids. Using a single camera and recorder system, audio and video signals are recorded on videotape which can be played back on a videocassette machine and television screen or monitor.

The **advantages** of using videotapes are:

- Videotapes capture events the eye alone would not see. For example, a video camera attached to a laparoscope can project onto a television screen the details of tubal occlusion or gall bladder surgery.
- Individual steps of a clinical procedure or technique can be shown by slowing down the videotape or stopping (pausing) to analyze a single frame. Use of these techniques allows participants to watch and emulate a step-by-step demonstration of a technique, such as Norplant implants insertion, at their own pace.
- Videotapes provide better color and detail than traditional film.
- Videotapes can be prepared by the clinical trainer and/or participants to reflect local conditions.
- Commercially developed videotapes may be purchased or borrowed.
- Animation may be used to show an abstract concept, such as how various body organs function, in a concrete way; however, creating animated sequences requires special editing equipment.
- TV monitors, especially commercial grade, tolerate fluctuations in voltage much better than either overhead projectors or slide projectors.
- Video players are less expensive and easier to maintain than slide projectors.

There are some **disadvantages** to using videotapes in clinical training:

- Commercially prepared videotapes are often outdated and may show techniques or equipment that are inconsistent with currently approved medical practice.

- Videotapes may have been edited and therefore omit or rearrange key training steps in the procedure.
- Participants may be distracted by cultural differences such as accents, appearance or communication customs.

If it is **absolutely** necessary to use outdated videos, it is crucial that the clinical trainer point out the differences or inconsistencies **before** the video is shown. If there are considerable differences, omit the videotape entirely and substitute demonstrations with anatomic models or slides.

**Tips for Using  
Videotapes**

- Preview the videotape to ensure that it is appropriate for the participants and consistent with the course objectives.
- Before the training session, check to be sure that the videotape is compatible with the videotape player. Run a few seconds of the tape to ensure that everything is functioning properly.
- Cue the videotape to the beginning of the program.
- Arrange the room so that all participants can see the video monitor.
- Prepare the participants to view the videotape:
  - State the session objective
  - Provide an overview of the videotape
  - Focus participants' attention by asking that they look for a number of specific points during the viewing of the videotape
- Discuss the videotape after it has been shown. Review the main points that the participants were asked to watch for as they viewed the videotape.
- Prepare test items based on the videotape content if appropriate.

## FOUR

# USING INTERACTIVE TRAINING TECHNIQUES

## INTRODUCTION

An effective presentation can be one of the most exciting and rewarding aspects of a clinical trainer's responsibilities. The clinical trainer able to maintain participant interest with an exciting, dynamic delivery using a variety of training methods is more likely to be successful in helping participants reach training objectives. The time and effort invested in precourse planning pay off as the clinical trainer and participants interact, discuss, question and work together.

Every presentation (training session) should begin with an **introduction** to capture participant interest and prepare the participants for learning. After the introduction, the clinical trainer may deliver content using an **illustrated lecture**, **demonstration** or **small group activity**. Throughout the presentation, **questioning** techniques can be used to encourage interaction and maintain participant interest. Finally, the clinical trainer should conclude the presentation with a **summary** of the key points or steps.

This chapter focuses on developing presentation skills using a variety of training techniques.

**Chapter Objective** After completing this chapter, the participant will be able to use interactive training techniques when introducing new knowledge and clinical skills.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Introduce a training session
- Summarize a training session
- Use effective questioning techniques
- Plan and present an illustrated lecture
- Use a variety of small group activities (e.g., role play, case study, brainstorming, etc.)

## INTRODUCING A TRAINING SESSION

The first few minutes of any training session are critical. Participants may be thinking about other matters, wondering what the session will be like, or have little interest in the topic. The **introduction** should:

- Capture the interest of the entire group and prepare participants for the information to follow
- Make participants aware of the clinical trainer's expectations
- Help foster a positive training climate

### **Use a Variety of Techniques**

The clinical trainer can select from a number of techniques to provide variety and ensure that participants are not bored. Many introductory techniques are available, including:

- **Reviewing the session objectives.** Introducing the topic by a simple restatement of the objectives keeps the participants aware of what is expected of them.

*Example:* "This afternoon we will learn how to use the training arm model for Norplant implants. Our objective is to insert Norplant implants in the training arm using the standard insertion technique. Any questions before we begin?"

- **Asking a series of questions about the topic.** The effective clinical trainer will recognize when participants have prior knowledge concerning the course content and encourage their contributions. The trainer can ask a few key questions, allow participants to respond, discuss answers and comments, and then move into the body of the presentation.

### *Examples:*

"Can someone give us an example of an important infection prevention practice?"

"Silvia, the next topic in our Norplant implants course is client assessment. What are some of the questions we should ask the client?"

"Jose, this is a slide showing the floor plan of a family planning clinic. There are at least three problems related to client flow. Can you identify one of them?"

- **Relating the topic to previously covered content.** When a number of sessions are required to cover one subject, relate each session to previously covered content. This ensures that participants understand the continuity of the sessions and how each relates to the overall topic. Where possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.

*Example:* “When we finished yesterday we were discussing the no-touch technique for IUD insertion. Today, I will answer Mary’s question by reviewing why there is no need for prophylactic antibiotics with IUD insertion when the no-touch technique is used.”

- **Sharing a personal experience.** There are times when the clinical trainer can share a personal experience to create interest, emphasize a point or make the topic more job-related. Participants enjoy hearing these stories as long as they relate to the topic and are used only when appropriate.

*Example:* “Today we will practice the use of the uterine elevator in minilaparotomy. Before we begin, I would like to share with you my first experience in performing minilaparotomy. The client was....”

- **Relating the topic to real-life experiences.** Many training topics can be related to situations most participants have experienced. This technique not only catches the participant’s attention, but facilitates learning because people learn best by anchoring new information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.

*Example:* “Our next topic is pre-operative counseling for the minilaparotomy client. Have you ever had a client who was very nervous and anxious? What did she say or do? How did it affect you? Yasmina, tell us how you would feel if you were the client.”

- **Using a case study or problem-solving activity.** Case studies or problem-solving activities focus attention on a specific situation related to the training topic. Working in small groups generally increases interest in the topic.

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**Example:** “Our next topic is the side effects associated with the Copper T 380A IUD. Please read the case study on page three of your course handbook and answer the questions on page four. We will discuss your responses when everyone has finished.”

- **Using a videotape or other audiovisual aid.** Use of appropriate audiovisuals can be stimulating and generate interest in a topic.

**Example:** “Now that we have performed an easy removal of Norplant implants, we’ll use the slide set to review a ‘difficult’ removal procedure. Afterwards, we’ll discuss what made this removal different from the standard technique.”

- **Using an imaginative transparency.** Clinical trainers should keep a file of topic-related cartoons, signs, slogans, acronyms and similar items. When appropriate, these can generate a few smiles and interest at the same time.
- **Making a provocative statement.** This technique should be used sparingly and with great care. The idea is to make a controversial statement designed to create a reaction. The ensuing discussion will increase interest in the topic to be presented. Be careful, however, not to make a statement that will upset or alienate participants because this will have a negative impact on the learning climate.

**Example:** “Our topic this morning is infection prevention practices for minilaparotomy. Now, in my opinion, I think that if you are careful you don’t need to follow all of the recommended infection prevention practices. Ramon, what do you think?”

- **Giving a classroom demonstration.** Most clinical training courses involve equipment, instruments and techniques that lend themselves to demonstrations, which generally increase participant interest.
- **Using a content expert.** Speakers from outside the training facility often add credibility to a session. The clinical trainer must be sure that the speaker is capable of making an effective presentation and that comments from the participants will relate specifically to the topic. When this is the case, the content expert can motivate the participants’ interest in the topic.

**Example:** “This session will review infection prevention practices. To begin our discussion I would like to introduce Sister Ade Wachura, Infection Prevention Specialist for the hospital. Ade will share with us the hospital’s recommended infection prevention practices for surgical contraceptive methods. Please join me in welcoming....”

- **Using a game, role play or simulation.** Games, role plays and simulations generate tremendous interest through direct participant involvement and therefore are useful for introducing topics.

**Example:** “Today we will discuss staff motivation. What is it? How do we maintain it? To introduce this topic we are going to take a few minutes to play a game called ‘I Am a Winner.’ Our first step is to divide into four groups....”

- **Relating the topic to future work experiences.** Participants’ interest in a topic will increase when they see a relationship between training and their work. The clinical trainer can capitalize on this by relating objectives, content and activities of the course to real work situations.

**Example:** “This afternoon I will demonstrate an infection prevention practice that you use every day in your work. In fact, it is one of the most important things you do....”

## **SUMMARIZING A TRAINING SESSION**

A **summary** is used to reinforce the content of a presentation and provide a review of its main points. Generally, a summary is used at the end of a presentation. When training topics are complex, however, periodic summaries may be used to ensure that participants understand the material as it is being presented. In addition, summaries may be used prior to demonstrations or breaks which interrupt the presentation.

The summary should:

- **Be brief**
- Draw together the **main points**
- **Involve** the participants

Many summary techniques are available to the clinical trainer, including:

- **Asking the participants for questions** gives participants an opportunity to clarify their understanding of the instructional content. This may result in a lively discussion focusing on those points that seem to be the most troublesome.
- **Asking questions of the participants** which focus on major points of the presentation.
- **Administering a practice exercise or test** gives participants an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for a discussion by asking for correct answers and explaining why each answer is correct.
- **Using a game to review main points** provides some variety, when time permits. One popular game is to divide participants into two teams, give each team time to develop review questions and then allow each team to ask questions of the other. The clinical trainer serves as moderator by judging the acceptability of questions, clarifying answers, and keeping a record of team scores. This game can be highly motivational and serve as an excellent summary at the same time.

## USING QUESTIONING TECHNIQUES

What is a key characteristic of an effective clinical trainer? Which instructional strategy will the best clinical trainers employ? Which techniques will make the training session more interesting? Effective **questioning and reinforcement** techniques answer all three of these questions.

The primary purpose of questioning is to encourage the participant to **think** about the training topic. Most clinical trainers agree that participants often say that they understand the content, but a knowledge or skills assessment may prove otherwise. Effective questioning gives participants an opportunity to think through content and gain a fuller understanding of concepts being presented.

Involving participants through questioning will help to maintain interest and attention. This is especially critical when:

- The topic is complex
- Training sessions are lengthy
- The topic is not as exciting as the clinical trainer or participants hoped

Questions can be used at any time to:

- Introduce a topic
- Increase the effectiveness of the illustrated lecture
- Promote brainstorming
- Supplement the discussion process

### **Effective Questioning Techniques**

Use a variety of questioning techniques to maintain interest and avoid a repetitive style.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some participants may dominate while others may not participate.

*Example:* “Would someone please tell me why we...?”

- **Target the question to a specific participant by using her/his name prior to asking the question.** The participant is aware that a question is coming, can concentrate on the question and respond accordingly. The disadvantage is that once a specific participant is targeted, other participants may not concentrate on the question.

*Example:* “Jose, can you tell me what would happen if we...?”

- **State the question, pausing and then directing the question to a specific participant.** All participants must listen to the question in the event that they are asked to respond. The primary disadvantage is that the participant receiving the question may be caught off guard and ask the clinical trainer to repeat the question.

*Example:* “What type of instrument are we using today? Rosminah, can you tell us?”

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**The key in asking questions is to avoid a pattern.** The skilled clinical trainer uses all three of these techniques to provide variety and maintain the participants' attention.

- **Use participants' names** during questioning. This is a powerful motivator and also helps ensure that all participants are involved.
- **Repeat a participant's correct response.** This provides positive reinforcement to the participant and ensures that the rest of the group hears the response.

*Example:* "Juan is correct. The Copper T 380A IUD is now approved for use for up to 10 years."

- **Provide positive reinforcement for responses** to keep the participant interested in the topic. Positive reinforcement may take the form of praise, displaying a participant's work, using a participant as an assistant or using positive facial expressions, nods or other nonverbal actions.

*Examples:*

"I couldn't have said it better!"

"Very good answer, Alain!"

"I like the way you stated that, Aimee."

"Excellent thinking, Jose."

- **When a participant's response is partially correct,** the clinical trainer should reward the correct portion and then improve the incorrect portion or redirect a related question to that participant or to another participant.

*Examples:*

"I agree with the first part of your answer; however, can you explain...?"

"You almost have it! Lydia, can you give Virgilio some help?"

"Rachid is correct. When performing a minilaparotomy, we open the abdomen and the anterior rectus sheath; however, do we perform these in the order Rachid has indicated? Alain, what do you think?"

- **When a participant's response is incorrect**, the clinical trainer should make a noncritical response and restate the question to lead the participant to the correct response.

*Examples:*

“Sorry, Silvia, that's not correct. Let's look at the situation in a different way. Suppose we....”

“That's not quite what I was looking for. Let's go back to our previous session. Dr. Dimiti, think about the effect on the client's blood pressure. Now if we....”

“Maria, let me rephrase the question. What would happen if we were to adjust the...?”

- **When a participant makes no attempt to respond**, the clinical trainer may wish to follow the above procedure or redirect the question to another participant. After receiving the desired response, return to the first participant to involve her/him in the discussion.

*Example:* “Jose, can you add any other precautions for IUD use to those that Enrique has listed?”

When **participants ask questions**, the clinical trainer has two options:

- Respond to the question
- Respond with another question

The clinical trainer must draw on personal experience to determine which is appropriate for each situation. When the question deals with a complex subject or relates to a topic not previously discussed, the clinical trainer may wish to answer the question.

*Example:* “That's an excellent question, Alex. In fact, our discussion next hour will focus on postpartum minilaparotomy. To answer your question briefly,....”

Questions based on the topic, however, may be answered best by asking the participant another question.

**Example:** “Dr. Ramos, you asked ‘when’ we use the uterine elevator. Under what circumstances can you do a minilaparotomy without the uterine elevator?”

Two final cautions with regard to questions from participants are:

- When the clinical trainer cannot answer a question, s/he should acknowledge the question and admit that the answer is not known. After the session, research the answer and share it during the next session.
- When participants ask questions that will guide the discussion away from the topic, the clinical trainer must decide whether answering the question and the ensuing discussion will be valuable. When participants will benefit, and time permits, s/he may wish to follow the new line of discussion. If not, the clinical trainer must move the discussion back to the topic.

## **PLANNING AND PRESENTING ILLUSTRATED LECTURES**

The illustrated lecture is the most common method of classroom instruction. In an illustrated lecture, the content is derived largely from the knowledge area and presented verbally by the clinical trainer. Its effectiveness as a training method is markedly enhanced through the use of questioning techniques and well-designed audiovisuals such as transparencies, slides and videotapes. (See **Chapter 3** for detailed information on using audiovisuals.)

### **Advantages and Disadvantages**

The illustrated lecture offers many **advantages**:

- When properly designed and presented, an illustrated lecture is effective for mixed groups of fast and slow learners.
- An illustrated lecture will deliver large amounts of information in a relatively short period of time.
- The audience for an illustrated lecture can be larger groups than is feasible for brainstorming, discussions and other small group activities.
- The clinical trainer controls the content and delivery (what is said and when it is said).

There are, however, several **disadvantages** to the illustrated lecture:

- Lecturing is a demanding activity! The clinical trainer and participants must be able to sustain concentration and attention, sometimes for extended periods of time.
- Participant involvement and contributions may be minimal if the clinical trainer fails to encourage participant interaction.
- The lecture usually proceeds at a pace dictated by the clinical trainer. Participant understanding of the information should be monitored through questioning and feedback to assure that the presentation is not moving too rapidly or, equally important, too slowly.
- There is a tendency to overload participants with **too much information**. Presentation of too much information strains their short-term memory capacity.

**Planning an Illustrated Lecture**

The **first step** in planning an illustrated lecture is to review the lecture objectives. Will the illustrated lecture be the most appropriate strategy to meet the objectives? The clinical trainer's plan for giving an illustrated lecture should contain:

- The lecture objective(s)
- An outline of key points
- Questions to involve the participants
- Reminders of participant activities, use of an audiovisual aid, etc.

The purpose of the **outline** is to allow the clinical trainer to glance at the key points without reading the content to the participants. Questions to be asked should be noted at appropriate places in the outline. Notes regarding the use of audiovisuals or class activities also should be made at those points in the presentation where they are to be used.

An effective illustrated lecture:

- Begins with a **strong introduction**
- Is followed by a **smooth transition** into the body of the lecture
- Follows the **planned outline**
- Uses a variety of **audiovisual aids**

- Includes activities that **involve the participants**
- Concludes with an **effective summary**

**Presenting an Illustrated Lecture**

There are a number of **presentation skills** which can be used to make an illustrated lecture more effective. The skilled clinical trainer uses a variety of techniques to involve participants, maintain interest and avoid a repetitive presentation style. Some common techniques are listed below.

- **Follow the lecture plan and trainer's notes**, which include the lecture objectives, introduction, body, activity and audiovisual reminders, summary and evaluation.
- **Communicate on a personal level**. Many participants will be unfamiliar with the terms, jargon, acronyms and language of a new subject. The clinical trainer should use familiar words and expressions, explain new terms and attempt to relate to the participants during the training session.
- **Maintain eye contact with participants**. Eye contact provides the clinical trainer with feedback on how well participants understand the content and helps to communicate a caring attitude on the part of the trainer. Eye contact also is useful in establishing and maintaining a positive learning climate (see **Chapter 2**).
- **Project one's voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone and inflection to maintain participants' attention. Avoid using a monotone voice, which is guaranteed to put participants to sleep!
- **Avoid the use of slang or repetitive words, phrases, or gestures** that may become distracting with extended use.

*Examples:*

"OK, now...."

"Is that clear?"

"Do you see what I'm saying?"

Hands in pockets, pacing or rocking on heels.

- **Exhibit enthusiasm during the presentation**. Such enthusiasm may be demonstrated by acting excited about the topic, smiling, moving with energy and interacting with participants.

- **Move about the room.** Moving around the room ensures that the clinical trainer is close to all participants at some time during the session. As the clinical trainer moves toward a participant and maintains eye contact, the participant is encouraged to interact.

In order for the clinical trainer to move about the room from participant to participant, the desks or tables should be set up in a U-shaped arrangement. This allows the clinical trainer to move easily to any individual and also encourages participants to interact because they are facing each other.

- **Use appropriate audiovisual aids** during the presentation.
- Be sure to ask both **simple and more challenging questions**.
- **Provide positive feedback** to participants during the presentation.

*Examples:*

“Very good point, Ilka!”  
“Thanks for sharing that story.”  
“Anne Marie has made an excellent comparison!”

- **Use participant names as often as possible.**

*Examples:*

- During questioning and when providing positive feedback
- To help keep the participants focused on the presenter
- To foster a positive learning climate

- **Display a positive use of humor.**

*Examples:*

- Topic-related cartoons on an announcement board
- Topic-related humorous stories
- Topic-related cartoons for which participants are asked to create captions

- **Provide smooth transitions between topics.** Within a given presentation, a number of separate yet related topics may be discussed. When shifts between topics are abrupt, participants may become confused and lose sight of how the different topics fit into

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a bigger picture. The clinical trainer must ensure that the transition from one topic to the next is smooth. This can be accomplished by:

- A brief summary
- A series of questions
- Relating content to practice or using an application exercise (case study, role play, etc.) before moving on to the next topic
- **Be an effective role model.** The clinical trainer should be a positive role model in dress, appearance, enthusiasm for the training course, being on time and finishing at the scheduled time.

## **FACILITATING SMALL GROUP ACTIVITIES**

### **Guidelines for Small Group Activities**

There are many times during training when the participants will be divided into several **small groups** which usually consist of four to six participants. Examples of small group activities include:

- **Solving a problem** which has been presented by the clinical trainer or another participant
- **Reacting to a case study** which may be presented in writing, orally by the clinical trainer or through videotape or slides
- **Preparing a role play** within the small group and presenting it to the large group as a whole

Small group activities offer many advantages including:

- Providing participants an opportunity to **learn from each other**
- **Involving** all participants
- Creating a sense of **teamwork** among members as they get to know each other
- Providing for a **variety of viewpoints**

When small group activities are being conducted, it is important that participants are not in the same group every time. Different ways the clinical trainer can create small groups include:

- **Assigning** participants to groups
- Asking participants to **count off** “1, 2, 3,” etc. and having all the “1s” meet together, all the “2s” meet together, etc.
- Asking participants to **form their own groups**
- Asking participants to **draw a group number** (or group name) from a hat

The classroom(s) used for small group activities should be large enough to allow different arrangements of tables and chairs so that individual groups can work without disturbing one another. The clinical trainer should be able to move easily about the room to visit each group. If available, consider using smaller rooms near the primary classroom where small groups can go to work on their problem-solving activities, case studies or role plays.

Activities assigned to small groups should be **challenging, interesting and relevant; should require only a short time to complete; and should be appropriate for the background of the participants**. Each small group may be working on the same activity or each group may be taking on a different problem, case study or role play. Regardless of the type of activity, there is usually a time limit. When it is the case, inform groups when there are 5 minutes left and when their time is up.

Instructions to the groups may be presented:

- In a **handout**
- On a **flipchart**
- On a **transparency**
- **Verbally** by the clinical trainer

Instructions for small group activities typically include:

- **Directions**
- **Time limit**
- A **situation or problem** to discuss, resolve or role play
- **Participant roles** (if a role play)
- **Questions** for a group discussion

Once the groups have completed their activity, the clinical trainer will **bring them together** as a large group for a discussion of the activity. This discussion might involve:

- **Reports** from each group
- **Responses** to activity questions
- **Role plays** developed and presented by participants in the small groups
- **Recommendations** from each group

It is important that the clinical trainer provide an effective summary discussion following small group activities. This provides closure and ensures that participants understand the point of the activity.

**Case Study** A **case study** is a training method using realistic scenarios that focus on a specific issue, topic or problem. Participants typically read, study and react to the case study in writing or verbally during a group discussion. The primary **advantage** of the case study is that it focuses the attention of the participant on a **real situation**. Participants may work separately or in small groups to solve or complete a case study.

**Advantages** of using a case study are listed below.

- It is a **participatory** method of training which actively involves participants and encourages them to interact with each other.
- Participants react to **realistic** and **relevant cases** that directly relate to the training course and often to their work environment.
- Reactions often provide **different perspectives** and **different solutions** to problems presented in the case study.
- Reacting to a case study helps participants **develop problem-solving skills**.

**Case studies can be developed by the clinical trainer or the participants.** Situations for the case studies can be found in one or more of the following sources:

- Clinical experiences
- Medical histories/records, reference manuals, clinical journals, etc.
- Experiences from clinic staff, participants or clients

After participants have read the case study, either individually or in small groups, they should be given the opportunity to react to it. Typical reaction exercises include:

- **Analysis of the problem.** The participants are asked to analyze the situation presented in the case study and determine the source of the problem.
- **Focused questions.** These inquiries ask participants to respond to specific questions.

*Example:* “What are three observations suggesting that the client was not counseled properly?”

- **Open-ended questions.** These questions provide participants more flexibility in responding.

*Example:* “What are some of the consequences of failing to counsel a client properly prior to performing a minilaparotomy?”

- **Problem solutions.** The participants are asked to offer suggestions regarding the situation being presented.

*Example:* “How could this problem have been avoided?”

Once participants have reacted to the case study they should be given the opportunity to share their reactions. This sharing might take the form of one or more of the following:

- **Reports** from individuals or small groups
- **Responses** to case study questions
- **Role plays** presented by individuals or small groups
- **Recommendations** from individuals or small groups

The clinical trainer should summarize the results of the case study activity prior to moving on to the next topic.

An example of a case study can be found in **Sample 4-1** at the end of this chapter.

**Role Play** A role play is a training method in which participants act out roles in a situation related to the training objectives. **Advantages** of role play include:

- Role play can create a highly motivational climate because participants are actively involved in a realistic situation.
- Participants can experience a real-life situation without having to take real-life risks.
- Role play gives participants an understanding of the client's situation.

*Examples:*

- Make participants aware of the communication skills needed to counsel a client about family planning by asking them to assume the roles of the client seeking contraception and a family planning counselor.
- Practice a clinical skill by asking two participants to role play the procedure using an anatomic model (e.g., insert an IUD using the pelvic model).
- Reinforce a session on coaching skills by asking participants to prepare and present a role play demonstrating the coaching process during a minilaparotomy.

To conduct the role play, the clinical trainer should:

- Decide what the participants should learn from the role play (the objectives)
- Devise a simple situation
- Explain what the participants should do and what the audience should observe
- Discuss important features of the role play by asking questions of both the players and observers

- Summarize the session, what was learned and how it applies to the clinical skill or activity being learned

An example of a role play can be found in **Sample 4-2** at the end of this chapter.

**Brainstorming** Brainstorming is a training strategy that **stimulates thought and creativity** and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts or alternative solutions which focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that participants have some background related to the topic.

The following guidelines will facilitate the use of brainstorming:

- **Establish ground rules.**

*Example:* “During this brainstorming session we will be following two basic rules. All ideas will be accepted and Alain will write them on the flipchart. Also, at no time will we discuss or criticize any idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not,....”

- **Announce the topic or problem.**

*Example:* “During the next few minutes we will be brainstorming and will follow our usual rules. Our topic today is ‘Indications for Use of Norplant Implants.’ I would like each of you to think of at least one indication. Maria will write these on the board so that we can discuss them later. Who would like to be first? Yes, Ilka....”

- **Maintain a written record** of the ideas and suggestions on a flipchart or writing board. This will prevent repetition and keep participants focused on the topic. In addition, this written record is useful when it is time to discuss each item.
- **Involve the participants and provide positive feedback** in order to encourage more input.
- **Review written ideas and suggestions periodically** to stimulate additional ideas.
- **Conclude brainstorming by reviewing all the suggestions.**

**Group Discussion** The **group discussion** is a training technique in which most of the ideas, thoughts, questions and answers are developed by the participants. The clinical trainer typically serves as the **facilitator** and guides participants as the discussion develops.

Group discussion is useful:

- At the conclusion of a training session
- After viewing a videotape
- Following a clinical demonstration
- After reviewing a case study
- After a role play
- Any other time when participants have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when participants have limited knowledge or experience with the topic often will result in little or no interaction and thus an ineffective discussion. When participants are familiar with the topic, the ensuing discussion is likely to **arouse participant interest, stimulate thinking and encourage active participation**. This interaction affords the facilitator an opportunity to:

- Provide positive feedback
- Emphasize key points
- Create a positive learning climate

The facilitator must consider a number of factors when selecting group discussion as the training strategy:

- Discussions involving **more than 15 to 20 participants** may be difficult to lead and may not give all participants an opportunity to participate.
- Discussion requires **more time** than an illustrated lecture because of extensive interaction among the participants.
- **A poorly directed discussion may move off target** and never reach the objectives established by the facilitator.

- **If control is not maintained**, a few participants may dominate the discussion while others lose interest.

In addition to **group discussion** which focuses on the session objectives, there are two other types of discussions that may be used in a training situation:

- **General discussion** which addresses participant questions about a training topic (e.g., why one technique of tubal occlusion is preferred over another in minilaparotomy)
- **Panel discussion** in which a moderator conducts a question and answer session between panel members and participants

Follow these key points to ensure successful group discussions:

- **Arrange seating to encourage participant interaction** (e.g., tables and chairs set up in a “U” shape or a square or circle so that participants face each other).
- **State the topic** as part of the introduction.

*Example:* “To conclude this presentation on management styles, let’s take a few minutes to discuss the importance of human relations and the supervision of nursing staff. Youssef, what do you think about the role of human relations and supervision?”

- **Shift the conversation** from the facilitator to the participants.

*Examples:*

“Abdul, would you share your thoughts on...?”

“Rosa, what is your opinion?”

“Michelle, do you agree with my statement that...?”

- **Act as a referee** to intercede only when necessary.

*Example:*

“It is obvious that Alain and Ilka are taking two sides in this discussion. Alain, let me see if I can clarify your position. You seem to feel that...”

- **Summarize the key points** of the discussion periodically.

*Example:*

“Let’s stop here for a minute and summarize the main points of our discussion.”

- **Ensure that the discussion stays on the topic.**

*Examples:*

“Sandra, can you explain a little more clearly how that situation relates to our topic?”

“Monica, would you clarify for us how your point relates to the topic?”

“Let’s stop for a moment and review the purpose of our discussion.”

- **Use the contributions of each participant** and provide positive reinforcement.

*Examples:*

“That is an excellent point, Rosminah. Thank you for sharing that with the group.”

“Alex has a good argument against the policy. Biran, would you like to take the opposite position?”

- **Minimize arguments** among participants.
- **Encourage all participants to get involved.**

*Example:*

“Maria, I can see that you have been thinking about these comments. Can you give us your thoughts?”

- **Ensure that no one participant dominates the discussion.**

*Example:*

“Christina, you have contributed a great deal to our discussion. Let’s see if someone else would like to offer....”

- **Conclude the discussion with a summary** of the main ideas. The facilitator must relate the summary to the objective presented during the introduction.

## **SUMMARY**

Interactive training techniques require using a variety of methods and presentation skills to involve participants in the learning process. An effective presentation can be one of the most exciting and rewarding aspects of a clinical trainer’s responsibilities. The clinical trainer able to maintain participant interest with an exciting, dynamic delivery using a variety of training methods is more likely to be successful in helping participants reach training objectives. This is where the time and effort invested in precourse planning pay off as the clinical trainer and participants interact, discuss, question and work together.

The interactive training techniques discussed in this chapter included small group activities such as role play, brainstorming, case studies and group discussions as well as illustrated lectures. All of these require effective presentation skills to encourage participant attention and involvement. The skilled clinical trainer uses a variety of these methods. These skills are summarized in the self-assessment guide presented in **Sample 4-3** at the end of this chapter.

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## SAMPLE 4-1

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### Case Study for Service Provider Training Course in IUD Skills

**Directions for participants.** Divide into small groups. Read and study this case study individually. As a group, agree on the answers to the questions. When all the groups have finished their discussion, the case study and answers from all of the groups will be reviewed in a group discussion.

#### Case Study

*A 20-year-old recently divorced woman with no children comes to the clinic requesting an IUD. She is not currently sexually active but has recently started to see a man and thinks it may develop into a long-term relationship. She says that many of her friends are using IUDs and that they are very satisfied.*

**Question:** After exchanging greetings with this client, how should the service provider proceed? What kind of counseling issues need to be discussed?

**Notes for the clinical trainer:** There are several issues which can be raised using this case study:

1. How should counseling best proceed when a client requests a specific method? Should the counselor review all the methods or should the counselor focus on discussing those methods which might be most appropriate given the client's lifestyle and needs? Finally, should the provider focus on ensuring that the client's request is appropriate for her and ensure that in choosing that method, the client has made an informed choice? (Resource: IUD reference manual, Chapter 2, pp. 2-2 to 2-4)
2. Does this client have any risk factors for potential health problems with IUD use? (Resource: IUD reference manual, Chapter 3, p. 3-3)
3. Does the nature of the relationship with her partner (or proposed partner) play any part in determining whether the IUD is appropriate for this woman? (Resource: IUD reference manual, Chapter 3, p. 3-5)

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**SAMPLE 4-2**

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**Role Play for Service Provider Training Course in Minilaparotomy Skills**

**Directions for participants.** Two participants in your group will volunteer for (or will be assigned) roles. One will be a clinician, the other a client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play.

**Participant Roles**

**Clinician:** The physician is very experienced and has performed a number of minilaparotomies under local anesthesia. S/he is visiting a clinic for the first time to perform surgery and has not worked with the clinic staff before.

**Client:** The client is a 37-year-old woman with six children. She has never been examined by a physician, is very nervous, and has received limited counseling. She has consented to a minilaparotomy under local anesthesia. When the physician enters the examination room it becomes evident that the client is very nervous and frightened.

**Focus of the Role Play:** The focus of the role play is on the interaction between the physician and client. The physician must counsel and reassure the client. The client should continue to be nervous until the physician chooses the appropriate words and expressions that will inform and calm the client.

**Discussion Questions**

1. Did the physician approach the client in a positive, reassuring manner?
2. Did the physician's approach have the planned effect on the client? What other approaches would have been effective?
3. Were the client's fears realistic?
4. How could this problem have been avoided?

**SAMPLE 4-3**

**PRESENTATION SKILLS: SELF-ASSESSMENT GUIDE**

To what degree are the following statements true of your actions or behavior when making training presentations?

<b>STEP/TASK</b>	<b>YES</b>	<b>SOMETIMES</b>	<b>NO</b>
1. I present an effective introduction.			
2. I state the objective(s) of the session as part of the introduction.			
3. I ask questions of the entire group.			
4. I target questions to individuals.			
5. I ask questions at a variety of levels.			
6. I use participant names.			
7. I provide positive feedback.			
8. I respond to participant questions.			
9. I use trainer's notes or a personalized reference manual.			
10. I maintain eye contact with participants.			
11. I project my voice so that all participants can hear.			
12. I move about the room.			
13. I use audiovisuals effectively.			
14. I display a positive use of humor.			
15. I present an effective summary.			
16. I provide opportunities for application or practice of presentation content.			

Those presentation skills I feel competent in using include:

Those presentation skills I would like to improve include:

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# USING COMPETENCY-BASED ASSESSMENT INSTRUMENTS

## INTRODUCTION

Providing participants with good counseling and clinical skills is one of the central purposes of most family planning training courses. Being able to **measure learning progress satisfactorily** and **evaluate performance objectively** are extremely important elements in the process of improving the quality of clinical training.

It is the responsibility of the clinical trainer to determine whether each participant has achieved the knowledge, attitudinal concepts and skills defined in the training course objectives. This is accomplished through the use of knowledge and skill assessments. When these assessments are based on the **mastery learning** approach to clinical training (described in **Chapter 1**), learning is measured through the following means:

- Initial assessment of each participant's and the group's general knowledge and skills in the course topic. Such preliminary assessments guide the clinical trainer and participants in their work together during the course.
- Continuous assessment of each participant's mastery of the knowledge and skills defined in the course objectives.

With this approach, "testing" is used to assure competency in providing the clinical skill or activity rather than just to assess an increase in knowledge (i.e., differences between pre- and post-test scores).

**Chapter Objective** After completing this chapter, the participant will be able to use competency-based knowledge and skill assessment instruments to measure progress in learning and evaluate performance.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Explain how competency-based knowledge assessments are used in clinical training
- Describe the advantages and limitations of competency-based skill assessments

- Explain how competency-based skill assessments are used in clinical training

## **KNOWLEDGE ASSESSMENTS**

**Assessment of knowledge (testing) is an important factor in determining the success of training.** Knowledge assessment is conducted to:

- Determine participant knowledge of the subject at the beginning of the course (**precourse questionnaire**)
- Motivate the participant to acquire new knowledge
- Determine whether progress has been made toward achieving the training objectives (**midcourse questionnaire**)

Writing **valid** and **reliable** questions requires special skills and considerable practice and experience. Therefore, to improve the quality of knowledge assessment, clinical trainers increasingly are provided with pretested questionnaires, often as part of a training package.

### **Precourse Questionnaire**

The main objective of a **precourse questionnaire** in the mastery learning approach is to assess what the participants, individually and as a group, know about the course topic. This allows the clinical trainer to identify topics which may need additional emphasis or, in some cases, require less classroom time during the course. Providing the results of the precourse assessment to the participants enables them to focus on their individual learning needs. In addition, the questions alert participants to the content that will be presented in the course. Because only general information is being tested in a precourse questionnaire, questions should be presented in the **true-false** format which is simple and easy to score. (**Sample 5-1** is a section of the true/false questions from the Precourse Questionnaire for a Norplant implants course.)

A special form, the **Individual and Group Performance Matrix**, can be used to record the scores of all course participants (**Sample 5-2**). Using this form, the clinical trainer and participants can quickly chart the number of correct answers for each of the questions. By examining the data in the matrix, the group can easily determine their collective strengths and weaknesses and jointly plan with the clinical trainer how best to use the course time to achieve the desired learning objectives.

**For the clinical trainer**, results of this questionnaire will help identify particular topics which may need additional emphasis during the learning sessions. Conversely, for those categories where 80% or more of the participants answer the questions correctly, the clinical trainer may elect to use some of the allotted time for other purposes. In an IUD course, for example, if the participants as a group did well (80% or more correct) in answering the questions in the category "Indications, Precautions and Client Assessment" the clinical trainer might assign the relevant chapters of the reference manual as homework rather than discussing these topics in class.

**For the participants**, the learning objective(s) related to each question and the corresponding chapter(s) in the reference manual should be noted beside the answer column. To make the best use of the limited course time, participants may address their own individual learning needs by studying the designated chapter(s).

### **Midcourse Questionnaire**

The main purpose of a **midcourse questionnaire**, which is administered as soon as all scheduled subject areas have been covered, is to help each participant (and the clinical trainer) assess her/his progress in mastering the course objectives. **Multiple-choice** objective testing is used in this situation rather than **true-false** because it provides a better means of knowledge assessment, reduces the chance of guessing the correct answer and can be used to cover a broader range of content areas. (Sample 5-3 is a section of multiple choice questions from the Midcourse Questionnaire for a Norplant implants clinical skills course.)

It is suggested that a correct score of 85% or more indicates knowledge-based mastery of the material presented in the course. For participants scoring less than 85% on their first attempt, the clinical trainer should review the results with each participant individually and guide her/him on using the course materials (e.g., reference manual) to learn the required information. (Participants scoring less than 85% may repeat the midcourse questionnaire at any time during the remainder of the course.)

## **SKILL ASSESSMENTS**

In the past, deciding whether a participant was competent (qualified) to perform a skill or activity **during** and, most importantly, **after** clinical training often was extremely difficult. This was due, in part, to the fact that competency was tied to the completion of a specified number of supervised procedures or activities. Unfortunately, unless participant

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performance is objectively measured relative to a predetermined standard, it is difficult to determine competency.

Competency-based skill assessments (learning guides and checklists), which measure clinical skills or other observable behaviors relative to a predetermined standard, have made this task much easier. While **learning guides** are used to **facilitate learning** the steps or tasks (and sequence, if necessary) in performing a particular skill or activity, **checklists** are used to **objectively evaluate performance** of the skill or activity.

**Terms Associated  
with Skill  
Assessments**

Use of competency-based skill assessment instruments involves two terms that may be new to the clinical trainer. They are:

- **Psychomotor domain.** The domain or area of learning that involves performing skills which typically require the manipulation of instruments and equipment (e.g., inserting an IUD).
- **Competency-based skill assessment.** An instrument used to objectively measure clinical (psychomotor) skills or other observable behaviors (e.g., counseling).

**Psychomotor Skills  
(Levels of  
Performance)**

The **psychomotor** or **skill area** involves tasks such as:

- Counseling a client
- Inserting Norplant implants
- Sterilizing instruments
- Inserting a Copper T 380A IUD
- Putting on sterile gloves

Progress in the skill area is measured in terms of **various levels or stages** of performance. The three levels of performance in acquiring a new skill, which were briefly described in **Chapter 1** (and are used throughout this manual), are defined more fully as follows:

- **Skill acquisition** represents the **initial phase** in learning a new clinical skill or activity. One or more practice sessions are needed for learning how to perform the required steps and the sequence (if necessary) in which they should be performed. Assistance and coaching are necessary to achieve correct performance of the skill or activity.

- **Skill competency** represents an **intermediate phase** in learning a new clinical skill or activity. The participant can perform the required steps in the proper sequence (if necessary) but may not progress from step to step efficiently.
- **Skill proficiency** represents the **final phase** in learning a new clinical skill or activity. The participant efficiently and precisely performs the steps in the proper sequence (if necessary).

### Advantages and Limitations

The **single greatest advantage** of a competency-based assessment is that it can be used to facilitate learning a wide variety of skills or activities and to measure participant behaviors in a **realistic job-related situation**. Competency-based assessment instruments such as learning guides:

- Break down the skill or activity into the essential steps required to complete the procedure
- Focus on a skill that the participant typically would be expected to perform on the job

Important considerations regarding the use of competency-based assessments are that they:

- Require **time and effort** to develop
- Must be used by clinical trainers who are **proficient** in the clinical procedure or activity to be learned
- Require the availability of an **adequate number** of skilled clinical trainers to conduct the training because competency-based clinical training usually requires a one-on-one relationship (see **Chapters 6 and 7**)

### Using Learning Guides

A learning guide contains the individual steps or tasks in sequence (if necessary) required to perform a skill or activity in a standardized way. Learning guides are designed to help the participant learn the correct steps and sequence in which they should be performed (**skill acquisition**) and measure progressive learning in small steps as s/he gains confidence and skill (**skill competency**).

Learning guides and checklists can be developed for any clinical skill or activity (e.g., counseling or IUD insertion). If the clinical trainer is

working with a training package, these assessments, together with instructions on their use, usually are included.

The samples in this chapter are taken from a training package designed to train service providers in IUD counseling and clinical skills. They are:

**Sample 5-4.** Instructions for Using the IUD Counseling and Clinical Skills Learning Guide

**Sample 5-5.** IUD Counseling Skills Learning Guide

**Sample 5-6.** IUD Clinical Skills Learning Guide

Reviewing these samples will provide a better understanding of how to use competency-based learning guides.

Using learning guides in competency-based clinical training:

- Ensures that training is based on a standardized procedure
- Standardizes training materials and audiovisual aids
- Forms the basis of classroom or clinical demonstrations as well as participant practice sessions

In addition, learning guides can be used as a self- or peer-assessment tool.

Examples of how learning guides can be used at different stages of the course include:

- **Initially**, participants can use the learning guides to follow the steps as the clinical trainer role plays counseling a client or demonstrates a clinical procedure using anatomic models.
- **Subsequently**, during the classroom sessions where participants are paired, one “service provider” participant performs a step or task while the other participant uses the learning guide to prompt the “service provider” on each step. During these sessions, the clinical trainer(s) can circulate from group to group to monitor how learning is progressing and check to see that the participants are following the steps outlined in the learning guide.

- Once participants become confident in performing the skill or activity (e.g., inserting an IUD in the pelvic model), they can use the learning guide to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference **before** participants provide services to clients.
- Prior to the first clinic session, participants again are paired. Here, one "service provider" participant performs the procedure while the other observes and uses the learning guide to remind the "service provider" of any missed steps. During this session, the clinical trainer circulates, coaching the participants as necessary as they perform the steps or tasks.

### **Using Checklists**

The checklist generally is derived from a learning guide. Unlike learning guides, which are by necessity quite detailed, competency-based checklists focus only on the key steps or tasks. Well-constructed checklists should contain only sufficient detail to permit the clinical trainer to evaluate and record the overall performance of the skill or activity. If a checklist is too detailed, it can distract the clinical trainer from her/his **primary purpose**, which is to **objectively observe** the overall performance of the participant.

Using checklists in competency-based clinical training:

- Ensures that participants have mastered the clinical skills and activities
- Ensures that all participants will have their skills measured according to the same standard
- Forms the basis of followup observations and evaluations

**Sample 5-7** contains the instructions for using the **Checklist for IUD Counseling and Clinical Skills**. Reviewing these instructions will provide additional insight into the use of competency-based performance checklists.

The IUD clinical skills checklist can be found in **Sample 5-8**. When compared with the corresponding clinical portion of the learning guides (**Samples 5-5** and **5-6**) note that the checklist is shorter and focuses only on the key steps in the whole process.

When completed, this checklist, together with the clinical trainer's comments and recommendations, provides objective documentation of

the participant's level of performance. Furthermore, it serves as one part of the process of attesting that the participant is qualified to provide the clinical service (e.g., IUD insertion) or activity (e.g., counseling). (See section on "Qualification" in **Chapter 8** for additional information.)

## **SUMMARY**

Providing participants with good counseling and clinical skills is one of the central purposes of most family planning courses. The use of well-designed competency-based knowledge and skill assessment instruments can make mastering these skills easier.

The knowledge questionnaires described in this chapter are used to guide the clinical trainer in conducting the course. Furthermore, in contrast to pre- and post-tests which are one-time assessments of knowledge increase, the questionnaires described here measure **progress** in learning.

Learning guides enable each participant to chart her/his progress in learning new skills and to pinpoint areas for improvement by breaking the skill or activity down into its essential elements.

Finally, evaluating whether participants have acquired new skills can be done using competency-based (performance) **checklists**. These checklists can be used to measure a wide variety of participant skills and behaviors in **realistic job-related situations**.

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**SAMPLE 5-1**

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**PRECOURSE QUESTIONNAIRE**

**Instructions:** In the space provided, print a capital **T** if the statement is **true** or a capital **F** if the statement is **false**. Each correct response is worth one (1) point.

**COUNSELING**

- |  |       |  |
|--|-------|--|
| 1. The physician is the best qualified person to choose a contraceptive method for a woman in good health.   | _____ | Participant Objective 1<br>(Chapter 2)             |
| 2. Counseling should be integrated into each interaction with the client.  | _____ | Participant Objective 1<br>(Chapter 2)             |
| 3. Knowing that Norplant implants have few side effects may help make a woman more confident about choosing Norplant implants as her contraceptive method. | _____ | Participant Objective 1<br>(Chapter 2)             |
| 4. If inserted within the first 7 days of the menses, Norplant implants become effective in preventing pregnancy within 24 hours.                          | _____ | Participant Objectives 1 & 7<br>(Chapters 1 and 6) |
-

**SAMPLE 5-2**

**INDIVIDUAL AND GROUP PERFORMANCE MATRIX**

**COURSE:**

**DATES:**

**CLINICAL TRAINER(S):**

Question Number	PARTICIPANTS												CATEGORIES
	1	2	3	4	5	6	7	8	9	10	11	12	
1													COUNSELING
2													
3													
4													
5													INDICATIONS, PRECAUTIONS AND CLIENT ASSESSMENT
6													
7													
8													
9													INFECTION PREVENTION
10													
11													
12													METHOD PROVISION (INSERTION & REMOVAL)
13													
14													
15													
16													FOLLOWUP, SIDE EFFECTS AND OTHER PROBLEMS
17													
18													
19													
20													

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**SAMPLE 5-3**

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**MIDCOURSE QUESTIONNAIRE**

**USING THE QUESTIONNAIRE**

This questionnaire is designed to help participants monitor their progress during the course. It can be given at any time during the training. An 85% or more correct score indicates knowledge-based competency on the material presented in the reference manual.

By the end of the course, all participants are expected to achieve a score of 85% or better. For those scoring less than 85% on the first attempt, the trainer should review the results with the participant and guide her/him on how to use the reference manual in learning the required new information.

Repeat testing should be done only after the participant has had sufficient time to study the reference manual.

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**Instructions:** Write the letter of the single best answer to each question in the blank next to the corresponding number on the attached answer sheet.

1. For a woman in good health, a contraceptive method is best selected by the:
    - a. woman herself
    - b. physician providing health services to the woman
    - c. counselor who sees the woman
    - d. woman's husband
  
  2. The most important part of counseling is:
    - a. providing brochures about contraceptive methods to the woman for review with her partner
    - b. identifying the woman's concerns about using contraceptives and answering her questions
    - c. obtaining formal consent for the procedure from the client
    - d. describing adverse side effects
- 

**ANSWER KEY**

1. For a woman in good health, a contraceptive method is best selected by the:
  - A. WOMAN HERSELF**
  - b. physician providing health services to the woman
  - c. counselor who sees the woman
  - d. woman's husband
  
2. The most important part of counseling is:
  - a. providing brochures about contraceptive methods to the woman for review with her partner
  - B. IDENTIFYING THE WOMAN'S CONCERNS ABOUT USING CONTRACEPTIVES AND ANSWERING HER QUESTIONS**
  - c. obtaining formal consent for the procedure from the client
  - d. describing adverse side effects

## SAMPLE 5-4

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### INSTRUCTIONS FOR USING THE LEARNING GUIDES FOR IUD COUNSELING AND CLINICAL SKILLS

#### USING THE LEARNING GUIDES

The *Learning Guides for IUD Counseling and Clinical Skills* are designed to help the participant learn the steps or tasks involved in:

- Counseling a potential family planning client
- Counseling a client requesting IUD removal
- Inserting and removing the Copper T 380A IUD

There are two types of learning guides in this handbook:

- *Learning Guide for IUD Counseling Skills*
- *Learning Guide for IUD Clinical Skills*

Each learning guide contains the steps or tasks performed by the counselor and clinician when providing IUD services. These tasks correspond to the information presented in relevant chapters of the reference manual as well as in the training slide set. This facilitates participant review of essential information.

The participant is not expected to perform all the steps or tasks correctly the first time s/he practices them. Instead the learning guides are intended to:

- Assist the participant in learning the correct steps and sequence in which they should be performed (**skill acquisition**)
- Measure progressive learning in small steps as the participant gains confidence and skill (**skill competency**)

Prior to using the *Learning Guide for IUD Clinical Skills*, the clinical trainer will review the entire counseling, insertion and removal activity with the class using the training videos and training slide set. In addition, each participant will have the opportunity to witness a counseling demonstration session or IUD insertion/removal using an anatomic (pelvic) model and/or to observe the activity being performed in the clinic on a client. Thus, by the time the group breaks into pairs to begin practicing and rating each other's performance, each participant should be familiar with the process for IUD counseling and insertion.

Used consistently, the learning guides enable each participant to chart her/his progress and to pinpoint areas for improvement. Furthermore, they are designed to make communication (coaching and feedback) between the participant and clinical trainer easier and more helpful. When using the learning guide, it is important that the participant and clinical trainer work together as a team. For example, **before** the participant attempts the skill or activity (e.g., IUD insertion) the first time, the clinical trainer (or person rating the participant, if not the clinical trainer) should briefly review the steps involved and discuss the expected outcome. In addition, immediately **after** the skill or activity has been completed, the clinical trainer or rater should debrief with the participant. The purpose of the debriefing is to provide **positive feedback** regarding the learning progress and to define the areas where improvement (knowledge, attitude or practice) is needed in subsequent practice sessions.

Because both types of learning guides are used to assist in developing skills, it is important that the rating (scoring) be done carefully and as objectively as possible. The participant's performance of each step is rated on a three point scale as follows:

- 1 **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
- 2 **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but does not progress from step to step efficiently
- 3 **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

The *Learning Guide for IUD Counseling Skills* can be used initially during practice (simulated) counseling sessions using volunteers or with clients in real situations.

The *Learning Guide for IUD Clinical Skills* is designed to be used primarily during the early phases of learning (i.e., skill acquisition) when participants are practicing with the anatomic (pelvic) model. Therefore, it does not include the steps involved in pre- and postinsertion counseling of clients. (If IUD insertion/removal training is conducted only with clients instead of using pelvic models, the clinical skills learning guide should be supplemented with relevant portions of the *Basic Learning Guide for IUD Counseling Skills*.)

- Initially, participants can use the basic learning guides to follow the steps as the clinical trainee role plays counseling a client or demonstrates IUD insertion using a pelvic model.
- Subsequently, during the classroom practice sessions, they serve as step-by-step guides for the participant as s/he performs the skill using pelvic models or counsels a volunteer "client." During this phase, participants work in teams with one "service provider" participant performing the skill or activity while the other participant uses the basic learning guide to rate the performance or prompt the "service provider" as necessary. During this initial learning phase, clinical trainer(s) will circulate to each group of participants to oversee how the learning is progressing and check to see that the participants are following the steps outlined in the basic learning guides.
- Once participants become confident in performing the procedure using pelvic models, they can use the learning guide to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference before the participants begin providing services to clients.
- For clinic practice sessions with clients, participants again are paired. Here, one "service provider" participant performs the procedure while the other observes and uses the practice learning guide to remind the "service provider" of any missed steps. During this phase the clinical trainer(s) is always present in the clinic to supervise the initial client encounter for each participant. Thereafter, depending on the circumstances, s/he circulates from group to group of participants to be sure that there are no problems and coaches them as they perform the skill/activity.

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**Remember:** It is the goal of this training that every participant perform every task or activity correctly with clients by the end of the course.

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**SAMPLE 5-5**

**LEARNING GUIDE FOR IUD COUNSELING SKILLS**  
(To be used by Participants)

Rate the performance of each step or task observed using the following rating scale:

- 1 Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
- 2 Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but does not progress from step to step efficiently
- 3 Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if

LEARNING GUIDE FOR IUD COUNSELING SKILLS					
STEP/TASK	CASES				
<b>COUNSELING (INSERTION)</b>					
<b>Initial Interview (Client Reception Area)</b>					
1. Greet woman respectfully and with kindness					
2. Establish the purpose of the visit and answer questions					
3. Ask the client about her reproductive goals (Does she want to space or limit births?)					
4. Explore any attitudes or religious beliefs that either favor or rule out one or more methods					
5. Provide general information about counseling					
6. Explain what to expect during the clinic visit					
<b>Method Counseling (Counseling Area)</b>					
7. Assure necessary privacy					
8. Obtain biographic information (name, address, etc.)					
9. Give the woman information about the contraceptive choices available and the risks and benefits for each: <ul style="list-style-type: none"> <li>• show where and how the method is used</li> <li>• explain how the method works and its effectiveness</li> <li>• explain possible side effects and other health problems</li> <li>• explain the most common side effects</li> </ul>					
10. Discuss the client's needs, concerns and fears in a thorough and sympathetic manner					
11. Help the client begin to choose an appropriate method					

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LEARNING GUIDE FOR IUD COUNSELING SKILLS					
STEP/TASK	CASES				
<b>If client chooses an IUD:</b>					
12. Screen the client carefully to make sure there is no medical condition that would be a problem (complete <i>Client Screening Checklist</i> )					
13. Explain potential side effects and make sure that each is fully understood					
<b>Pre-Insertion Counseling (Examination/Procedure Area)</b>					
14. Review <i>Client Screening Checklist</i> to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place					
15. Inform client about required physical and pelvic examinations					
16. Check that client is within 7 days of last menstrual period					
17. Check for pregnancy if beyond day 7 (refer if non-medical counselor)					
18. Describe the insertion procedure and what to expect during the insertion and afterwards					
<b>Postinsertion Counseling</b>					
19. Complete client record					
20. Teach client how and when to check for strings					
21. Discuss what to do if the client experiences any side effects or problems					
22. Provide followup visit instructions					
23. Remind client of 10-year effective life of the Copper T 380A IUD					
24. Assure client she can return to the same clinic at any time to receive advice or medical attention, and, if desired, to have the IUD removed					
25. Ask the client to repeat instructions					
26. Answer client questions					
27. Observe client for at least 15 minutes and ask how she feels before sending her home					
<b>COUNSELING (REMOVAL)</b>					
<b>Preremoval Counseling (Client Reception Area)</b>					
1. Greet woman respectfully and with kindness					
2. Establish purpose of visit					
3. Ask client her reason for removal and answer any questions					
4. Ask client about her present reproductive goals (Does she want to continue spacing or limiting births?)					
5. Describe the removal procedure and what she should expect during the removal and afterwards					

LEARNING GUIDE FOR IUD COUNSELING SKILLS					
STEP/TASK	CASES				
<b>Postremoval Counseling</b>					
6. Discuss what to do if client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain)					
7. Ask client to repeat instructions					
8. Answer any questions					
9. Review general and method-specific information about family planning methods if client wants to continue spacing or limiting births					
10. Assist client in obtaining new contraceptive method or provide temporary method (barrier) until method of choice can be started					
11. Ask client how she feels before sending her home					

**SAMPLE 5-6**

**LEARNING GUIDE FOR IUD CLINICAL SKILLS**  
(To be used by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

- 1 **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
- 2 **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but does not progress from step to step efficiently
- 3 **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR IUD CLINICAL SKILLS					
STEP/TASK	CASES				
<b>CLIENT ASSESSMENT</b>					
1. Determine that client has been counseled for insertion procedure					
2. Take a reproductive health history: Ask for and record the following information to determine if the woman is an appropriate candidate for an IUD:					
• Date of last menstrual period, menstrual interval (days) and bleeding pattern					
• Parity, pregnancy outcomes and date of last pregnancy					
• History of ectopic pregnancy					
• Severe dysmenorrhea (painful periods)					
• Severe anemia (Hb < 9gm/dl or HCT < 27)					
• History of sexually transmitted genital tract infections (GTIs), PID or other STDs					
• Multiple sexual partners (either partner)					
• Known or suspected cancer of genital tract					
<b>Physical Examination</b>					
3. Wash hands thoroughly with soap and water and dry with clean, dry cloth					
4. Tell client what is going to be done and encourage her to ask questions					
5. Ask client if she has emptied her bladder					

LEARNING GUIDE FOR IUD CLINICAL SKILLS					
STEP/TASK	CASES				
6. Palpate abdomen and check for suprapubic or pelvic tenderness and masses or other abnormalities					
<b>Pelvic Examination</b>					
7. Drape woman appropriately for pelvic exam					
8. Put new examination or high-level disinfected or sterile surgical gloves on both hands					
9. Arrange instruments and supplies on sterile tray or in high-level disinfected container					
10. Provide adequate light to see cervix					
11. Inspect external genitalia					
12. Insert vaginal speculum					
13. Perform speculum exam: <ul style="list-style-type: none"> <li>• check for vaginal lesions or discharge</li> <li>• inspect cervix and urethra</li> <li>• obtain specimens of vaginal and cervical secretions for microscopic examination if indicated (and facilities are available)</li> </ul>					
14. Gently remove speculum and set it aside on instrument tray					
15. Perform bimanual exam: <ul style="list-style-type: none"> <li>• determine if there is cervical motion tenderness</li> <li>• determine size, shape and position of uterus</li> <li>• check for pregnancy</li> <li>• palpate adnexa for abnormalities</li> </ul>					
16. Perform rectovaginal exam if indicated: <ul style="list-style-type: none"> <li>• determine size of retroverted (posterior-directed) uterus</li> <li>• check for cul-de-sac mass or tenderness</li> </ul>					
17. Remove examination gloves and dispose of according to guidelines					
18. If reusing surgical gloves, immerse both gloved hands in chlorine solution, remove by turning inside out and submerge in chlorine for decontamination					
<b>Microscopic Examination (if indicated and available)</b>					
1. Test specimen with pH tape					
2. Prepare saline and KOH wet mounts					
3. Identify: <ul style="list-style-type: none"> <li>• vaginal epithelial cells</li> <li>• trichomoniasis (if present)</li> <li>• monilia (if present)</li> <li>• clue cells (if present)</li> </ul>					



LEARNING GUIDE FOR IUD CLINICAL SKILLS					
STEP/TASK	CASES				
4. Prepare Gram stain (if indicated and available) and identify: <ul style="list-style-type: none"> <li>• WBC (polymorphonuclear white cells)</li> <li>• Gram-negative intracellular diplococci (GNID) (if present)</li> </ul>					
<b>INSERTION OF COPPER T 380A IUD</b>					
<b>Pre-insertion Tasks</b>					
1. If microscopic exam done, wash hands thoroughly with soap and water and dry with clean, dry cloth					
2. Tell client what is going to be done and encourage her to ask questions					
3. Load Copper T 380A in sterile package: <ul style="list-style-type: none"> <li>• partially open package and bend back flaps</li> <li>• put white rod (plunger) inside inserter tube</li> <li>• place package on flat surface</li> <li>• slide I.D. card underneath arms of the IUD</li> <li>• hold tips of IUD arms and push on the inserter tube to start bending arms down</li> <li>• when folded arms touch sides of inserter tube, pull tube out from under arms of IUD</li> <li>• elevate inserter tube and push and rotate to catch tips of arms in tube</li> </ul>					
<b>Insertion of IUD</b>					
4. Put new examination or high-level disinfected or sterile surgical gloves on both hands					
5. Insert vaginal speculum to see the cervix					
6. Swab cervix (especially os) and vagina two or more times with antiseptic					
7. Gently grasp cervix with tenaculum					
8. Without touching side walls of vagina or speculum gently pass uterine sound once through cervix					
9. Determine depth of uterine cavity and position of uterus; remove sound					
10. Set depth gauge to measured depth with IUD still in sterile package, then completely open package					
11. Remove loaded inserter without touching any unsterile surfaces; be careful not to push white rod towards IUD					
12. Hold blue depth gauge in horizontal position. Gently pass loaded inserter tube through the cervix while gently pulling on tenaculum until depth gauge touches cervix or resistance is felt					
13. Hold tenaculum and white rod stationary in one hand					
14. Release arms of IUD using <b>withdrawal</b> technique (pull inserter tube toward you until it touches thumb grip of white rod)					

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LEARNING GUIDE FOR IUD <i>CLINICAL SKILLS</i>					
STEP/TASK	CASES				
15. Remove white rod and gently push upward on inserter tube until slight resistance felt					
16. Partially withdraw the inserter tube and cut IUD strings to 3-4 cm length					
17. Remove inserter tube					
18. Gently remove the tenaculum					
19. Examine cervix and if there is bleeding at the tenaculum puncture site(s), place cotton (or gauze) swab over bleeding and apply gentle pressure for 30-60 seconds					
20. Gently remove speculum					
<b>Postinsertion Tasks</b>					
21. Place used instruments in 0.5% chlorine solution for 10 minutes for decontamination					
22. Dispose of waste materials (used gauze, cotton, examination gloves) according to guidelines					
23. If reusing surgical gloves, immerse both gloved hands in chlorine solution, remove by turning inside out and submerge in chlorine for decontamination					
24. Wash hands with soap and water					
25. Complete IUD card and record in client record					
<b>REMOVAL OF THE COPPER T 380A IUD</b>					
1. Tell the client what is going to be done and encourage her to ask questions					
2. Wash hands thoroughly with soap and water and dry with clean, dry cloth					
3. Put new examination or high-level disinfected or sterile surgical gloves on both hands					
4. Perform bimanual exam: <ul style="list-style-type: none"> <li>• determine if there is cervical motion tenderness</li> <li>• determine size, shape and position of uterus</li> <li>• palpate adnexa for abnormalities</li> </ul>					
5. Insert vaginal speculum and look at cervix					
6. Swab cervix (especially os) and vagina two or more times with antiseptic					
7. Grasp strings close to the cervix with hemostat or other narrow forceps					
8. Pull strings gently but firmly to remove IUD					
9. Show IUD to client					
10. Gently remove speculum					

LEARNING GUIDE FOR IUD CLINICAL SKILLS					
STEP/TASK	CASES				
<b>Postremoval Tasks</b>					
11. Place used instruments in 0.5% chlorine solution for 10 minutes for decontamination					
12. Dispose of waste materials (gauze, cotton, examination gloves) according to guidelines					
13. If reusing surgical gloves, immerse both gloved hands in chlorine solution, remove by turning inside out and submerge in chlorine for decontamination					
14. Wash hands with soap and water					
15. Record IUD removal in client record					

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SAMPLE 5-7

**INSTRUCTIONS FOR USING THE  
CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS**

**USING THE CHECKLIST**

The *Checklist for IUD Counseling and Clinical Skills* is used by the clinical trainer to evaluate each participant's performance in providing IUD services to clients (i.e., counseling, client screening, infection prevention practices, insertion or removal). This checklist is derived from the information provided in the IUD reference manual as well as that in the teaching slide set and the learning guides. Unlike the learning guides, which are quite detailed with the counseling activities and insertion and removal skills separated, the checklist focuses on only the key steps in the entire process.

Criteria for satisfactory performance by the participant are based on the knowledge, attitudes and skills set forth in the reference manual and learning guides.

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

**Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines

**Not Observed:** Step, task or skill not performed by participant during evaluation by trainer

Evaluation of the **counseling skills** of each participant may be done with clients; however, it also may be accomplished through observation during role plays with volunteers or clients in real situations at any time during the course.

Evaluation of **clinical skills** usually will be done during the last three days of the course (depending on class size and client caseload). In the first few cases, it is not mandatory (or even possible) for the trainer to observe the participant performing a procedure from beginning to end. For example, early on s/he may watch the participant load the IUD in the sterile package in one case, insert the IUD in another and decontaminate instruments in yet a third. What is important is that each participant demonstrates the steps or tasks at least once for feedback and coaching prior to the final evaluation. (If a step or task is not done correctly, the participant should repeat the entire skill or activity sequence, **not** just the incorrect step.) In addition, it is recommended that the clinical trainer not stop the participant at the incorrect step unless the safety of the client is at stake. If it is not, the clinical trainer should allow her/him to finish the skill/activity before providing coaching and feedback on her/his overall performance.

In determining whether the participant is competent, the clinical trainer(s) will observe and rate the participant's performance on each step of a skill or activity. The participant must be rated "Satisfactory" for each skill/activity group covered in the checklist in order to be evaluated as qualified.

Finally, during the course, it is the clinical trainer's responsibility to observe each participant's overall performance in providing IUD services. Only by doing this can the clinical trainer assess the way the participant uses what s/he has learned (e.g., her/his attitude towards clients). This provides a key opportunity to observe the impact of the participant's **attitude** on clients—a critical component of quality service delivery.

## **QUALIFICATION**

The number of procedures each participant needs to observe, assist with and perform will vary depending on her/his previous training and experience as well as how the current training is being conducted (e.g., whether models are being used for initial skill acquisition). The number of clinical cases needed must be assessed on an individual basis; there is no “magic number” of cases which automatically makes a person qualified to provide IUD services.

When anatomic models are used for initial skill acquisition, nearly all participants will be judged to be competent after only two to four cases. Proficiency, however, invariably requires additional practice. Therefore, when training participants who will become new IUD service providers (i.e., participants without prior training or experience), each participant may need to provide IUD services to at least 5 to 10 clients in order to “feel confident” about her/his skills. Thus, in the final analysis, the judgment of a skilled clinical trainer is the most important factor in determining competence (i.e., whether the participant is qualified).

The goal of this training is to enable every participant to achieve competency (i.e., be qualified to provide IUD services). Therefore, if additional practice in, for example, counseling or IUD insertion is needed, sufficient extra cases should be allocated during the course to ensure that the participant is competent. Finally, each participant should have the opportunity to apply her/his new knowledge and skills as soon as possible. Failure to do so quickly leads to loss of **provider confidence** and ultimately **loss of competence**.

**SAMPLE 5-8**

**CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS**

(To be completed by **Clinical Trainer**)

Place a "✓" in case box if step/task is performed **satisfactorily**, an "X" if it is **not performed satisfactorily**, or N/O if not observed.

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

**Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines

**Not Observed:** Step or task or skill not performed by participant during evaluation by clinical trainer

**PARTICIPANT** \_\_\_\_\_ **Course Dates** \_\_\_\_\_

<b>CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS</b>					
<b>STEP/TASK</b>	<b>CASES</b>				
<b>IUD INSERTION</b>					
<b>Pre-Insertion Counseling</b>					
1. Greets woman respectfully and with kindness					
2. Asks woman about her reproductive goals					
3. If IUD counseling not done, arranges for counseling prior to performing procedure					
4. Determines that the client's contraceptive choice is the IUD					
5. Reviews <i>Client Screening Checklist</i> to determine if the client is an appropriate candidate for the IUD					
6. Assesses client's knowledge about the IUD's side effects					
7. Is responsive to client's needs and concerns about the IUD					
8. Describes insertion procedure and what to expect					
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>					
<b>Insertion of Copper T 380A IUD</b>					
1. Obtains or reviews brief reproductive health history					
2. Asks client if she has emptied her bladder					
3. Tells client what is going to be done and encourages her to ask questions					
4. Washes hands thoroughly with soap and water and dries with a clean, dry cloth					

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PARTICIPANT \_\_\_\_\_ Course Dates \_\_\_\_\_

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS				
STEP/TASK	CASES			
5. Palpates abdomen and checks for suprapubic or pelvic tenderness and adnexal abnormalities				
6. Puts new examination or high-level disinfected or sterile surgical gloves on both hands				
7. Arranges instruments and supplies				
8. Performs speculum examination				
9. Collects vaginal and cervical (urethral) specimens if indicated				
10. Removes speculum and sets aside on instrument tray or high-level disinfected container				
11. Performs bimanual examination				
12. Performs rectovaginal examination if indicated				
13. Removes gloves and properly disposes of examination gloves or places surgical gloves in chlorine solution for decontamination				
14. Performs microscopic examination if indicated (and equipment is available)				
15. Washes hands thoroughly with soap and water and dries with clean, dry cloth				
16. Loads Copper T 380A inside sterile package				
17. Puts new examination or high-level disinfected or sterile surgical gloves on both hands				
18. Inserts vaginal speculum and looks at cervix				
19. Swabs cervix and vagina with antiseptic				
20. Gently grasps cervix with tenaculum				
21. Sounds uterus using no-touch technique				
22. Inserts the Copper T 380A IUD using the <b>withdrawal</b> technique				
23. Cuts strings and gently removes tenaculum and speculum				
24. Places used instruments in chlorine solution for decontamination				
25. Disposes of waste materials according to guidelines				
26. If reusing surgical gloves, removes and places them in chlorine solution				
27. Washes hands thoroughly with soap and water				
28. Completes client record				
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>				

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PARTICIPANT \_\_\_\_\_ Course Dates \_\_\_\_\_

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS					
STEP/TASK	CASES				
<b>Postinsertion Counseling</b>					
1. Teaches client how and when to check for strings					
2. Discusses what to do if client experiences any side effects or problems					
3. Assures client that she can have the IUD removed at any time					
4. Observes client for at least 15 minutes before sending her home					
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>					
<b>IUD REMOVAL</b>					
<b>Preremoval Counseling</b>					
1. Greets woman respectfully and with kindness					
2. Asks client her reason for removal and answers any questions					
3. Reviews client's present reproductive goals					
4. Describes the removal procedure and what to expect					
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>					
<b>Removal of Copper T 380A IUD</b>					
1. Washes hands thoroughly with soap and water and dries with clean, dry cloth					
2. Puts new examination or high-level disinfected or sterile surgical gloves on both hands					
3. Performs bimanual exam					
4. Inserts vaginal speculum and looks at cervix					
5. Swabs cervix and vagina with antiseptic					
6. Grasps strings close to cervix and pulls gently but firmly to remove IUD					
7. Places used instruments in chlorine solution for decontamination					
8. Disposes of waste materials according to guidelines					
9. If reusing surgical gloves, removes and places in chlorine solution					
10. Washes hands thoroughly with soap and water					
11. Records IUD removal in client record					
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>					

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PARTICIPANT \_\_\_\_\_ Course Dates \_\_\_\_\_

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS					
STEP/TASK	CASES				
<b>Postremoval Counseling</b>					
1. Discusses what to do if client experiences any problems					
2. Counsels client regarding new contraceptive method, if desired					
3. Assists client in obtaining new contraceptive method or provides temporary (barrier) method until method of choice can be started					
<b>SKILL/ACTIVITY PERFORMED SATISFACTORILY</b>					

PARTICIPANT IS  QUALIFIED  NOT QUALIFIED TO DELIVER IUD SERVICES, BASED ON THE FOLLOWING CRITERIA:

- Score on Midcourse Questionnaire \_\_\_\_\_ %
- Counseling and Clinical Skills Evaluation:  Satisfactory  Unsatisfactory
- Provision of services (practice):  Satisfactory  Unsatisfactory

Trainer's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## COACHING IN CLINICAL TRAINING

### INTRODUCTION

As shown in the following case study, being an effective clinical trainer requires more than just possessing the technical skills to perform a procedure.

#### CASE STUDY

##### *The Case of the Misplaced Uterine Elevator*

*The client was a 34-year-old woman who had five children. During counseling she reported that she and her husband had decided to have no more children and, after her family planning options were explained, she decided to have a minilaparotomy under local anesthesia.*

*The surgery was performed 1 week later by a young physician who was being trained to perform minilaparotomy by a more experienced physician trainer. The surgery did not go well. The procedure took nearly an hour to perform and the client became extremely uncomfortable, at times writhing on the operating table and uttering loud cries. Ultimately, the surgery was completed but the client clearly was disturbed about the operation, saying, "They told me this was supposed to be a simple and painless operation."*

*Following the surgery, the physician and the clinical trainer discussed the case. The clinical trainer noted that the incision had been made too high, making location of the fallopian tubes difficult. He advised that the physician "work more slowly" and correctly locate the site of the incision by using the uterine elevator. The physician did not respond to this advice but instead complained that the instruments had not been arranged properly on the trolley (Mayo stand) by the nurse. He said, "The problem I had was that I got mixed up by the arrangement of the instruments. Also, the client was not cooperative. She hadn't been counseled properly."*

*The clinical trainer pointed out that it was the physician's responsibility to make sure his instruments were placed correctly on the trolley and that it was not helpful to blame the client. "It is your responsibility to ensure that the client remains cooperative," he said.*

*After a lengthy discussion the physician finally admitted that the real cause of the problem was that the uterine elevator had slipped out of place early in the procedure. It was difficult therefore to locate the correct position for the incision point and to move the uterus during the operation in order to locate the fallopian tubes. The clinical trainer was shocked. "You knew the elevator wasn't in place. Why didn't you do something?"*

The above scene took place during an actual clinical training course. Although an extreme example, it illustrates some of the following problems often encountered during clinical training:

- Clients sometimes receive poor treatment at the hands of ill-prepared clinicians-in-training (participants).
- Participants often are fearful and anxious during clinical training which can interfere with their performance.

- Communication between the clinical trainer and participants can be inadequate.
- Rather than seeking solutions to problems, participants sometimes attempt to blame others.
- Clinical trainers may do a poor job of assisting participants during training.

This chapter will present **coaching** as a technique **to address these problems and to improve the quality of clinical training.**

**Chapter Objective** After completing this chapter, the participant will be able to use **coaching** as an effective clinical training strategy.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Identify the characteristics of an effective trainer/coach
- Describe the COACH Model
- Provide a **clear performance model**
- Create a learning environment that is **open to learning**
- **Assess learning** during the coaching process
- **Communicate** during coaching
- Provide **help and followup** after coaching

## **CHARACTERISTICS OF AN EFFECTIVE TRAINER/COACH**

Health professionals conducting clinical training courses are continually changing roles. They are **trainers** or **instructors** when presenting illustrated lectures and giving classroom demonstrations. They act as **facilitators** when conducting small group discussions and using role plays and case studies. Once they have demonstrated a clinical procedure, they then shift to the role of **coach** as the participants begin practicing. An effective clinical trainer:

- Is **proficient** in the skills to be taught
- **Encourages** participants in learning new skills
- Promotes **open (two-way) communication**

- Provides **immediate feedback**:
  - Informs participants whether they are meeting the objectives
  - Does not allow a clinical task or skill to be performed incorrectly
  - Gives positive feedback as often as possible
  - Avoids negative feedback and instead offers specific suggestions for improvement
- Recognizes that clinical training can be stressful and knows how to **regulate participant as well as trainer stress**:
  - Uses appropriate humor
  - Observes participants and watches for signs of stress
  - Provides regular breaks during training sessions
  - Provides for changes in the training routine
  - Focuses on participant success as opposed to failure
- Uses a **variety of training methods and audiovisual aids**:
  - Illustrated lecture
  - Demonstration
  - Brainstorming
  - Discussion
  - Individual or small group problem-solving exercises
  - Role play
- **Involves the participants** as much as possible
- **Plans all training sessions in advance** and provides participants with the course schedule and outline, homework assignments and any supplemental materials (e.g., handouts)

The characteristics of an **effective coach** are the same as those of an **effective clinical trainer**. Additional characteristics especially important include:

- Being patient and supportive
- Providing praise and positive reinforcement



- Correcting participant errors while maintaining participant self-esteem
- Listening and observing

To fully understand the role of the coach, it is helpful to compare the **do's** and **don'ts** of effective coaching. The effective coach involves all participants and provides them with positive feedback. The ineffective coach is controlling, avoids involving the participants and typically fails to provide positive feedback. A comparison of the **effective** and **ineffective** coach is presented below.

<b>The Effective Coach...</b>	<b>The Ineffective Coach...</b>
Focuses on the practical	Focuses on the theoretical
Encourages working together (collegial relationship)	Maintains a distance (status is above the participants)
Works to reduce stress	Often creates stress
Fosters two-way communication	Uses one-way communication
Sees her/himself as a facilitator of learning	Sees her/himself as the authority or the only source of knowledge

## **THE COACH MODEL**

Coaching, or “behavior modeling” as it sometimes is called, has been used successfully for years by industry in technical training. The essential elements of the clinical training strategy of coaching can be described in five concepts that form the acronym **COACH**. Any clinical training course should include these elements.

- C Clear Performance Model:** Participants should be shown in a clear and effective manner the skills they are expected to learn.
- O Openness to Learning:** The clinical coach should include activities designed to create readiness to learn and use new skills.
- A Assessment of Performance:** Clinical training should include measures for assessing competence in the skills being taught and providing feedback about progress toward a satisfactory standard of performance.

**C Communication:** Effective two-way communication between the trainer/coach and participant is essential to skill acquisition and attaining skill competency.

**H Help and Followup:** Clinical training should include planning for application of the new skills in the participant's work environment and help in overcoming obstacles to utilization of the skills.

The COACH elements do not represent a sequence of training or training design; instead, they describe activities that should be present in any clinical training. Take a few minutes to complete the **COACH Self-Assessment Guide (Sample 6-1)** at the end of this chapter.

## CLEAR PERFORMANCE MODEL

As previously discussed, people learn best by observing the correct **modeling** of a clinical procedure by an expert practitioner. **Modeling**, or observational learning, takes place in three stages. In the first stage, **skill acquisition**, the learner sees others perform the procedure, and acquires a mental picture of the required steps. Once the mental image is acquired, the learner attempts to perform the procedure, usually with supervision. Finally, the learner practices until **competency** is achieved and s/he feels confident performing the procedure. Once this stage is accomplished, if the consequences of practicing the modeled behavior are rewarding, the learner is likely to continue performing it until **proficiency** is reached.

In this section the importance of establishing standards of effective performance will be described.

### Establishing Standards of Effective Performance

Approved, agreed-upon **standards of performance** (see **Chapter 1**) are essential to the coaching process, particularly when assessing progress in learning a new skill. The clinical trainer must accurately demonstrate the approved technique for carrying out the clinical skill or procedure so that the participant has a clear picture of the expected performance.

Medical practice, especially performing surgical procedures, is an art that varies from clinician to clinician. Clinicians often develop personal styles or approaches in which they take great pride, much like the personal styles exhibited by artists or athletes. These individual differences in approach are acceptable (and are necessary for progress) so long as basic quality standards are observed and the welfare of the client is not jeopardized. For clinical training purposes, however, it is

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important that the participant be presented with a performance model that is:

- **Consistent** among clinical trainers
- **Practical** given local conditions
- As **simple** and **easy** to learn as possible

## **OPENNESS TO LEARNING**

New skills are most easily learned when the participant is **highly motivated** to learn and is **not overwhelmed** by feelings of anxiety and fear. Adults often experience fear when learning new tasks, especially if they feel their self-esteem or image with colleagues will be damaged or if previous learning experiences, in medical school for example, have been embarrassing or threatening.

When learning new skills or techniques, a participant associates them with the entire context of the training. Therefore, if the context is **pleasant, supportive and enhances self-esteem, the participant is more likely to learn and use the skills**. If the behavior of the clinical trainer or the training environment produces feelings of discomfort or stress, the participant may try to relieve the discomfort by discounting the quality of the training and the relevance of the skill. The participant also may use other defense mechanisms that restrict learning.

When learning new skills, an individual passes through predictable stages of competence:

- **Unconscious incompetence.** The participant lacks certain skills or knowledge and is unaware of the deficiencies.
- **Conscious incompetence.** The participant becomes aware of skill weaknesses but has not learned the new skills.
- **Conscious competence.** The participant is learning the new skill but must concentrate in order to perform the skill correctly.
- **Unconscious competence.** After much practice, the participant becomes comfortable in performing the skill and incorporates it into her/his repertoire of skills.



To help move the participant from **unconscious incompetence** to **unconscious competence**, the clinical trainer must take the participant through the learning stages in a way that maintains and enhances self-esteem.

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Motivation to learn can be increased by creating a learning environment that boosts each participant's confidence in her/his own ability to learn.

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## ASSESSING LEARNING DURING THE COACHING PROCESS

For clinical skills training to be effective, participants must have a way to continually assess their progress in learning new skills. Using a **competency-based learning guide** during training enables participants to:

- Assess their skill level and learning needs when entering training
- Set realistic learning goals
- Self-assess learning progress during training
- Receive useful, objective feedback from the clinical trainer and other participants
- Determine when the skill or activity has been mastered

**Competency-based learning guides** can be developed for any clinical activity or skill (e.g., counseling or inserting an IUD). A learning guide such as the one presented in **Chapter 5 (Sample 5-6)** provides a simple way of charting participant progress in mastering each skill area as s/he practices the procedure.

### **When to Provide Feedback**

In addition to using a learning guide, providing detailed and specific verbal feedback about individual performance enhances learning. Each time the participant performs the procedure using an anatomic model or with a client, there are **three** separate opportunities to provide feedback:

- **Before Practice.** The clinical trainer and participant meet briefly before each practice session to review participant performance in previous practice sessions (by checking the learning guide). This

pinpoints areas of strength and weakness. Before each practice session, the trainer and participant also set learning goals specifying the skills that will receive special attention during the session.

- **During Practice.** The clinical trainer completes the learning guide **during the practice session** while observing the performance of the participant. This step enables the trainer to give the participant feedback **after** the practice session. In addition, the clinical trainer may provide immediate specific verbal feedback to the participant on skills performed correctly. Corrective feedback during procedures with clients who are wide awake or only slightly sedated should be limited to errors that could harm or cause discomfort to the client. Excessive feedback in the operating room, especially negative comments, can create anxiety for both the participant and the client.
- **After Practice.** It is essential that the postpractice feedback session take place as soon as possible after the practice session. In this feedback session, the clinical trainer first asks the participant what s/he observed about the procedure to encourage self-assessment and good problem-solving behavior. Following the participant's self-assessment, the clinical trainer provides feedback based on what was observed and recorded in the learning guide. Again, it is important to concentrate on positive feedback initially before pointing out ways in which performance could be improved.

### **How to Give Feedback**

Many clinical trainers find it difficult to acquire the skill of giving performance-enhancing feedback. Although the following guidelines for **giving** and **receiving** feedback may be helpful, **practice** is required to become more confident with this essential skill.

Guidelines for the clinical trainer to follow in **giving** feedback are:

- **Be timely.** Give your feedback soon after the event.
- **Be specific.** Describe specific behaviors and reactions, particularly those that the participant should keep and those s/he should change. (Consult the information recorded on the learning guide to help focus the feedback on key points.)
- **Be descriptive,** not judgmental. Describe the consequences of the behavior; do not judge the person.
- **Own your own feedback.** Speak for yourself, not for others.

**Example** (descriptive, specific feedback): “When you gave the injection of local anesthetic, you did not tell the client what to expect. I saw her wince and tense up, making it difficult for you to gain her cooperation later in the procedure.”

**Example** (judgmental, non-specific feedback): “You always seem to be in such a hurry that you completely ignore the client’s needs.”

Guidelines for the participant to follow in **receiving** feedback include:

- **Ask for it.** Find clinical trainers who will be direct with you. Ask them to be specific and descriptive.
- **Direct it.** If you need information to answer a question or to pursue a learning objective, ask for it.
- **Accept it.** Do not defend or justify your behavior. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest.

## COMMUNICATING DURING COACHING

**Active Listening** This is a communication technique that enables a clinical trainer to stimulate open and frank exploration of ideas and feelings and establish trust and rapport with participants. It helps the clinical trainer clarify participant comments and enables the participant to be heard and understood. In **active listening**, the trainer accepts what is being said without making any value judgments, clarifies the ideas or feelings being expressed and reflects these back to participants.

The following are examples of active listening techniques:

- Stop talking, listen to the speaker.
- Restate the speaker’s exact words (parrot).
- Paraphrase what the speaker said in your own words.
- Understand and reflect the underlying feelings of the speaker (identify the emotion).
- Identify with the speaker’s emotions and state the implications of those feelings. (“If I won that award, I would be ecstatic.”)

It is appropriate when actively listening to ask nonleading questions such as, “Can you tell me more about that?” or “Help me understand what you said.” It is appropriate also to ask for help as a part of active listening; for example, “I’m not sure I fully understand what you are saying.” or “I’m confused as to whether you mean the doctor or the nurse. Can you explain more?”

**Active listening does not include probing questions** of a cross-examination type such as “Why did you do that?” or “What are you going to do about that?” Active listeners are not accusatory nor do they ask questions that lead to only one answer. Active listening reflects what a participant says and draws her/him out to expand further on the meaning or feelings. It also is a communication tool that can be used to reinforce effective behavior in a positive way and to shape learning.

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Everyone likes being heard and appreciated. Supportive comments from the clinical trainer **strengthen** and **reinforce** desired behavior.

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## **Questioning**

Questioning is used in clinical training to assess the participant’s knowledge and to teach problem solving. Clinicians, when interviewing clients, normally use two types of questions: **closed questions** that have a small range of answers (often *yes* or *no*); and **open questions** that allow a wide range of responses. Both types of questions are useful to assess the participant’s level of knowledge.

When using questioning to assess a participant’s knowledge in a clinical situation, the clinical trainer should consider using different types of questions:

- **Factual questions** can be used to get information and begin discussion. These are questions that begin with *what*, *where*, *when*. “What are the precautions for vasectomy?” is an example of a factual question.
- **Broadening questions** can be used to assess additional knowledge. For example, you might ask, “If the client felt pain after you injected the local anesthetic, what would you do?”
- **Justifying questions** can be used to challenge ideas and to assess depth of knowledge and understanding. For example, suppose you

are discussing a possible surgical complication. You might ask, “What treatment do you recommend and why?”

- **Hypothetical questions** can be used to explore new situations. “Suppose this client were 21 years old and had only one child. Would you still recommend voluntary sterilization?”
- **Alternative questions** can be used to assess decision-making skills. “What are the possible actions you would take if the client’s blood pressure fell suddenly?”

Questioning does **not** mean interrogating. Let participants know that the purpose of questioning is to help you target instruction, not to berate and belittle them. Asking them what **they** know and what **they** want to learn will help assess their needs and focus training more precisely.

### **Problem Solving**

One of the main purposes of clinical training is to help service providers become confident, independent problem solvers. Each client and each clinical situation is unique. **Because one cannot hope to anticipate every problem the participant will encounter, teaching rote responses will not work.** Effective problem solving is based on the following steps:

- **Analyze** the possible causes of the clinical problem
- **Identify** what further information is needed
- **Formulate** theories about possible solutions
- **Decide** on the most effective solution
- **Implement** and **evaluate** the solution

Problem solving in clinical learning is the same as the process of clinical reasoning that all medical students learn. A wide range of formats can be used for presenting clinical situations to enhance problem-solving capability such as:

- Written case studies
- Videotaped situations to trigger discussion
- Case presentations by participants based on their own experiences
- Discussion of practice cases during clinical training sessions

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As in most training situations, **the more “here and now” the cases are, the more effective will be the problem-solving discussion.** The most effective way to teach problem solving is to use the participant’s own clinical practice cases as the material to be discussed. For example, participants might have clinical practice cases in the morning and get together with the clinical trainer in a group in the afternoon. During the discussion session, they would be asked to present any problem situations they encountered in the morning, and the group would then discuss alternative solutions to the problem.

Many medical schools are finding that “problem-based learning” can replace many of the lecture-based classes that have been the traditional fixture of medical teaching. The acceptability of problem-based teaching generally is high both among students and faculty, at least by those who are trained and comfortable with it.

## **HELP AND FOLLOWUP AFTER CLINICAL TRAINING**

### **Application of Clinical Learning**

Clinical training often fails to produce long-term results when attention is not given to transferring training to the workplace. Application of newly acquired skills to the job is **not only the participant’s responsibility.** The clinical trainer and the training/service delivery organization should make every effort to ensure that the participant has the opportunity, resources and motivation to apply the learning on the job. This is especially true for the complex surgical skills learned in clinical training.

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**New skills and activities such as counseling, IUD insertion and infection prevention practices need to be practiced soon after training or they will be lost and never applied.**

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Clinical trainers can ensure that training is effective, stays with each participant and gets applied on the job by:

- Using training activities that promote transfer of the new skill or activity to the workplace
- Contracting (developing action plans)
- Providing for followup sessions

**Effective Transfer of Skills**

Before training starts, there should be a clear idea of how the participant will use her/his newly acquired clinical skills. The clinical trainer should know that all parties—supervisors, participants and other trainers—understand and **agree to what the participant will be expected to do when s/he returns to the job**. Any resources, including time, staff support, equipment and supplies needed to carry out the new skills should be **planned for before the participant enters training**, not after s/he has gone back to the job.

In addition to the pretraining planning needed to ensure transfer of new skills back to the workplace, there are a number of other training activities which will increase the probability that participants will use their new skills. For example, **any training activity that is seen by the participant as realistic and work-related will increase the probability that what has been learned will be applied**. Finally, skill practice with clients, problem-solving discussions and role plays give the participant confidence to apply new skills effectively and avoid the embarrassment of failure while on the job.

The following specific training materials and activities also can increase transfer of training to the job:

- Problem-solving **reference manuals and handouts** that participants can use to refresh their memories once they return to their jobs
- **Learning guides** that summarize the key steps of a skill or activity
- **Analysis of work-related barriers** to applying skills
- **Role plays** focusing on ways to deal with difficult situations on the job
- **Action planning** to map out how and when new skills will be applied
- **Training people in “teams”** from the same work unit (e.g., training the counselor and the service provider together)

**Contracting**

Another way that clinical trainers can increase learning transfer is “**contracting**” with course graduates about implementation of their action plans. In this context, a “contract” means a **nonlegal pledge to carry out a plan**. Like any contract, it should pledge action by the person (e.g., to perform a specific number of procedures or to report on difficult cases) as well as action by the clinical trainer (e.g., to consult on problem cases or provide help in overcoming barriers).

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**To help ensure that contracts are effective**, they should include the following elements:

- **Early commitment.** Secure commitment for goals (action plan) early in the training or before the training begins, if possible.
- **Realistic goals setting.** Make sure that goals are specific, measurable, achievable and realistic.
- **Public discussion.** Provide opportunities for discussion of action plans with fellow participants. Feedback helps create realistic planning, discussion can create a support network of colleagues who can help carry out the plans, and public commitment increases the likelihood that the plans will be implemented.
- **Monitoring procedures.** When possible, build in opportunities for clinical trainers or local expert service providers to visit a participant's work site to monitor progress in carrying out the action plan. When personal visits are not possible, write or telephone to check on implementation of the plan.

**Followup Sessions**

Most clinical trainers know that training followup is essential but few do it. The excuses are many and include:

- "I have no time."
- "I have no budget."
- "I have other courses to conduct."

Perhaps clinical trainers would take followup more seriously if they realized that **relapse** (participants who go back to their pretraining ways of doing things) **rates can be as high as 90% without followup.**

Followup can be almost any contact between the clinical trainer and participant that helps the participant apply what s/he learned more effectively. **The more intensive and frequent the followup, the more likely it will support transfer of learning.** For effective followup, the clinical trainer can:

- Send relevant articles to participants after training
- Exchange correspondence about successes and problems
- Encourage participants to "network" and support each other

- Collect data on use of new skills for evaluation or research
- Send equipment or supplies to support the work
- Make personal visits to consult on problems or meet with supervisors
- Organize refresher training to renew and extend skills
- Arrange followup meetings with training groups to share experiences and discuss mutual problems

## **SUMMARY**

Effective clinical trainers must be able to assume different roles during training. For example, they are **instructors** or **trainers** when presenting illustrated lectures and giving classroom demonstrations; they act as **facilitators** when conducting small group sessions or when using role plays and case studies; they must shift to the role of **coach** when helping participants practice the procedure. Finally, when assessing performance, they must serve as **evaluators**.

The essential elements of the COACH model of clinical training require that the clinical trainer be able to:

- Model in a clear and effective manner the skills participants are expected to learn
- Include course activities designed to create openness to learning and application of new skills
- Provide detailed, specific feedback to enhance participant learning
- Assess participant progress in learning new clinical skills and activities through the use of competency-based learning guides and by providing detailed and specific feedback

In addition, the clinical trainer must master the art of **active listening** and **questioning** and be able to help participants become effective **problem solvers**.

Finally, clinical training often fails to produce long-term results because attention is not given to **helping participants transfer** the training to the workplace. When possible, the clinical trainer should ensure that

participants have the opportunity, resources and motivation to apply the learning on the job by:

- Using training materials and activities that promote transfer of skills
- Developing followup action plans (contracts)
- Providing for followup sessions or visits

**SAMPLE 6-1**

**COACH SKILLS: SELF-ASSESSMENT GUIDE**

To what degree are the following statements true of your actions or behavior when teaching or coaching new skills to participants?

COACH SKILLS	YES	SOMETIMES	NO
<b>Clear Performance Model</b>			
1. I am careful to demonstrate the procedure according to approved standards.			
2. I verbally explain each step in the procedure while I demonstrate it.			
3. In my demonstration I use materials, equipment and a setting similar to what is available to my participants.			
4. While demonstrating the procedure I ask questions of participants such as "What should I do next?" or "What would happen if...?", to keep their interest and test their understanding.			
<b>Openness to Learning</b>			
1. I make it easy for participants to acknowledge that they lack knowledge or skills.			
2. I show sensitivity to participants' natural feelings of fear and anxiety when learning new skills.			
3. I encourage participants to be helpful and supportive of each other.			
4. I do not belittle or ridicule participants if they make a mistake.			
<b>Assessment of Performance</b>			
1. I use a learning guide to give written feedback on participant performance.			
2. My feedback to participants is very specific and is given as soon as possible after I have observed them.			
3. Following each practice session I meet with the participant to discuss her/his strengths first and then review areas where improvement could be made.			
4. I encourage participants to take personal responsibility for problems—never to blame the client or others.			
5. When giving feedback I point out things participants are doing well and offer suggestions for improvement.			

COACH SKILLS	YES	SOMETIMES	NO
<b>Communication with Participants</b>			
1. I encourage mutual, two-way communication with participants.			
2. I request participant opinions before expressing mine.			
3. I emphasize solving problems rather than blaming people.			
4. I help participants find their own solutions to problems.			
<b>Help and Followup</b>			
1. I make sure each participant has a plan for continuing to practice and apply the skills after training.			
2. I take steps to ensure that participants have the necessary equipment and supplies to apply the skills they learned.			
3. I get feedback from participants or their supervisors about how well they are performing the skills.			
4. I make sure the participants' supervisors understand and support the procedures participants learned.			

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# COMBINING COACHING WITH OTHER CLINICAL TRAINING TECHNIQUES

## INTRODUCTION

As described in **Chapter 6**, clinical trainers are continually changing roles. When demonstrating a clinical procedure or helping participants learn a new skill or activity, a clinical trainer must be a good “coach.” In the role of coach, s/he must be able to create an atmosphere that facilitates the learning process. To accomplish this successfully, the skilled coach uses a wide variety of clinical training techniques:

- First, **explaining** the skill or activity to be learned
- Next, **showing** the skill or activity to be learned using a videotape or slide set
- Following this, **demonstrating** the skill or activity using an anatomic model (if appropriate) or role play
- Then, allowing the participants to **practice** the demonstrated skill or activity using an anatomic model or in a simulated environment (role play)
- After this, **reviewing** the practice session and giving constructive feedback
- Finally, after competence is gained using models or practice in a simulated situation, having participants begin to **practice** the skill or activity with clients under a clinical trainer’s guidance

Mastering the art of **giving clinical demonstrations** and being able to **effectively train with anatomic models**, especially when combined with **good coaching skills** (e.g., active listening, use of positive feedback, questioning and problem solving), provides the participant with the tools to be an accomplished clinical trainer.

**Chapter Objective** After completing the chapter, the participant will be able to combine coaching with other clinical training techniques.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Identify the practical elements of coaching in the clinical setting
- Conduct an effective demonstration
- Use anatomic models for clinical training
- Practice clinical procedures with clients
- Ensure that clients' rights are considered at all times during clinical training

## **COACHING IN THE CLINICAL SETTING**

**Clinical training** places the participant with an experienced clinician-trainer in a real or simulated clinical setting to observe and practice the skills required to reach an established standard of performance. Clinical training is sometimes called a clinical tutorial, preceptorship or "practical." An intensive, usually one-on-one interaction between the clinical trainer and the participant is required. This interaction is needed to help the participant:

- Learn specific knowledge and positive attitudes
- Develop clinical and problem-solving skills

Although much has been written about classroom training, less help is available to clinicians who wish to improve their clinical training skills. The result of inadequate clinical training has been that while clinicians can name every bone and muscle in the body and quote from hundreds of medical studies, they may not be able to perform medical procedures in a caring, skillful manner. Unacceptable rates of surgical complications and high levels of client dissatisfaction can result from a lack of integration of classroom (theoretical) and practical skills. The "see one, do one, teach one" approach, in which a clinician is **thought** to be qualified to perform a clinical procedure after one observation, and then be able to train others, is **not acceptable**.

Unfortunately, the **teaching model** with which medical trainers are most familiar is the classroom teacher lecturing to a group of students who anxiously take notes so they can pass a written examination. This approach to **teaching**, used by a skilled clinical trainer, can be quite effective in providing basic knowledge. It is, however, a very poor way

of imparting clinical skills such as inserting an IUD, strengthening problem-solving skills or teaching positive clinical attitudes.

**Coaching is appropriate when:**

- The training needs assessment reveals that service providers lack specific skills needed to carry out their jobs competently.
- Specific performance standards have been established for the skills or procedures.
- Experienced clinical trainers are available to demonstrate and teach the skills needed to reach the established performance standards.
- Facilities, instruments and anatomic models are available to practice the skills.
- Participants will have the resources and opportunity to apply newly acquired skills in their work situation **soon** after being trained.

As described in **Chapter 6**, coaching is an effective clinical training approach. The next two sections describe how to combine the coaching strategy with other clinical training techniques to enhance learning. **Tables 7-1** and **7-2** summarize how coaching can be used to guide participants through the three levels of performance during a clinical skills training course. **Sample 7-1** presents a self-assessment guide for using the coach process for learning and developing skills.

**Table 7-1. Coaching in Clinical Training**

ROLES	LEVEL OF PERFORMANCE		
	Skill Acquisition	Skill Acquisition/ Competency (with models)	Skill Competency (with clients)
<b>Clinical Trainer</b>	Demonstrates skill/activity	Coaches the participant	Evaluates participant performance
<b>Participant</b>	Observes the demonstration	Practices the skill/activity	Performs the skill/activity
The participant progresses from skill acquisition to skill competency using anatomic models. Once the participant reaches skill competency using a model, the process begins again as s/he performs the skill/activity with clients.			

**Table 7-2. Using the COACH Process for Learning and Developing Skills**

DEMON-STRATION OR PRACTICE SESSION	LEVELS OF PERFORMANCE		
	Skill Acquisition	Skill Acquisition/Competency	Skill Competency
<b>Before</b>	<p>Clinical trainer (CT)</p> <ul style="list-style-type: none"> <li>• Provides an overview of the skill/activity</li> <li>• Uses audiovisual and other training aids</li> <li>• Reviews the learning guide</li> <li>• Asks for questions</li> </ul>	<p>Clinical trainer</p> <ul style="list-style-type: none"> <li>• Reviews steps/tasks in the learning guide</li> <li>• Answers questions about the skill/activity</li> </ul> <p>CT and participant discuss the role of the clinical trainer as coach</p>	<p>Clinical trainer</p> <ul style="list-style-type: none"> <li>• Discusses previous practice sessions with participant</li> <li>• Reviews the checklist</li> </ul> <p>Both discuss the role of the clinical trainer as evaluator</p>
<b>During</b>	<p>Clinical trainer</p> <ul style="list-style-type: none"> <li>• Demonstrates each step of the skill/activity</li> <li>• Uses audiovisual and other training aids</li> </ul> <p>Participant</p> <ul style="list-style-type: none"> <li>• Observes using the learning guide</li> </ul> <p>Both</p> <ul style="list-style-type: none"> <li>• Two-way interaction takes place</li> </ul>	<p>Both</p> <ul style="list-style-type: none"> <li>• Participant performs the procedure while coach observes using the learning guide</li> <li>• Participant asks questions as needed while coach provides positive feedback and offers suggestions</li> </ul>	<p>Participant performs the procedure</p> <p>CT observes and evaluates participant performance using the checklist</p>
<b>After</b>	<p>Both</p> <ul style="list-style-type: none"> <li>• Discuss the skill/activity</li> <li>• Review the learning guide</li> </ul> <p>CT answers any questions</p> <p>Participant is ready to practice</p>	<p>Participant</p> <ul style="list-style-type: none"> <li>• Shares feelings about positive aspects of the practice session</li> <li>• Offers suggestions for self-improvement</li> </ul> <p>Both review the steps in the learning guide</p> <p>CT provides positive feedback and offers suggestions for improvement</p> <p>Both set goals for additional practice if needed</p>	<p>Participant</p> <ul style="list-style-type: none"> <li>• Shares feelings about positive aspects of the clinical session</li> <li>• Offers suggestions for self-improvement</li> </ul> <p>Both review the steps in the checklist</p> <p>Clinical trainer</p> <ul style="list-style-type: none"> <li>• Provides positive feedback and offers suggestions for improvement</li> <li>• Determines if participant is qualified or if additional practice is needed</li> </ul>

## CONDUCTING AN EFFECTIVE CLINICAL DEMONSTRATION

When introducing a new clinical skill, a variety of methods can be used to demonstrate the procedure. For example:

- Show **slides** or a **videotape** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
- Use **anatomic models** such as pelvic or Norplant implants training arm models to demonstrate a procedure and skills.
- Perform a **role play** in which a participant simulates a client and responds much as a real client would.
- Demonstrate the procedure with **clients** in the operating or procedure room.

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**Starting with demonstrations that do not involve clients enables the clinical trainer to take plenty of time, stop and discuss key points and repeat difficult steps without endangering the health or comfort of a client.**

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Whatever methods are used to demonstrate the procedure, the clinical trainer should set up the activities using the “**whole-part-whole**” approach:

- Demonstrate the **whole procedure** from beginning to end to give the participant a visual image of the entire procedure or activity.
- **Isolate or break down the procedure or activity** into parts (e.g., pre-operative counseling, getting the client ready, pre-operative tasks, performing the procedure, etc.) and allow practice of the individual parts of the procedure or activity.
- Demonstrate the **whole procedure** again and then allow participants to practice the procedure from beginning to end.

When planning and giving a demonstration of a clinical procedure using anatomic models (or with clients if appropriate), the clinical trainer should use the following guidelines:

- Prior to beginning, **state the objectives** of the demonstration and point out what the participants should do (e.g., interrupt with questions, observe carefully, etc.).
- Make sure that **everyone can see** the steps involved.
- **Never** demonstrate the skill or activity incorrectly.
- Demonstrate the procedure in as **realistic** a manner as possible, using actual instruments and materials in a simulated clinical setting.
- Include **all steps** of the procedure in the **proper sequence** according to the approved performance standards. This includes demonstrating “nonclinical” steps such as pre- and postoperative counseling, communication with the client during surgery, use of recommended infection prevention practices, etc.
- During the demonstration, explain to participants what is being done—especially any difficult or hard-to-see steps.
- **Ask questions** of participants to keep them involved. “What should I do next?” or “What would happen if...?”
- **Encourage** questions and suggestions.
- **Take enough time** so that each step can be observed and understood. Remember that the objective of the demonstration is for the participant to learn the skills, **not** for the clinical trainer to show her/his dexterity and speed.
- **Use equipment and instruments properly** and make sure participants clearly see how they are handled.

The essential elements of an effective clinical demonstration are summarized in the self-assessment guide presented in **Sample 7-2** at the end of the chapter.

In addition, participants should use a clinical skills **learning guide** (see **Chapter 5**) to observe the clinical trainer’s performance during the initial demonstration. Doing this:

- Familiarizes the participant with the use of competency-based learning guides

- Reinforces the standard way of performing the procedure
- Communicates to participants that the clinical trainer, although very experienced, is not perfect and can accept constructive feedback on her/his performance

As the role model the participants will follow, the clinical trainer must practice what s/he **demonstrates** (i.e., the approved **standard method** as detailed in the learning guide). Therefore, it is essential that the clinical trainer use the standard method when demonstrating a procedure or skill with clients. During the demonstration, the clinical trainer also should provide supportive behavior and cordial, effective communication with **the client** and **staff** to reinforce the desired outcome.

## **USING ANATOMIC MODELS FOR CLINICAL TRAINING**

Training clinicians in complex skills, such as performing a minilaparotomy or removing Norplant implants, requires that participants carefully observe skilled clinical trainers and practice the skills repeatedly. Skills acquisition with clients, however, exposes the clients to a potentially increased risk of complications and discomfort during the procedure. To overcome this problem, **anatomic models** often are used to **demonstrate** clinical procedures and to allow participants to **learn** and **practice** these skills without harming clients (**humanistic approach**).

The use of anatomic models enhances skill development by providing participants with the opportunity to practice a skill or specific portion of a procedure repeatedly until they are comfortable with it and have achieved some degree of proficiency (i.e., can perform the skill efficiently). As stated in **Chapter 1**, clinical training with models has been shown to reduce significantly the number of IUD clients needed for clinicians to become competent in IUD insertion.

### **Advantages of Using Anatomic Models**

The advantages of using anatomic models include:

- Clients are not harmed or inconvenienced if a mistake is made.
- The demonstration or practice can be stopped at any time for further explanation or correction by the clinical trainer.

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- Several participants can practice simultaneously, reducing training time.
- Difficult tasks (e.g., using the tubal hook to identify and bring the fallopian tubes out of the pelvic cavity for a minilaparotomy) can be practiced repeatedly on a pelvic model without actually performing surgery on a client.
- Practice is not limited to the clinic or operating room or during the time when clients are scheduled.
- Practice of a sequence of steps or skill can be repeated at any time and as often as needed.
- Clinical training is possible even where client caseload is low because fewer cases are needed for participants to attain skill competency.
- Training time is reduced.

Any simulation, however, is only an approximation of the real situation. To enhance learning, it is important that the **anatomic models and the simulated setting be as close to the real experience as possible**. Where significant differences exist between working with a model and a real client, these differences should be pointed out to the participant. For example, the “subcutaneous tissue” on the training arm model used for Norplant implants training is less pliable than that of a human arm. Participants should know that it is easier to insert the trocar too deep in a client’s arm than on the model.

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To use a model effectively, the clinical trainer must be as proficient in performing the procedure on the model as s/he is with a client. This requires considerable practice with the model, including learning how to assemble and disassemble it.

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To be effective, participants should have frequent opportunities to work with the models using the actual instruments in a realistic setting. Furthermore, the procedure should be performed numerous times using the relevant sections of the clinical skills learning guide to assure that the standard approach is being followed. Finally, practice with the model should continue until **skill competency** and some degree of **skill proficiency** have been demonstrated by the participant. Then, **and only**

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**then**, should the participant be permitted to perform the procedure with a client.

When using models in clinical training, it is important that:

- Sufficient models are available (usually one model for two or at most, three participants).
- The model is placed in the same position as a client would be. This enables the participant to perform the skill/activity in the position s/he will experience with clients.
- Conditions, such as instruments used to perform the procedure and recommended infection prevention practices, duplicate the real situation as much as possible.
- The model is treated gently and with the same respect given an actual client.

The following example illustrates how the use of models can facilitate learning a clinical skill such as insertion of Norplant implants.

#### **Using Anatomic Models in Norplant Implants Training**

In the 3-day training course on insertion and removal of Norplant implants, use of the subdermal implant training arm model is an essential component. During the **first day** of the course, following a complete demonstration on the model of how to insert Norplant capsules, participants are taught how to assemble and use the model. They then practice inserting Norplant capsules on the model following the steps outlined in the *Learning Guide for Norplant Implants Clinical Skills* developed specifically for this procedure. Coaching is provided by the clinical trainer throughout the practice session.

At the end of the first day, participants take the training arm model and insertion equipment to their hotel or home for continued practice. At the beginning of **day two** of the course, the clinical trainers assess their skill in inserting Norplant capsules using the learning guide. Those who are rated "competent" in insertion on the model are permitted to begin working with a client under guidance of the clinical trainer. Those who have **not** been rated "competent" continue to practice on the model arm until competency is achieved. This sequence is repeated for training participants in the removal of Norplant implants.

As this example illustrates, combining use of models with effective coaching facilitates learning and reduces training time.

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## **PRACTICING CLINICAL PROCEDURES WITH CLIENTS**

The final stage of clinical skill development involves practice of the procedure (e.g., minilaparotomy) with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, breathing, feeling and reacting human being.

The **disadvantages** of using real clients during initial clinical skills practice are obvious. Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. To minimize these risks, it is recommended that the following guidelines be observed:

- When possible and appropriate, participants should be allowed to **practice** with clients only after they have **demonstrated skill competency** and some degree of **skill proficiency** on an anatomic model or in a simulated situation.
- During pre-operative counseling, clients should be informed that their procedure will be performed by a clinician-in-training under the supervision of an experienced clinical trainer. Standard clinic practices regarding counseling and signed informed consent should be followed.
- The clinical trainer should be present in the operating or procedure room when participants are performing clinical procedures. Furthermore, the clinical trainer should be ready to intervene if the client's safety is in jeopardy or if the client is experiencing severe discomfort.
- Clients should be chosen carefully to ensure that they are appropriate for clinical training purposes. For example, participants should **not** practice on "difficult" clients until they are proficient in performing the procedure.

## **CLIENT'S RIGHTS DURING CLINICAL TRAINING**

The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination, it should be carried out in an environment in which the right to bodily privacy is respected. When receiving counseling, undergoing a physical examination or receiving

surgical contraceptive services, the client should be informed about the role of each person involved (e.g., clinical trainers, individuals undergoing training, support staff, researchers, etc.).

**The client's permission should be obtained** before having a clinician-in-training observe, assist with or perform any procedures. The client should understand that s/he has the right to refuse care from a clinician-in-training. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit a clinician-in-training to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, **the clinical trainer should be present during any client contact in a training situation.**

Clinical trainers must be careful how coaching and feedback are given during training with clients. Corrective feedback in the presence of a client should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.

## **SUMMARY**

Clinical training requires an intensive, usually one-on-one interaction between the trainer and the participant. This interaction is necessary to enable the participant to learn specific knowledge and attitudes and develop motor and problem-solving skills. In the past, lack of integration of classroom and practical training has contributed to clinicians often being unable to perform clinical procedures in a caring and skillful manner.

The approach to clinical training presented in this chapter is based on coaching or "behavior modeling." Combining the elements of coaching (e.g., questioning, positive feedback and problem solving) with the clinical training techniques described **facilitates learning, shortens training time and minimizes risk to clients.** These techniques include:

- Use of anatomic models and other training aids for clinical demonstrations and participant practice to facilitate skill acquisition (**humanistic approach**)
- Use of **standardized learning guides** which list the key steps and sequence, if necessary, for performing the new skill or activity

Using this training approach provides participants with a comfortable, low-stress environment where they may learn the new skill or activity and practice it repeatedly until they feel confident.

The final stage in clinical training involves practicing the procedure or activity with clients. This should occur only after the participant has demonstrated **skill competency** and some degree of **skill proficiency** on **models** or in a simulated situation that closely mimics the real experience.

When practicing with clients in a training situation, participants should **not** attempt to perform the newly learned procedure with “difficult” clients (cases). Furthermore, during all clinical training situations, the right of clients to privacy, confidentiality and refusal to receive care from clinicians-in-training must be maintained.

SAMPLE 7-1

COACHING FOR CLINICAL SKILLS: SELF-ASSESSMENT GUIDE

TASK/ACTIVITY	Yes	Sometimes	No
<b>BEFORE PRACTICE SESSION</b>			
1. I greet the participant.			
2. I ask the participant to review her/his performance in previous practice sessions.			
3. I ask the participant which steps or tasks s/he would like to work on during the practice session.			
4. I review any difficult steps or tasks in the learning guide that will be practiced during the session.			
5. I work with the participant to set specific goals for the practice session.			
<b>DURING PRACTICE SESSION</b>			
1. I observe the participant as s/he practices the procedure.			
2. I provide positive reinforcement and suggestions for improvement as the participant practices the procedure.			
3. I refer to the learning guide during observation.			
4. I record notes about participant performance on the learning guide during the observation.			
5. I am sensitive to the client when providing feedback to the participant during a clinical session.			
6. I provide corrective comments only when the comfort or safety of the client is in doubt.			
<b>AFTER PRACTICE FEEDBACK SESSION</b>			
1. I greet the participant.			
2. I ask the participant how s/he felt about the practice session.			
3. I ask the participant to identify those steps s/he did well.			
4. I ask the participant to identify those steps where her/his performance could be improved.			
5. I refer to my notes on the learning guide.			

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*Combining Coaching with Other Clinical Training Techniques*

<b>TASK/ACTIVITY</b>	<b>Yes</b>	<b>Sometimes</b>	<b>No</b>
6. I provide positive reinforcement regarding those steps or tasks the participant performs well.			
7. I offer specific suggestions for improvement.			
8. I work with the participant to establish goals for the next practice session.			

Those coaching skills I feel competent in using include:

Those coaching skills I would like to improve include:

**SAMPLE 7-2**

**CLINICAL DEMONSTRATION SKILLS: SELF-ASSESSMENT GUIDE**

To what degree are the following statements true of your actions or behavior when demonstrating new skills to participants?

TASK/ACTIVITY	Yes	Sometimes	No
<b>CLINICAL DEMONSTRATION</b>			
1. I use trainer's notes, personalized manual or learning guide.			
2. I state the objective(s) as part of the introduction.			
3. I present an effective introduction.			
4. I arrange the demonstration area so that participants are able to see each step in the procedure clearly.			
5. I never demonstrate an incorrect procedure or short cuts.			
6. I communicate with the model or client during the demonstration of the activity/skill.			
7. I ask questions and encourage participants to ask questions.			
8. I demonstrate or simulate appropriate infection prevention practices.			
9. When using a model, I position the model as an actual client.			
10. I maintain eye contact with participants as much as possible.			
11. I project my voice so that all participants can hear.			
12. I provide opportunities for the participants to practice the activity/skill under direct supervision.			

Those demonstration skills I feel competent in using include:

Those demonstration skills I would like to improve include:

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# CONDUCTING A CLINICAL TRAINING COURSE

## INTRODUCTION

To improve the quality of clinical training as well as to objectively evaluate participant performance, there is a need to standardize the way clinical training is conducted. In addition, when a clinical course has been **correctly designed**, it is more likely to meet the needs of the participants. As a consequence, clinical trainers often are provided with pretested **training packages** which usually consist of:

- A content-specific reference manual
- A participant's course handbook which contains the course syllabus, outline and schedule and competency-based learning guides
- A trainer's notebook which contains the participant course handbook, competency-based (knowledge and skill) assessment instruments and practical tips for teaching the course
- Anatomic models and audiovisual and other training aids

Given these circumstances, clinical trainers are not asked to develop the course but to **adapt** it to the local setting and **conduct** it using appropriate training methods.<sup>1</sup>

The key steps in conducting a clinical course are described briefly in this chapter. They are drawn from the training techniques presented in previous chapters and provide the framework for organizing each part of the course.

**Chapter Objective** After completing this chapter, the participant will be able to describe how to organize and conduct an effective clinical training course.

**Enabling Objectives** To attain the chapter objective, the participant will:

- Describe the components of clinical training packages and how they are used

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<sup>1</sup> Designing a clinical training course usually is the responsibility of a master or advanced trainer. Course design requires expertise in writing primary and enabling objectives, developing concise course outlines and schedules, and developing and selecting appropriate educational and training materials. These subjects are beyond the scope of this manual.

- Organize and prepare the logistical support and materials needed for a clinical training course
- Develop plans for conducting training sessions
- Use competency-based assessments
- Determine whether a participant is qualified based on observed and measured performance
- Evaluate a clinical training course

## **COURSE MATERIALS**

The training materials described below are used to conduct an effective, competency-based clinical course. Increasingly, these materials are provided to the clinical trainer as a **training package**.

The **reference manual** provides all of the essential information needed to conduct the course in a logical manner. Because it serves as the “text” for the participants and the “reference source” for the clinical trainer, special handouts usually are not needed. (Country-specific supplemental material, however, may be prepared and distributed as appropriate. Such material could include information on the country’s demographic profile, medical records and reporting system, local drug lists, etc.) In addition, because the manual contains **only** information that is consistent with course goals and objectives, it becomes an integral part of all classroom exercises—from giving an illustrated lecture to providing problem-solving information. Finally, it provides a readily available reference for review of newly learned information and for problem solving when the participant returns to her/his home clinic or hospital.

The **participant’s course handbook** serves as the roadmap to guide the participant through each phase of the course. It contains a model **course syllabus, outline and schedule** (each are described in more detail below) as well as all supplemental printed materials such as the precourse knowledge assessment, skill learning guides and course evaluation.

The **trainer’s notebook** contains the participant handbook materials as well as other trainer-specific information such as answer keys to the pre- and midcourse questionnaires and practical tips for conducting the course.

**Anatomic models, audiovisual and other training aids** are used for classroom demonstrations and practice of skills and activities. Examples include a pelvic model (Zoe®) for IUD skills training or the training arm for Norplant implants training as well as annotated training slide sets and videotapes.

Even if the course materials are not provided as a “training package,” the clinical trainer should develop a course syllabus, outline and schedule. These are described below.

**Course Syllabus** The **course syllabus** (also known as a **course description**) provides a summary of the major components of a course and should be given to participants before they arrive for the training course. It is important that the syllabus accurately describe the **course content, goals and objectives**. This enables participants to be aware of the most important components of the course.

**Course Outline** The **course outline** is a detailed listing of how the training will be delivered. The course outline is a **planning document**, to be used by the clinical trainer, and **not** a teaching document. **Sample 8-1** shows a **portion** of a model course outline for an IUD skills training course. The course outline is divided into four columns which are described below.

- **Time:** Lists the approximate **amount of time to be devoted to each learning objective and training activity**. This helps the clinical trainer budget time so that all learning objectives are addressed in the allotted amount of time.
- **Objectives/Activities:** Contains the learning objectives which outline the **sequence of training**, and the training activity(s) for each objective. The combination of objectives and activities (e.g., small-group exercises, clinical practice sessions) outlines the **flow of training**.
- **Training/Learning Methods:** Outlines the various methods, activities and strategies to be **used to deliver the content and skills** related to the learning objective. It is important that a **variety** of methods be used.
- **Resources/Materials:** States the reference materials and audio-visual aids needed to deliver training for each learning objective.

**Course Schedule** A **course schedule** is a brief day by day summary of the major training activities. Information appearing on a course schedule includes:

- Course name
- Days of training (days of the week and/or day numbers)
- Time blocks for all training activities
- Brief description of the major training activities

Information for the course schedule is taken from the course outline once it has been finalized. **Sample 8-2** is an example of a course schedule for a 2-week IUD skills training course.

**Adapting the  
Clinical Training  
Course**

The course outline and schedule are intended to serve as a **model** for the clinical trainer and have been designed to permit the course participants and clinical trainer the widest possible latitude in adapting the training to the participants' (group and individual) learning needs.

Prior to the course, the clinical trainer should determine what changes are needed regarding allocation of classroom and clinical time (see **Chapter 2**). For example, client availability is a critical factor in assuring that the participants will have enough supervised practice to complete the course and be competent and confident in their skills. Typically, the schedule will have to be modified to accommodate the clinic schedule or the number of course participants.

The clinical trainer should revise the model course outline and schedule prior to the course and participants should receive a copy of the new course schedule on the first day of the course. In addition, at the beginning of each course an assessment should be made of each participant's knowledge and clinical skills. The results of this precourse assessment can be used jointly by the participants and the clinical trainer to adapt the course content as needed so that the training focuses on acquisition of **new** information and skills. For example, if the group demonstrates sufficient knowledge (e.g., more than 80% correctly answered questions about a particular category of information such as indications, precautions for use or client assessment), the clinical trainer may elect to assign those topics as reading assignments and use the allotted time for other purposes, rather than discuss them in class.

## **PLANNING FOR THE COURSE**

The responsibilities of the clinical trainer for planning and organizing a training course will vary depending on her/his position within the organization or agency sponsoring the training or within the institution where the training will be conducted. Generally, the clinical trainer will be involved in the planning process and may be responsible for overseeing logistical arrangements for the course as well.

**Timeline** Planning a clinical training course takes several months and ideally should begin at least 6 months before the course. A typical timeline for planning activities is presented in **Table 8-1**; a more detailed checklist of tasks can be found in **Appendix A**.

**Materials, Supplies and Equipment** The course notebook being used by the clinical trainer generally will specify the materials, supplies and equipment needed for the course and further specify what is needed for each activity. **Sample 8-3** lists the items needed to conduct a 2-week IUD skills training course.

**Clinical Practice Sites** The key to ensuring successful clinical practice sessions is to begin planning for them as early as possible. The energy and effort invested by the clinical trainer in identifying appropriate sites and developing a relationship with the staff will be paid back many times over when the course participants have clinical training experiences that allow them to become competent in those skills or activities required to successfully complete the course.

It may be necessary to visit a number of potential clinical sites in order to identify several that are best suited to receiving the participants and providing them with sufficient clinical practice. Aspects of service provision which are essential are as follows:

- **Adequate client caseload.** The clinic must have a demonstrated caseload of clients requesting the clinical method in which participants are being trained. There should be enough clients in each clinic session to keep all participants occupied for several hours. The clinic should receive a variety of clients so that the participants will be able to practice counseling for as many different family planning methods as possible, as well as method provision for the specific skill (e.g., IUD or Norplant implants insertion). It is possible that no single site will have enough clients to accommodate all of the course participants at one time. In this case, the participants may be divided into two or three groups and scheduled for several different sites. A clinical trainer or someone

**Table 8-1. Suggested Timeline for Preparing for a Clinical Skills Training Course**

<b>TIME PRIOR TO COURSE</b>	<b>ACTIVITY</b>
<b>6 months</b>	Confirm training site (classroom and clinical facilities) Select housing accommodations (if necessary) Select and confirm clinical training consultants or special content experts (if necessary) Meet with staff at clinical training site
<b>3 months</b>	Select and notify participants Initiate administrative arrangements Confirm housing accommodations Reconfirm clinical training consultants or content experts Order educational materials, supplies and equipment Confirm arrangements to receive participants at the clinical training facility
<b>1 month</b>	Review course syllabus, schedule and outline and adapt if necessary (if possible, send copies of the schedule to participants and other clinical trainers) Review content material and prepare for each session to be delivered by clinical trainer Prepare audiovisuals (transparencies, slides, flipcharts, etc.) Arrange for all audiovisual equipment (overhead projector, video player, monitor, slide projector, camera with recorder/monitor, etc.) Visit classroom training site(s) and confirm arrangements Visit clinical training site and confirm arrangements Confirm receipt of educational materials, supplies and equipment Finalize administrative arrangements Reconfirm housing arrangements
<b>1 week</b>	Review final list of participants for information on experience and clinical responsibilities Assemble educational materials Prepare course certificates Reconfirm availability of clients at clinical training site Meet with cotrainer(s), clinical training consultants or special content experts to review individual roles and responsibilities
<b>1 to 2 days</b>	Prepare classroom facility Prepare and check audiovisual and other training aids Arrange anatomic models and all needed instruments Check with cotrainers to be sure there are no problems

familiar with the course design and content should accompany each group.

- **Adequate space.** The clinical training site should be able to accommodate additional personnel (participants). The quality of services must be maintained while the participants are present, and this includes being sure that clients, staff and participants can move easily through the clinic without impeding client flow and service provision. Since clinical sites often are already crowded with staff and clients, this is another reason for dividing the participants into smaller groups and using several clinical training sites.
- **Adequate supplies.** It is important that the sites chosen have enough instruments and supplies to provide services (sites that are chronically short of supplies do not attract many clients). In addition, it may be necessary to supplement the clinic's basic supplies of consumable items (e.g., chlorine bleach) or to provide additional or special instruments needed for the procedure.
- **Appropriate service provision practices.** Sites selected for clinical training sessions should already be providing services in a manner consistent with the course standards (i.e., practices consistent with those outlined in the learning guides and checklists). The staff can serve as role models for the participants and should be able to guide them in their practice. The participants will feel more comfortable and at ease if their training is supported by what they see happening around them in the clinic.
- **Staff who are receptive to having the participants.** Most clinic staff will be receptive to having participants come to their work site to practice their new skills. Try not to use sites where staff are opposed to having participants because their attitude will not create a positive learning environment for the participants.

Prior to the course, especially if it is the first time that a clinic is being used as a clinical practice site, the clinical trainer should meet with the clinic staff and review with them the goals and objectives of the training course, as well as the interactive training techniques being used (e.g., the clinical trainer as coach). Time should be spent reviewing the learning guides and explaining how they are used.

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## CONDUCTING A TRAINING SESSION

The clinical trainer is both the content and skills expert in a clinical skills training course. The course outline provides a foundation for the planned training; however, it is the clinical trainer who is responsible for turning the training plan into a successful training course. The clinical trainer must plan how to deliver the content creatively, in a way that keeps the training focused on the participants and ensures that the learning objectives are achieved.

To ensure an effective clinical training session, the clinical trainer should:

- Review the session **objectives** (found in the course outline).
- Select **training activities** which will support the participant in reaching the session objective (activities are suggested in the course outline).
- Write **instructions** for the training activity.
- Organize **materials** to support the training activity (supporting materials may be suggested in the course outline).
- Prepare an **introduction** to the training activity.
- Develop **process questions** which will focus a discussion on the relevance of the content to the job responsibilities of the participants.
- Develop a **summary** which ties together the session objectives and content and reviews the main points of the session.

**Objectives** Objectives, which can be found in the course outline, should be clearly stated for each course session. A learning objective is defined as a statement of what the participant will know or be able to do after completion of training. Before each session begins, write the objective on the flipchart, the writing board or a transparency. Place the written objective in a visible place for all to see during the training session.

**Training Activities** Training activities support participants in attaining the learning objectives. The goal is to keep the participants interested, active and involved. The enthusiasm of the clinical trainer has a direct impact on the responsiveness of the participants. If the clinical trainer has high

expectations of success, the participants will follow. The effective clinical trainer focuses on the progress of the participants rather than on her/himself.

Appropriate training activities will be recommended in the course outline and may include activities which:

- Allow participants to **get to know each other**
- Produce or heighten **energy in the group**
- Influence how participants **think about certain issues**
- Provide the opportunity to **learn and practice a particular skill**

Begin each day with a warmup activity to **bring the group together** to begin work with a positive, energetic attitude. Warmups provide the group an opportunity to learn something in a nontraditional way and usually help the group get to know each other better. It is the clinical trainer's responsibility to provide balance between serious work and work that is lighter in content and tone. Several examples of warmup activities are provided in **Chapter 2**.

Activities to **produce or heighten energy** are useful during the day (especially after lunch) when the trainer notices that the group's energy is fading and they need a boost. An energizer can take from 5 to 20 minutes. It can be as simple as "let's stand and stretch." The purpose is to divert attention away from the topic at hand to give the mind and body a rest by using them differently. Several short energizers can be found in **Appendix B**.

Activities designed to **influence attitudes**, however, are more complex and usually take more time. Role plays, case studies and coaching are examples of such activities and are fully described in **Chapters 4 and 6**.

The steps in **learning and practicing a clinical skill** are detailed in **Chapter 6**. Providing participants with meaningful classroom and clinic practice and training sessions is critical to the success of any clinical training course. In preparing and conducting these sessions, the clinical trainer relies heavily on clinical skills learning guides (see **Chapter 5**).

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Participants will follow the example set by the clinical trainer in correctly using the learning guides.

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These guides provide the clinical trainer with the standardized way of performing the skill or activity and should be used by the participants while learning and practicing it.

Participants also should use the learning guide to follow slide or videotape demonstrations and the demonstration of the skill in the classroom (e.g., using anatomic models for a clinical skill or role play for counseling skills).

During classroom practice sessions, the participants work in teams with one “service provider” participant performing the skill or activity while the other participant uses the learning guide to rate the performance or prompt the “service provider” as necessary. The participants then switch roles.

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Allow sufficient time for the participants to discuss areas needing improvement (feedback). This discussion is critical because it places the responsibility for learning on the participant.

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Prior to the first clinical practice session the clinical trainer should review with the participants their responsibilities during the practice sessions and the importance of working together to make their time in the clinic as successful as possible for the participants, staff and clients. (Their clinical practice needs should not come before the needs and concerns of the clients.) The clinical trainer and participants also should tour the clinic so that participants may become familiar with the facility and meet the staff.

During the clinical practice sessions, the clinical trainer is responsible for the participants, and should observe and interact with them at all times. The trainer should be prepared to suggest alternative activities or exercises if the client caseload is low during a particular session.

In addition to the clinical skill or activity, there are other skills participants are expected to learn. These include building a relationship with the client, listening attentively to her/his reproductive goals and providing information that is clear, simple and direct. These skills may be unfamiliar or deemed unimportant by some participants. Under these circumstances, the clinical trainer will need to design activities which provide a low-risk opportunity to explore new behaviors and help change these attitudes. For example, conducting a counseling role play

after which the participants receive constructive feedback may be an effective way to highlight areas needing improvement.

**Instructions for Participants**

Writing instructions for an activity, particularly if there are multiple steps or parts, is important to the activity's success. The process of writing clear instructions helps the trainer to think through each part of the activity with the participants in mind. It also results in more realistic timing of each activity.

Instructions can be presented verbally but also should be presented in writing, using paper (handout), the writing board, the flipchart or an overhead projector so that participants can refer to them during the activity. Written instructions provide clarity for everyone; without them, confusion and chaos can result.

**Training Activity Materials**

The materials needed to support a training activity usually are suggested in the course outline. The clinical trainer is responsible for ensuring their availability and organizing them prior to the training session. In particular, s/he should review:

- Supplies and equipment needed (e.g., anatomic models, IUDs, complete sets of surgical instruments, bleach and buckets, paper and pencils)
- Space needs and arrangements (e.g., chairs and tables arranged in a certain configuration)
- The chapters (or pages) in the reference manual which will be referred to during the activity
- Any supplemental written materials needed for the activity (e.g., a role play, case study, diagram, etc.)

**Introductions**

The introduction of each training session in the course sets the tone and atmosphere for that session. **Chapter 4** provides several specific examples for introducing a training session. The clinical trainer should choose a technique with which s/he is comfortable. As the clinical trainer gains more experience in interactive training methods, the variety of introductions used will increase. The important thing to remember is that the trainer's enthusiasm and interest in the topic should be genuine. The participants will recognize if they are not and, as a consequence, the momentum the clinical trainer intends to build will be reduced.

During the introduction, monitor and assess the group's attentiveness. When the group is focused totally on what is unfolding before them, they will be ready to move to the next part of the session.

**Process Questions**

After a training activity is completed, the participants need time to integrate what they have just experienced with what they already know. The clinical trainer should develop thoughtful questions which will deepen the participants' understanding of the concepts or skills presented in the training session. These questions can be answered individually or by small groups (pairs or trios). Examples of process questions include:

**After observing a counseling role play:**

- “What were the behaviors you observed that made this clinician effective with this client?”
- “How comfortable are you practicing these behaviors?”
- “How will you know you are being successful when you behave in these ways?”

**After participating in a coaching session with a participant:**

- “Take the next few minutes to fill out the *COACH Skills Self-Assessment Guide*. Select three specific areas in which you excelled and three specific areas where you want to improve. After you have made your list, choose a partner with whom to discuss your self-assessment.”

**After the discussion in pairs:**

- “Be prepared to report to the total group one area in which you excelled and one area you want to improve.”

Using process questions in this way illustrates several concepts. By using the *COACH Skills Self-Assessment Guide*, the participants take responsibility for observing and monitoring their own behavior and learning. There is a balance in asking them about what they did well and what they want to improve. In choosing a partner with whom to discuss these items, each participant realizes that s/he is not the only one who needs to improve. Finally, reporting to the group as a whole has the potential for reinforcing behavior changes.

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When developing process questions, the clinical trainer returns to the objective stated for the session. The questions are then crafted to support the participants in integrating their new learning with their previous experience.

**Summaries** The purpose of the summary following a training activity is to highlight the main points of the activity and bring the session to a close. Several useful suggestions for summaries are included in **Chapter 4**.

When clinical trainers first use interactive training techniques, the activity itself often becomes central to the discussion. It is important to remember that the activity is merely a vehicle to demonstrate a concept or skill the participants need to learn. The critical point is whether the thinking or doing will continue after the training. While application of the clinical training is not within the control of the clinical trainer, insights into the application clearly are among the trainer's responsibilities. The summary provides the opportunity for the clinical trainer to reinforce the participant's learning and to further challenge the group towards excellence.

**Trainer's Notes** Many clinical trainers find that preparing "trainer's notes" (see **Chapter 2**) assists them in conducting training. Outlining each step of a training activity requires the most planning. Clarity on the part of the clinical trainer regarding the flow and timing of the activity will result in a smooth, organized training session for the participants. The following example (which was developed based on suggestions in the course outline) can be used as a guide in planning a training activity.

**Example of Outline and Timing of a Training Activity in an IUD Clinical Skills Course**

**Objective:** Load the Copper T 380A IUD in the sterile package

10:00 Explain rationale for loading in sterile package.

10:10 Show slides 11-17 of the IUD training slide set.

10:20 Demonstrate loading the IUD (depending on size of group, it may be necessary to do this twice so that all participants can observe the demonstration).

10:30 Practice (Round I): Ask participants to turn to *Learning Guide for IUD Clinical Skills* and review Step 3. Divide group into pairs and distribute IUDs in sterile packages.

**Instructions:** One person loads the IUD in the sterile package while the second person reads each step aloud from the basic learning guide. Participants then switch roles. The clinical trainer circulates around the room, coaching where needed. After the first practice round is completed, the clinical trainer asks "What helped you accomplish this task?" and "What was difficult for you in accomplishing this task?"

10:50 Practice (Round II): Same instructions and activity as above (participants build on what they learned in Round I).

11:00 Summarize session, including recap of rationale and summary of cost analysis studies for this particular country.

## GIVING KNOWLEDGE AND SKILL ASSESSMENTS

**Knowledge Assessment** Clinical trainers should **prepare themselves before giving a knowledge assessment** (pre- or midcourse questionnaire):

- Refrain from any special coaching on the subject matter in an attempt to reduce anxiety and frustration.
- Make certain that the testing area is ready.
- Make sure that there are adequate supplies for the test.
- Review the test procedures.
- Rehearse by reading the instructions.
- Try to anticipate any questions that might be asked before the test begins.
- Make arrangements so that participants being tested will not be interrupted.

Two factors that are important in giving the test are **providing instructions and setting time limits**.

**Giving Instructions to Participants.** To perform to the best of their abilities, participants must know the purpose of the assessment and the

basic rules under which they will operate. This means that they must be aware of the **time allowed**, the manner in which they are to **select and record answers** and the **scoring system** used. The clinical trainer should review the instructions with the participants before they begin answering the questions. Instructions for selecting answers must be written carefully. Stating directions with too much detail is better than stating them with too little.

**Setting Time Limits.** Many individuals fail to do well when faced with the pressures of a timed assessment. Time limits (if used) should be based on a trial run of the questionnaire. As a general rule, clinical trainers should allow participants about twice the time it takes a clinical trainer to read through and complete the assessment.

The **precourse questionnaire** is not intended to be a test but rather an assessment of what the participants, individually and as a group, know about the course topic. Participants, however, are often unaware of this and may become anxious and uncomfortable at the thought of being “tested” in front of their colleagues on the first day of a course. The clinical trainer should be sensitive to this attitude and administer the questionnaire in a neutral and nonthreatening way as the following guide illustrates:

- Participants draw numbers to assure anonymity (e.g., from 1 to 12 if there are 12 participants in the course).
- Participants complete the precourse questionnaire.
- The clinical trainer gives the answers to each question.
- Pass around the individual and group learning matrix for each participant to complete according to her/his number.
- Post the completed matrix.
- Discuss the results of the questionnaire as charted on the matrix and jointly decide how to allocate course time.

### **Skill Assessments**

Even the best-designed checklists will not be successful in measuring performance if they are not used correctly. To facilitate the use of checklists, the clinical trainer should be certain that the:

- Classroom or clinic is equipped with all equipment, materials and other supplies necessary to complete the assessment

- Clinical skills evaluation setting is as similar as possible to the environment in which the participant normally works
- Directions are carefully reviewed with the participants and any questions are answered before the assessment begins

## QUALIFICATION

Much controversy surrounds the issue of determining **qualification in clinical training**. Most people believe that clinicians are qualified to perform a procedure or activity when they have demonstrated a defined level of skill competence and can maintain that level after training. In practice, **objective measurement of clinical competence during training may be very difficult**, and it is still more difficult to measure competence **after training**.

Because of this, in the past many organizations equated being qualified with completion of a specified number of supervised procedures. Clearly, while some participants can achieve competency after only a few practice cases, others may require several more and a very few may never achieve an acceptable level of competency. Therefore, determining whether or not a participant is qualified should be based on **observed and measured** performance using competency-based (knowledge, attitude and skill) assessments rather than on completion of a set number of practice cases.

When anatomic models are used for initial skill acquisition (e.g., training in IUD or Norplant implants insertion), nearly all participants will be judged to be **competent** after only a few cases with clients. **Proficiency**, however, invariably requires additional practice. Therefore, when training participants who will become new service providers (i.e., they have had no prior experience), each participant may need to perform the procedure with at least 5 to 10 clients in order to feel **confident** about her/his skills. Thus, the judgment of a skilled clinical trainer is the most important factor in determining whether the participant is qualified.

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Qualification is a statement by the training institution(s) that the participant has met the requirements of the course in knowledge, skills and practice. Qualification does **not** imply certification, which is granted only by an authorized organization or agency.

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Qualification may be based on the participant's achievement in three areas:

- **Knowledge.** A recommended score of at least 85% on the Midcourse Questionnaire
- **Skills.** Satisfactory performance of clinical activities and skills as evaluated by the clinical trainer using a competency-based skills checklist. In determining whether the participant is competent, the clinical trainer(s) will observe and rate the participant's performance for each step of the skill or activity. The participant must be rated "satisfactory" in each skill or activity to be evaluated as competent.
- **Practice.** Demonstrated ability to provide client services in the clinical setting. During the course, it is the clinical trainer's responsibility to observe each participant's overall performance in providing client services. This provides a key opportunity to observe the impact on clients of the participant's **attitude**—a critical component of quality service delivery. Only by doing this can the clinical trainer assess the way the participant uses what s/he has learned.

Training clinical trainers to reliably use competency-based performance instruments such as those described above provides an opportunity to base competency on demonstrated performance and application of knowledge in the clinical setting rather than "lecture time" or number of practice cases performed.

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As discussed in **Chapter 1**, responsibility for the participant becoming qualified is shared by the participant and the trainer.

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It is recommended that, if possible, course graduates be observed and evaluated in their institution, within 3 to 6 months of completing the course, by a **course trainer** using the counseling and clinical skills checklist that was used in the course. (At the very least, the graduate should be observed by a **skilled provider** soon after completing training.) This postcourse evaluation activity is important for several reasons. **First**, it provides the graduate direct feedback not only on her/his performance, but also provides the opportunity to discuss any startup problems or constraints to service delivery (e.g., lack of instruments, supplies or support staff). **Second**, and equally important,

it provides the training center, via the clinical trainer, key information on the adequacy of the training and its appropriateness to local conditions. Without this type of feedback, clinical training easily can become routine, stagnant and irrelevant to service delivery needs.

## **EVALUATING THE COURSE**

Evaluation should be an integral part of the clinical training process to determine whether the training has met its goals (i.e., whether participants' knowledge, attitudes and skills improved) and to identify aspects of the course that should be strengthened. As discussed above, evaluation of **participant achievement** is accomplished through competency-based skill and knowledge assessments (see **Chapter 5**).

Evaluation of **participant reaction** to the course should occur, however, both during and at the end of the course. To determine how participants like the course and how they perceive its value, participants can be asked to use one of the following methods:

- Daily reactions (oral or written)
- Evaluations of individual sessions or trainers
- End-of-course written questionnaires
- End-of-course informal reactions of participants

In addition, the clinical trainers can meet daily to review the participants' reactions to training activities.

### **Daily Reactions**

Clinical trainers should monitor the training continually. Daily monitoring encourages participants to think and talk about what was learned during the day and to make suggestions for course improvements to the entire group. Such monitoring can be conducted as a participant-led exercise at the end of each training day. A useful technique is to have each participant:

- Write on a piece of paper the two or three most important ideas or concepts s/he learned during the day as well as suggestions for course improvement.
- Share with the group one or two items from her/his list.

**Session/Trainer Evaluations** Throughout the course, participants can be given the opportunity to evaluate session content for its overall relevance to their work and clinical trainers for their training ability. At the beginning of each course day, give participants a session or clinical trainer evaluation form. (**Sample 8-4** is a sample session evaluation form and **Sample 8-5** can be used to rate the instruction skills of clinical trainers.) Participants should complete the form after each session and return it to the course organizer. The results of session evaluations and clinical trainer evaluations will provide a basis for determining whether sessions need to be modified and whether the clinical trainers' training or coaching skills need improvement.

**End-of-Course Written Questionnaires** Reaction questionnaires allow trainers to identify the:

- Extent to which the course met participants' expectations
- Aspects of the course that were the most or least helpful
- Relevance of the course content to the participants' work
- Appropriateness of the training methodology
- Extent to which administrative aspects of the course were satisfactory (e.g., the training environment, accommodations, travel arrangements)

When developing end-of-course written questionnaires (also known as course evaluations—see **Sample 8-6**) the clinical trainer should be guided by the following considerations:

- Include close-ended questions so that trainers can easily tabulate data and identify response patterns.
- Use a rating scale for questionnaire items. If the majority of participants rate an item very high or very low, it is usually worth the trainer's attention.
- Ensure the anonymity of participants to encourage truthful responses.

The clinical trainer should schedule sufficient time during the course for participants to complete the questionnaire. Questionnaires should **not** be distributed late on the last day of training when participants are tired and may be preparing to depart.

**End-of-Course  
Informal Reactions**

Informal discussions can accompany the formal written questionnaire so that the clinical trainer can better understand the reaction questionnaire data. For example, participants can be asked, individually or in small groups, to respond verbally to the following questions:

- “What were your expectations for the course? To what degree were they met?”
- “Based on the stated course objectives, did you learn what you expected to learn?”

Answers to these questions can be summarized by a group reporter during this session and shared with the clinical trainer(s) either verbally or in writing.

Alternatively, the clinical trainer can select several categories that relate to the course (e.g., course content, training methods, administrative matters), and ask participants to write their reactions **anonymously**. Participant comments can be posted under their respective category headings on flipchart sheets or on a writing board. The clinical trainer (or a participant) can then lead a general discussion with the participants about the comments.

**Daily Clinical  
Trainer Meetings**

If there is more than one clinical trainer conducting the course, it is important that the trainers meet briefly each day to discuss the participants' evaluation of the day's training activities, as well as each clinical trainer's personal assessment of the training. This exercise may identify elements of the clinical training that need to be changed.

**SUMMARY**

In order to improve the quality of clinical training as well as to evaluate participant performance objectively, clinical trainers increasingly are working with pretested training packages. In these circumstances, clinical trainers may adapt the course to the local setting and then conduct it using appropriate training methods.

**Planning for a clinical training course** ideally begins 6 months before the course. Although the clinical trainer may not be directly responsible for all of the preparatory tasks, where possible, s/he should personally coordinate the clinical training arrangements and arrange the classroom facility prior to the beginning of the course.

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Using the course outline as a guide, the clinical trainer should decide how to present individual training sessions, using the participatory training techniques described in this manual.

It is the clinical trainer's responsibility to ensure that competency-based knowledge and skill assessments are used correctly to objectively evaluate participant performance. Such evaluation is part of the qualification process for each participant.

Finally, evaluation of the course by participants should be an integral part of the clinical training process. Several methods of evaluating participant reactions were described in this chapter.

**SAMPLE 8-1**

<b>MODEL IUD COURSE OUTLINE (Standard Course: 10 days, 20 sessions)</b>			
<b>TIME</b>	<b>OBJECTIVES/ACTIVITIES</b>	<b>TRAINING/LEARNING METHODS</b>	<b>RESOURCES/MATERIALS</b>
<b>Session One: Day 1, AM</b>			
(45 minutes)	<b>Opening</b> <b>Objective:</b> Identify participant expectations	<b>Warmup Exercise</b> <b>Discussion</b>	
(30 minutes)	<b>Objective:</b> Describe course goals and objectives, approach to clinical training, materials and schedule	<b>Discussion</b>	<b>IUD Reference Manual</b> (1 per participant) <b>IUD Course Handbook</b> (1 per participant)
(30 minutes)	<b>Objective:</b> Assess participants' precourse knowledge	Complete Precourse Questionnaire	<b>Handbook:</b> Precourse Questionnaire
(15 minutes)	<b>Break</b>		
(30 minutes)	<b>Objective:</b> Identify individual and group learning needs	<b>Exercise:</b> Group grades questionnaires and completes Individual and Group Performance Matrix	<b>Handbook:</b> Individual and Group Performance Matrix
(60 minutes)	<b>Objective:</b> Describe how people learn and identify adult learning characteristics	<b>Exercise/Discussion:</b> ●Activity 1: Loading TCu 380A IUD in sterile package or Building a Box ●Activity 2: Numbers Game ●Activity 3: Nine Dots Puzzle	<b>Handbook:</b> "How People Learn"
<b>TOTAL: 210 minutes</b>		<b>Equipment for course</b> ● 35 mm slide projector and screen ● Overhead projector ● Videotape player (VCR) ● Blackboard/chalk (or flipchart/marker pens)	● ZOE® pelvic models ● Hand-held uterine models ● IUD insertion/removal kits ● Copper T IUDs in sterile packages

SAMPLE 8-2

MODEL IUD COURSE SCHEDULE (Standard Course: 10 days, 20 sessions)				
DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
<p>0830-1200</p> <p><b>Opening</b></p> <ul style="list-style-type: none"> <li>• Welcome</li> <li>• Participant expectations</li> </ul> <p><b>Overview of course</b></p> <ul style="list-style-type: none"> <li>• Goals and objectives</li> <li>• Approach to training</li> <li>• Review of course materials</li> </ul> <p><b>Precourse Questionnaire</b> Identify individual and group learning needs</p> <p><b>Exercise: "How People Learn"</b></p>	<p>0830-1200</p> <p><b>Demonstration:</b> Standard Copper T 380A insertion and removal methods using:</p> <ul style="list-style-type: none"> <li>• Slide set</li> <li>• Videotape</li> <li>• Pelvic models</li> </ul> <p><b>Exercise:</b> How to use the learning guides for IUD clinical skills</p> <p><b>Tour of Clinic Facilities</b></p>	<p>0830-1200</p> <p><b>Review key steps in:</b></p> <ul style="list-style-type: none"> <li>• Counseling a client</li> <li>• IUD insertion/removal</li> </ul> <p><b>Classroom Practice:</b> Divide into two groups to practice:</p> <ul style="list-style-type: none"> <li>• Counseling a client</li> <li>• IUD insertion/removal using pelvic models</li> </ul> <p>Participants assess each other's performance using learning guides.</p>	<p>0830-1200</p> <p><b>Classroom Practice:</b> Divide into two groups to practice:</p> <ul style="list-style-type: none"> <li>• Counseling a client</li> <li>• IUD insertion/removal using pelvic models</li> </ul> <p>Participants assess each other's performance using learning guides.</p>	<p>0830-1200</p> <p><b>Classroom Practice:</b> Divide into two groups to practice:</p> <ul style="list-style-type: none"> <li>• Counseling a client</li> <li>• IUD insertion/removal using pelvic models</li> </ul> <p>Participants assess each other's performance using learning guides. Clinical trainer assesses participants for skill competency on models.</p>
<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>
<p>1330-1630</p> <p><b>Precourse Assessment</b> Assess each participant's skills:</p> <ul style="list-style-type: none"> <li>• Counseling (role play)</li> <li>• Pelvic exam (pelvic models)</li> </ul> <p><b>Lecture/Discussion:</b> Key features of Copper T 380A IUD</p> <p><b>Demonstration and Practice:</b> Loading the Copper T 380A IUD in the sterile package</p>	<p>1330-1630</p> <p><b>Review of counseling methods</b></p> <ul style="list-style-type: none"> <li>• Framework for family planning (FP) counseling</li> <li>• Essential components</li> <li>• Characteristics of a good counselor</li> </ul> <p><b>Role Play:</b> Divide into teams to practice counseling:</p> <ul style="list-style-type: none"> <li>• FP acceptor</li> <li>• IUD acceptor</li> </ul> <p>Participants assess each other's performance using learning guides.</p>	<p>1330-1630</p> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• How IUDs work</li> <li>• Indications, precautions and other conditions</li> <li>• Client screening and assessment</li> </ul> <p><b>Exercise/Discussion:</b> Reducing risk of HBV/HIV transmission in FP clients</p>	<p>1330-1630</p> <p><b>Discussion/Videotape:</b> Role of infection prevention practices in IUD services</p> <ul style="list-style-type: none"> <li>• Definitions</li> <li>• Handwashing and use of gloves</li> <li>• Processing instruments</li> <li>• Waste disposal</li> </ul> <p><b>Demonstration:</b> In simulated clinical area, demonstrate infection prevention practices for each step of IUD insertion/removal.</p>	<p>1330-1630</p> <p><b>Discussion:</b> Managing GTIs in family planning clients</p> <ul style="list-style-type: none"> <li>• Simplified approach to diagnosing GTIs</li> <li>• Client screening and assessment</li> <li>• GTIs and IUD use</li> </ul> <p><b>Midcourse Questionnaire</b></p>
Review of day's activities	Review of day's activities	Review of day's activities	Review of day's activities	Review of day's activities
Reading Assignment: Chapters 1, 2, 7 and Appendix A	Reading Assignment: Chapters 3, 4 and Appendix B	Reading Assignment: Chapter 6	Reading Assignment: Chapter 5	Reading Assignment: Chapters 1,8 and 9

**MODEL IUD COURSE SCHEDULE (Standard Course: 10 days, 20 sessions)**

<b>DAY 6</b>	<b>DAY 7</b>	<b>DAY 8</b>	<b>DAY 9</b>	<b>DAY 10</b>
<b>0830-1200</b>	<b>0830-1200</b>	<b>0830-1200</b>	<b>0830-1200</b>	<b>0830-1200</b>
<p><b>Clinic Practice:</b> Provide IUD services in the clinic:</p> <ul style="list-style-type: none"> <li>• Counseling clients</li> <li>• GTI screening</li> <li>• Client assessment</li> <li>• IUD insertion</li> <li>• IUD removal (if available)</li> <li>• Followup care</li> <li>• Management of problems</li> </ul> <p>Participants assess each other's performance using learning guides.</p>	<p><b>Clinic Practice:</b> Provide IUD services in the clinic:</p> <ul style="list-style-type: none"> <li>• Counseling clients</li> <li>• GTI screening</li> <li>• Client assessment</li> <li>• IUD insertion</li> <li>• IUD removal (if available)</li> <li>• Followup care</li> <li>• Management of problems</li> </ul> <p>Participants assess each other's performance using learning guides.</p>	<p><b>Clinic Practice:</b> Provide IUD services in the clinic:</p> <ul style="list-style-type: none"> <li>• Counseling clients</li> <li>• GTI screening</li> <li>• Client assessment</li> <li>• IUD insertion</li> <li>• IUD removal (if available)</li> <li>• Followup care</li> <li>• Management of problems</li> </ul> <p>Clinical trainer conducts competency-based evaluation using checklist (qualification).</p>	<p><b>Clinic Practice:</b> Provide IUD services in the clinic:</p> <ul style="list-style-type: none"> <li>• Counseling clients</li> <li>• GTI screening</li> <li>• Client assessment</li> <li>• IUD insertion</li> <li>• IUD removal (if available)</li> <li>• Followup care</li> <li>• Management of problems</li> </ul> <p>Clinical trainer conducts competency-based evaluation using checklist (qualification).</p>	<p><b>Clinic Practice:</b> Provide IUD services in the clinic:</p> <ul style="list-style-type: none"> <li>• Counseling clients</li> <li>• GTI screening</li> <li>• Client assessment</li> <li>• IUD insertion</li> <li>• IUD removal (if available)</li> <li>• Followup care</li> <li>• Management of problems</li> </ul> <p>Clinical trainer conducts competency-based evaluation using checklist (qualification).</p>
<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>
<b>1330-1630</b>	<b>1330-1630</b>	<b>1330-1630</b>	<b>1330-1630</b>	<b>1360-1630</b>
<p><b>Clinical Conference</b>  <b>Discussion:</b> Management of side effects and other problems  <b>Demonstration/Exercise:</b> Management of lost strings and lost IUDs (hand-held and pelvic models)  <b>Role Play:</b> Managing side effects                      Clinical trainer reviews results of Midcourse Questionnaire with each participant.  <b>Review of day's activities</b></p>	<p><b>Clinical Conference</b>  <b>Discussion/Role Play:</b> Postinsertion and followup care  <b>Discussion:</b> Indications for removal  <b>Role Play:</b> Counseling a client for follow up care after IUD removal                      Clinical trainer reviews results of Midcourse Questionnaire with each participant.  <b>Review of day's activities</b></p>	<p><b>Clinical Conference</b>  <b>Discussion:</b> Assessing and improving quality of IUD services  <b>Discussion:</b> Organizing and managing an IUD service    <b>Review of day's activities</b></p>	<p><b>Clinical Conference</b>  <b>Discussion:</b> Medical barriers and policy issues  <b>Discussion:</b> Problems and constraints to IUD service delivery in participant's own clinical setting    <b>Review of day's activities</b></p>	<p><b>Clinical Conference</b>  <b>Discussion:</b> Course accomplishments relative to objectives, training methods and materials  <b>Course Evaluation</b> by participants    <b>Closing</b></p>
<p><b>Reading Assignment:</b> Chapters 8 and 9</p>	<p><b>Reading Assignment:</b> Chapters 10 and 11</p>			

**SAMPLE 8-3**

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**Materials Needed for a 2-Week IUD Training Course**

**Supplies and Equipment**

- Flipchart easels (2)
- Flipchart pads (5-6)
- Flipchart pens (3 boxes)
- Masking tape (3 rolls)
- Name tents (1 for each participant, clinical trainer, observer, etc.)
- Transparency film (3 boxes of 100 of either the film used in the copy machine or boxes of plain acetate sheets)
- Transparency pens (4 sets of nonpermanent pens)
- Overhead projector with an extra bulb
- Slide projector with tray
- Screen
- Videotape player and monitor
- Extension cords (2)
- Extra bulbs

**Training Materials**

- Reference Manual
- Participant's Course Handbook
- Trainer's Notebook
- Training Slide Set(s)
- Training Video(s)
- Anatomic models (Zoe pelvic and hand-held uterine)
- IUD insertion and removal kits
- IUDs in sterile packages
- Buckets and bleach
- Course certificates

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**SAMPLE 8-4**

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**SESSION EVALUATION**  
(To be completed by **Participants**)

**Session Title:** \_\_\_\_\_ **Clinical Trainer:** \_\_\_\_\_

**Instructions:** Please circle the number that reflects your reaction to the session presentation, using the following rating scale:

**5-Strongly Agree 4-Agree 3-No opinion 2-Disagree 1-Strongly disagree**

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

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

Other suggestions:

**SAMPLE 8-5**

**EVALUATION OF CLINICAL TRAINER**  
(To be completed by Participants)

Name of clinical trainer: \_\_\_\_\_

**Instructions:** Please indicate on a 1 to 5 scale your opinion of the performance of the clinical trainer.

1-Strongly agree   2-Agree   3-No opinion   2-Disagree   1-Strongly disagree

The clinical trainer:	Rating	Comments/Suggestions
1. Made me feel welcome when I entered the course		
2. Showed sensitivity to my natural feelings of fear and anxiety when learning new skills		
3. Showed or admitted her/his limitations on the subject		
4. Encouraged interaction with all participants		
5. Made it easy for me to ask questions and express my concerns		
6. Assessed my skills before training		
7. Clearly stated objectives of the new skills or activities to be learned		
8. Established clear standards for the performance expected of me		
9. Gave reasons why each step of the skill or activity is important		
10. Demonstrated each new skill or activity following the learning guide		
11. Demonstrated the skill or activity through role play or by using models before demonstrating on client(s)		
12. Provided me with enough opportunities to practice and achieve competence in the new skills or activities		
13. Gave me specific and immediate feedback so I knew how well I was performing		
14. Met with me to discuss my performance following each practice session		

Other Comments:

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**SAMPLE 8-6**

**IUD COURSE EVALUATION**  
(To be completed by Participants)

**Instructions:** Please indicate on a 1-5 scale your opinion of the following course components:

**5-Strongly agree    4-Agree    3-No opinion    2-Disagree    1-Strongly disagree**

COURSE COMPONENT	RATING
1. The Precourse Questionnaire helped me to study more effectively.	
2. The role play sessions on counseling skills were helpful.	
3. There was sufficient time scheduled for practicing counseling through role play with clients and volunteers.	
4. The training slide set and video helped me get a better understanding of how to insert and remove IUDs prior to practicing with the pelvic model.	
5. The practice sessions with the pelvic model made it easier for me to insert the Copper T 380A IUD in clients.	
6. There was sufficient time scheduled for practicing IUD insertion and removal with clients.	
7. I am now confident in Copper T 380A IUD insertion and removal.	
8. I am now able to use the recommended infection prevention practices for IUD insertion and removal.	
9. I am now able to screen clients for GTIs.	
10. The training approach used in this course made it easier for me to learn how to provide IUD services.	
11. Ten days were adequate for learning how to provide IUD services.	

**ADDITIONAL COMMENTS**

1. What topics (if any) should be **added** (and why) to improve the course?
  
2. What topics (if any) should be **deleted** (and why) to improve the course?

## APPENDIX A

# CHECKLIST FOR PREPARING FOR A CLINICAL SKILLS TRAINING COURSE

**Six Months  
Prior to Course**

Confirm training site(s):

- Venue for classroom sessions
  - Is it large enough for the number of participants, clinical trainers and others who will be attending?
  - Are small rooms (number and size) near the primary classroom available if needed for small group activities?
  - Does the classroom have enough electrical outlets for audiovisual equipment?
  - Is food service available at the training site or within walking distance?
- Site for clinical training sessions
  - Are there sufficient numbers of clients seeking the clinical service which is the topic of the training course (e.g., women requesting insertion and removal of Norplant implants)?
  - Is the clinic fully supplied with all instruments and equipment necessary to provide the service?
  - Are appropriate infection prevention practices followed?
  - Are staff prepared to accept and assist participants in a training situation?

Select housing accommodations (if necessary):

- Are accommodations close to training site and not far from town? If not, can transportation be arranged? Cost?
- Is a deposit required?
- What is the cancellation policy?

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*Checklist for Preparing a Clinical Skills Training Course*

Select and confirm additional cotrainers, consultants or content experts (if necessary):

- Inform them of dates, site, subject of course, expected number of participants, their role and responsibilities, compensation (if appropriate) and name and telephone number of the person who will be responsible for making their travel and lodging arrangements.
- Do they have any special requirements for the presentations or training sessions they will deliver?

**Three Months  
Prior to Course**

Select and notify participants:

- Inform them of dates, site, subject of course, course goals and objectives (i.e., why they were selected for the course, if appropriate), financial arrangements and the name and telephone number of a contact for additional information if required.
- Obtain biographical information on the participants if this was not available during the selection process. Important information for the clinical trainer includes education, experience and current job responsibilities.

Initiate administrative arrangements:

- Arrange for travel for participants and consultants, as appropriate.
- Confirm arrangements for per diem payments for participants and consultants, as appropriate.

Confirm housing accommodations:

- Confirm number of rooms and arrival/departure dates.
- Arrange for deposit if required.

Reconfirm availability of cotrainers, consultants or content experts.

Order training materials, supplies and equipment.

Confirm arrangements to receive participants at clinical training facility:

- Send list of participants and pertinent background information to the facility.

*Checklist for Preparing a Clinical Skills Training Course*

- Request any special client scheduling (e.g., clients for Norplant implants removal).

**One Month  
Prior to Course**

Review course syllabus, schedule and outline and adapt if necessary (send copies to participants and cotrainers).

Review course content and prepare for each session to be delivered by clinical trainer (e.g., prepare trainer's notes if used).

Prepare audiovisuals (transparencies, slides, flipcharts, etc.).

Visit training classroom site and confirm arrangements:

- Is the classroom appropriate for the type of training sessions and number of participants?
- Where is the administrative support person or office located?
- Where are the copy machine and printer located?
- Where are the telephones?
- Where are the bathrooms?
- What arrangements have been made for lunch and refreshments?
- Where will refreshments be served during the breaks?

Visit clinical training site(s) and confirm arrangements:

- Are staff ready to receive participants?
- Will clients be available during the training period?
- Are required supplies, instruments and equipment available?

Confirm receipt of educational materials, supplies and equipment.

Finalize administrative arrangements (e.g., local transportation to and from training site).

Reconfirm housing arrangements.

**One Week  
Prior to Course**

Review final list of participants for information on experience and clinical responsibilities.

Assemble educational materials.

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Prepare certificates of attendance.

Reconfirm availability of clients at clinical training site.

**One to Two Days  
Prior to Course**

Prepare classroom facility:

- Arrange room for correct number of participants.
- Place training materials at each participant's place.
- Place name tents and marker pens at each participant's place.

Prepare and check audiovisual and other training aids:

- Clean writing board; arrange easel; ensure supply of newsprint, marker pens and masking tape.
- Arrange screen, overhead projector, slide projector and videotape player and monitor; test all electrical equipment.
- Ensure supply of extra bulbs and extension cords.

Arrange anatomic models and all needed instruments.

Meet with cotrainer(s), outside consultants or content experts and review individual roles and responsibilities.

## APPENDIX B

# ENERGY-HEIGHTENING ACTIVITIES

## BOOM!

**OBJECTIVE:** Fun, Concentration

**MATERIALS:** Chairs

**APPROXIMATE  
TIME REQUIRED:** 10 minutes

**STEPS:**

1. All participants sit in a circle. They are instructed to count out loud around the circle. Each person whose number is a **multiple of 3** (3-6-9-12, etc.) or a number that **ends with 3** (13-23-33, etc.) must say **BOOM!** instead of the number. The next person continues the normal sequence of numbers.

**Example:** the first person starts with **1**, the next one says **2**, the person who should say **3** says **BOOM!** instead, and the next person says **4**.

2. Anyone who fails to say **BOOM!** or who makes a mistake with the number that follows **BOOM!** is disqualified.
3. The numbers must be said rapidly (5 seconds maximum); if a participant takes too long to say her/his number, s/he is disqualified.
4. The last two participants are the winners.

**Note:** The game can be made more complex by using multiples of bigger numbers, or by combining multiples of three with multiples of five.

*Source:* Unknown.

## **USE OF SAYINGS UNIQUE TO EACH COUNTRY**

**OBJECTIVE:** Fun, Concentration

**MATERIALS:** Flipchart, markers, envelopes, chairs

**APPROXIMATE  
TIME REQUIRED:** 10 minutes

**STEPS:** 1. At the beginning of the week, as a warmup exercise, form groups of three or four participants. Ask each group to record some of the sayings frequently used in their country. After 5 to 7 minutes, ask the groups to report their list of sayings. As each group reports their list, the trainer should check that the entire group understands each saying.

Keep this list of sayings for another warmup later in the week. Write each saying on a piece of paper and place in an envelope.

2. Later in the week (the third or fourth day), divide the participants into two groups, one group at each end of the room.
3. One representative from each group comes to the center of the room to receive an envelope containing a saying. The representatives read the sayings (silently) and return to their groups.
4. Without speaking, the representatives draw a picture to represent the saying they have received. The drawings cannot contain any words or parts of words.
5. The members of each group guess the saying that their representative has drawn. The first team to guess the correct saying receives one point.
6. After one group has guessed the saying, all groups send a new representative to the center to receive another envelope with a saying and the activity proceeds as described above.
7. The activity continues for 10 minutes or until all the sayings have been drawn and identified. The group with the higher number of points wins.

*Source:* Unknown.

## **HOT PEPPER**

**OBJECTIVE:** To boost the energy level in the group (good to use after lunch)

**MATERIALS:** Small ball

**APPROXIMATE  
TIME REQUIRED:** 10 to 15 minutes, depending on the size of the group

- STEPS:**
1. Participants sit in a circle away from the conference table and close their eyes.
  2. Trainer gives a small ball to one participant who is instructed to pass the ball quickly to the next person saying “**Hot!**” Participants continue to pass the ball around the group.
  3. As the ball is passed from participant to participant, the trainer turns her/his back, closes eyes and calls out “**Pepper!**”
  4. The person who is holding the ball when “**Pepper!**” is called is removed from the circle.
  5. The ball continues to be passed until only one person is left.

*Adapted from: Pfeiffer & Company 1983.*

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## **NEW CONCEPTS**

**OBJECTIVE:** To focus participants on the content of the training session

**MATERIALS:** Flipchart

**APPROXIMATE  
TIME REQUIRED:** 5 minutes

- STEPS:**
1. Form three or four small groups.
  2. Write the word **INTERACTIVE** on the flipchart.
  3. The groups have 5 minutes to create as many 3-letter words as possible from the word **INTERACTIVE**.
  3. Call time after 5 minutes. The group with the most words wins.

**Note:** Depending on the topic, other words can be used in this way, such as “demonstration,” “counseling,” etc.

*Source:* Unknown.

## **WHERE YOU STAND DEPENDS ON WHERE YOU SIT**

**OBJECTIVE:** To encourage participants to broaden their horizons, and look upon their environments as opportunities, not as limitations

**MATERIALS:** One transparency or handouts (one for each participant) of the top half of the figure

**APPROXIMATE  
TIME REQUIRED:** 5 to 10 minutes

- STEPS:**
1. Present the top half of the figure on the next page to participants, preferably by projection onto a screen so that everyone can see it at the same time.
  2. Ask how many people think that Circle A is larger and how many think Circle B is larger.
  3. Demonstrate, by revealing the bottom half of the figure, that both circles are really the same size.

### **DISCUSSION QUESTIONS:**

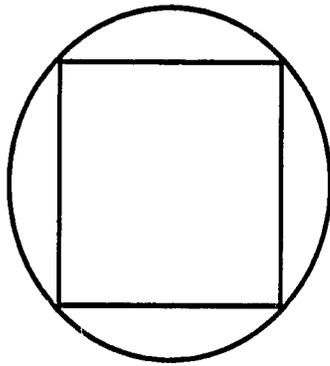
1. Why does one circle appear larger than the other?
2. In what ways do we let our minds work in similar fashion as we view our worlds? What impact does this tendency (i.e., to focus on constraints, problems and barriers) have on our own productivity?
3. How can we prevent or diminish our tendency to limit our own thinking pattern like this?
4. Does the saying "Where you stand depends on where you sit" hold equally true regarding our thought processes and perceptions (e.g., "what we perceive is what we will react to")?

*Source:* Ryder Systems, Inc. 1987.

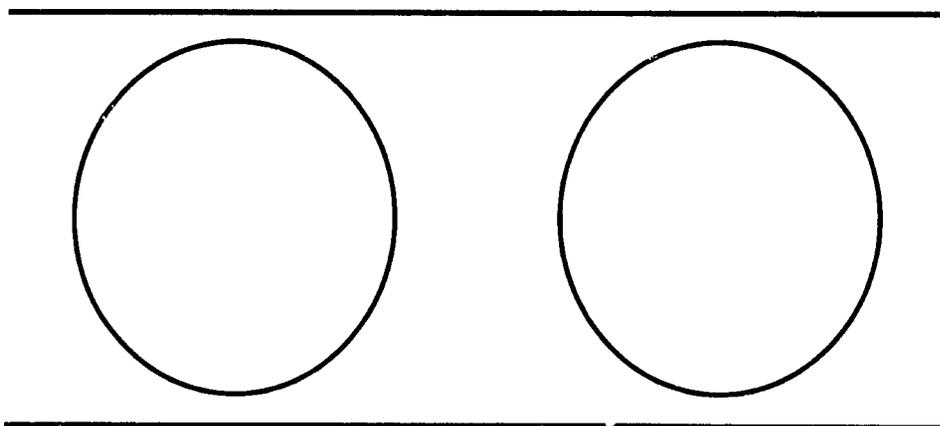
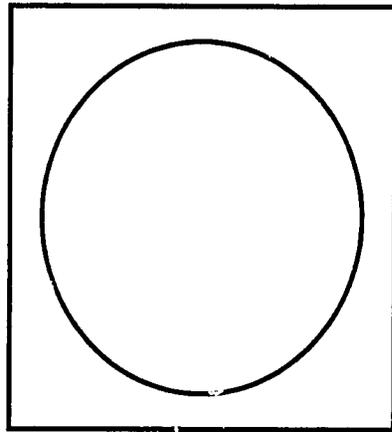
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**WHICH CIRCLE APPEARS LARGER?**

**A**



**B**



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## **THE SPIDER WEB**

**OBJECTIVE:** Introductions (for participants who do not know each other well)

**MATERIALS:** A ball of yarn, cord or thin rope

**APPROXIMATE  
TIME REQUIRED:** 10 minutes (depending on size of group and length of introduction)

- STEPS:**
1. The participants stand up and form a circle.
  2. A ball of yarn is given to one participant who tells the group something about her/himself, such as name, where s/he is from, her/his type of work, why s/he is attending the course, etc. (The information to include will depend on the size of the group and the time allotted for the activity.)
  3. The participant with the ball of yarn holds onto the end of the yarn and throws the ball to a colleague in the circle, who in turn must introduce her/himself in the same way. Participants continue introducing themselves by tossing the ball around the circle until all participants form part of this **spider web**.
  4. As soon as everyone has introduced her/himself, the person holding the ball (Z) returns it to the person who threw it to her/him (Y), as s/he (Z) repeats the information about that person (Y).

Person Y then returns the ball to the person who threw it to her/him (X) repeating her/his information. This continues around the circle, with the ball following its previous path in reverse order until it reaches the participant who first introduced her/himself.

**Note:** Warn the participants beforehand of the importance of paying attention to each introduction, since they will not know who will be throwing the ball at them.

*Source:* Unknown.

## **HIDDEN SQUARES**

**OBJECTIVE:** To encourage participants to dig deeper into problems, and visualize them from a different perspective; to see not only the whole, but also various combinations of parts.

**MATERIALS:** A flipchart, transparency or handout with the figure shown on the next page

**APPROXIMATE  
TIME REQUIRED:** 10 minutes

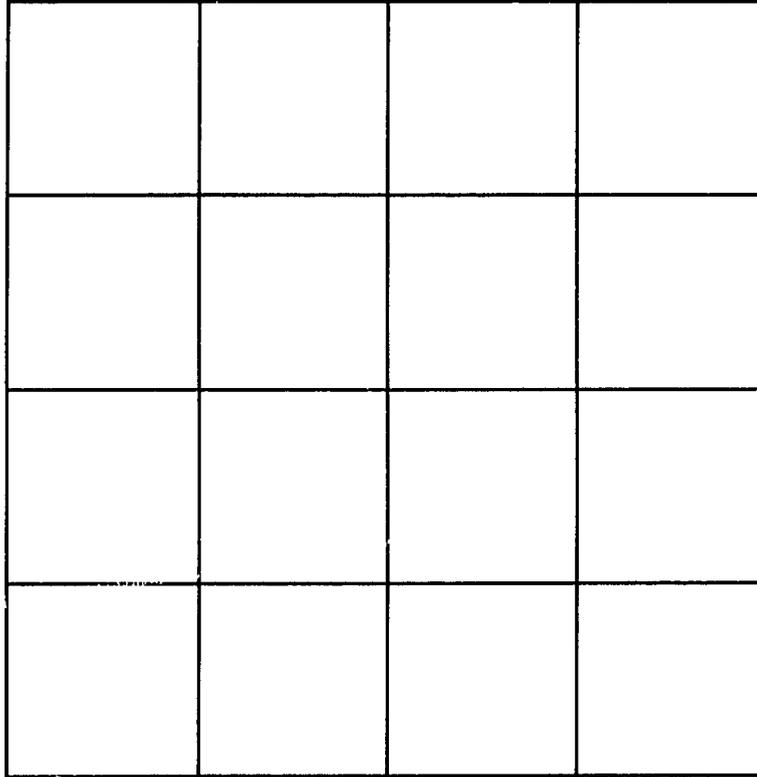
- STEPS:**
1. Provide participants with a drawing of a large square, divided as shown on the next page. Then direct them to quickly count the total number of squares seen, and report that number verbally.
  2. The correct answer is 30, developed as follows: 1 whole square, 16 individual squares, 9 squares of 4 units each, and 4 squares of 9 units each.

### **DISCUSSION**

- QUESTIONS:**
1. What factors prevent us from easily obtaining the correct answer? (We stop at the first answer, we work too fast.)
  2. How is this task like other problems we often face? (Many parts make up the whole.)
  3. What can we learn from this illustration that can be applied to other problems?

*Source:* Newstrom and Scannell 1980.

## HIDDEN SQUARES



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## **WARMUP EXERCISE: THE POST OFFICE**

**OBJECTIVE:** Fun, liveliness

**MATERIALS:** Chairs

**APPROXIMATE  
TIME REQUIRED:** 10 to 15 minutes (depending on size of group)

- STEPS:**
1. The participants sit in a circle, each having her/his own chair. The facilitator takes one chair away and the participant who is left standing stands in the center of the circle and begins the activity.
  2. The participant in the center of the circle says something like:  
“I bring a letter for all of my colleagues who have brown hair.”
  3. All of the participants who have the characteristic stated (e.g., brown hair) and the person in the center of the circle change places.
  4. Whoever ends up without a chair to sit on stands in the center of the circle and again states that s/he is bringing a letter, but for people with a different characteristic, such as:  
“I bring a letter for all of my colleagues who are wearing black shoes.”  
“I bring a letter for all of my colleagues who have never inserted a Copper T 380A IUD.”
  5. The activity can continue as long as the group is interested and enthusiastic (but no longer than 15 minutes).

*Source:* Unknown.

# GLOSSARY

**Active Listening** Communication technique that stimulates open and frank exploration of ideas and feelings and enables trainers to establish trust and rapport with participants. In active listening, the trainer accepts what is being said without making any value judgments, clarifies the ideas or feelings being expressed and reflects these back to the participants.

**Advanced Trainer** Trainer who can impart both clinical skills and clinical training skills to proficient clinicians. S/he also should be knowledgeable and experienced in developing and conducting various types of reproductive health courses. Generally, an advanced trainer first has been a proficient service provider, then a clinical trainer and has completed an apprenticeship (i.e., cotrained) with a master trainer.

**Audiovisuals** Materials used to supplement training activities which highlight key steps or information, reinforcing the learning process. They include writing boards, flipcharts, transparencies, slides and videotapes.

**Brainstorming** Training strategy that stimulates thought and creativity and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts or alternative solutions which focus on a specific topic or problem. Brainstorming requires that participants have some background related to the topic.

**Case Study** Interactive training method that uses real scenarios which focus on a specific issue, topic or problem. Typically, participants read, study and react to the case study in writing or verbally during a group discussion.

**Certification** Process for documenting that a participant can competently provide a service(s) (e.g., IUD or Norplant implants insertion and removal). Certification is bestowed by an authorized organization (Ministry of Education or Health), educational institution (medical or nursing school) or agency. **Generally, training organizations do not certify participants (see Competency).**

**Checklist** Competency-based (skill) assessment instrument which is used to evaluate a participant's performance of clinical skills or other observable behaviors (e.g., counseling or presentation skills). Checklists focus on the **key steps or tasks** of a procedure or activity. They are used by trainers to evaluate objectively performance of a procedure or activity.

<b>Clinical Training Skills (CTS) Course</b>	Course during which proficient (expert) service providers (e.g., physicians, nurses, midwives) acquire the training skills needed to <b>competently train</b> other health professionals in how to provide a clinical FP service (e.g., minilaparotomy under local anesthesia). In addition to providing training skills, the clinical skills of the service provider are standardized.
<b>Clinical Skills Course</b>	Training course for clinicians (e.g., physicians, nurses, midwives) during which they acquire the skills needed to <b>competently provide</b> a clinical FP service (e.g., IUD or Norplant implants insertion/removal) or other reproductive health service. Clinical skills courses usually focus on one contraceptive method (e.g., IUDs or minilaparotomy) although some courses may include a combination of contraceptive methods. (Also known as <b>Service Providers' Course</b> .)
<b>Clinical Skills Trainer</b>	Trainer who can impart clinical skills to service providers. A clinical skills trainer must be proficient (expert) in the clinical FP service for which s/he will be providing clinical training as well as competent in clinical training skills. To become a clinical skills trainer, the trainer must complete a clinical training apprenticeship (i.e., cotraining) with an advanced or master trainer.
<b>Clinician</b>	Anyone who provides <b>clinical</b> services in the health system (e.g., physician, medical assistant, nurse, nurse-midwife, midwife or paramedic). (See also/compare to <b>Service Provider</b> .)
<b>Coaching</b>	Training technique which involves the use of active listening, positive feedback, questioning and problem-solving skills to ensure a positive training climate. The trainer/coach demonstrates desired performance standards, encourages openness to learning and continually assesses participant performance. An effective coach focuses on practical issues, encourages working together, works to reduce stress and sees her/himself as a facilitator of learning.
<b>Competency</b>	Ability to perform a skill to a specific standard and apply knowledge in the provision of services.
<b>Competency-Based Training (CBT)</b>	Competency-based training is learning by <b>doing</b> . It emphasizes how the participant <b>performs</b> (i.e., a combination of knowledge, attitudes and, most importantly, skills) rather than what information the participant has <b>learned</b> . In CBT, participants' progress is continually measured against pre-established performance criteria (standards).

<b>Course Handbook (Participant)</b>	Document that outlines the framework for a training course. It contains a course syllabus, schedule and outline as well as all supplemental printed materials (precourse knowledge questionnaire, individual and group learning matrix, learning guides and course evaluation) needed during the course.
<b>Course Notebook (Trainer)</b>	Document that outlines the framework for conducting a training course and provides additional information and instructions for the trainer. A <b>Trainer's Notebook</b> includes all the material given to the participant as well as the precourse skills assessment; precourse knowledge questionnaire answer key; midcourse knowledge questionnaire, answer sheet and answer key; and the participant evaluation checklist. Additionally the "Tips for Conducting the Course" section briefly summarizes general information on conducting a clinical training course, being a good trainer and using interactive training techniques.
<b>Course Outline</b>	Detailed plan of topics to be presented in a course and <b>how</b> the training will be delivered. The course outline is a <b>planning document</b> .
<b>Course Schedule</b>	Brief day-by-day description of the major activities to be conducted in a training course. Information for the course schedule is taken from the <b>course outline</b> .
<b>Course Syllabus</b>	Summary of the major components of a course. The syllabus should be given to participants in advance of training. It is important that a syllabus accurately describe the course content, goals and objectives (also called a <b>Course Description</b> ).
<b>Demonstration (Clinical)</b>	Interactive training in which the trainer explains and shows the steps and sequence (if necessary) required to perform a skill or activity. A variety of methods can be used to demonstrate a procedure, including slides, videotape, anatomic models and role play.
<b>Discussion (Group)</b>	Interactive training technique in which most of the ideas, thoughts, questions and answers are developed by the participants. The trainer serves as the facilitator and guides participants as the discussion develops.
<b>Experiential Learning</b>	Training approach that actively involves participants and applies the use of new skills through a variety of instructional methods (e.g., case studies and role plays).

<b>Feedback</b>	Communication technique in which the trainer (or coach) provides information to participants about their progress in mastering a skill or activity or achieving the learning objectives of the course. Feedback is most effective when it is timely (provided immediately), positive and descriptive.
<b>Guided Clinical Practice</b>	Interactive training method in which the clinical trainer supervises and coaches participants as they practice a skill or activity in the classroom or in an actual situation (e.g., providing services to clients in the clinic).
<b>Humanistic Training</b>	Clinical training technique that uses anatomic models and other training aids such as slide sets and videotapes to enable participants to reach the performance levels of <b>skill acquisition</b> and beginning <b>skill competency</b> prior to working in the clinical setting with clients. Humanistic training facilitates learning, shortens training time and minimizes risks to clients.
<b>Illustrated Lecture</b>	Training in which the content is derived largely from the knowledge-based learning area and presented verbally by the clinical trainer. Its effectiveness as a training method is markedly enhanced through the use of questioning techniques and well-designed audiovisual aids.
<b>Learning Guide</b>	Competency-based skill assessment instrument that focuses on clinical skills (e.g., IUD insertion) or other observable behaviors (e.g., counseling). Learning guides contain the individual steps or tasks in sequence (if necessary) required to perform a skill or activity in a standardized way. Learning guides are designed to help the participant learn the correct steps and sequence in which they should be performed ( <b>skill acquisition</b> ) and measure progressive learning in small steps as s/he gains confidence and skill ( <b>skill competency</b> ).
<b>Master Trainer</b>	Trainer who can impart advanced and clinical training skills as well as clinical skills to other health professionals. S/he also should be knowledgeable and experienced in developing courses, conducting various types of training courses in reproductive health and evaluating training. Generally, a master trainer first has been a proficient service provider, then a clinical trainer and an advanced trainer.
<b>Mastery Learning</b>	Approach to learning which is based on the premise that <b>all</b> participants can master (learn) the required knowledge or skill, provided sufficient time and appropriate training methods are used. The goal of mastery learning is that 100% of the participants will “master” (learn) the knowledge and skills on which the training is based.

<b>Midcourse Questionnaire</b>	Competency-based knowledge assessment that allows each participant (and the clinical trainer) to determine the participants' progress in mastering the course material.
<b>Participant</b>	Individual receiving training; also known as student, trainee or learner. (The term participant is preferred as it lends more respect to postgraduate health professionals receiving training.)
<b>Participatory Learning</b>	Method of training which actively involves participants in the learning process (see <b>Experiential Learning</b> ).
<b>Precourse Questionnaire</b>	Competency-based knowledge assessment that is administered at the beginning of a course to determine what the participants, individually and as a group, know about the course topic. The assessment allows the <b>clinical trainer</b> to identify particular topics which may need emphasis or, in many cases, require less classroom time during the course. Providing the results to participants enables them to focus on their individual learning needs.
<b>Procedure (Medical)</b>	Encompasses all of the individual activities/skills required to perform a medical intervention (e.g., the IUD insertion procedure includes client counseling and assessment and infection prevention practices as well as the clinical aspects of inserting the IUD).
<b>Questionnaire</b>	Set of <b>validated</b> and <b>reliable</b> questions used to assess the participant's precourse knowledge or to measure mastery of the course material (e.g., <b>Pre- and Midcourse Questionnaires</b> ).
<b>Reference Manual</b>	Text containing essential, need-to-know information pertaining to a specific skill or activity (e.g., IUD insertion, infection prevention or clinical training skills). The reference manual contains all of the information needed to conduct a training course in a logical manner. Because it serves as the text for participants and the "reference source" for the trainer, special handouts or supplemental materials are not needed.
<b>Role Play</b>	Interactive training method in which participants act out roles in a realistic situation related to training objectives. A major advantage of this approach is that participants can experience a real life situation without taking real life risks.
<b>Service Provider</b>	Anyone who provides a service at any level in the health system (e.g., physician, nurse, midwife, CBD worker). (For comparison, see <b>Clinician</b> .)

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<b>Skill</b>	Group of tasks which use motor functions and typically require the manipulation of instruments and equipment. <b>Activity</b> is often used synonymously, but may or may not require motor functions. <b>Steps</b> and <b>Tasks</b> are subcomponents of a skill and/or activity.
<b>Skill Acquisition</b>	Represents the <b>initial phase</b> in learning a new clinical skill or activity. One or more practice sessions are needed for learning how to perform the required steps and the sequence (if necessary) in which they should be performed. Assistance and coaching are necessary to achieve correct performance of the skill or activity.
<b>Skill Competency</b>	Represents an <b>intermediate phase</b> in learning a new skill or activity. The participant can perform the required steps in the proper sequence (if necessary) but may not progress from step to step efficiently.
<b>Skill Proficiency</b>	Represents the <b>final phase</b> in learning a new skill or activity. The participant efficiently and precisely performs the steps in the proper sequence (if necessary). Proficiency is attained through repeated practice of the skill or activity. It usually is not obtainable in a basic (introductory) clinical or training skills course.
<b>Standardization</b>	Process of analyzing the essential steps in a skill or activity to determine the most efficient and safe way to perform it and train others.
<b>Steps</b>	Skills or activities broken down into specific assignments or duties. ( <b>Tasks</b> often used synonymously.)
<b>Tasks</b>	Skills or activities broken down into specific assignments or duties. ( <b>Steps</b> often used synonymously.)
<b>Teaching</b>	To impart or convey knowledge. This usually refers to instruction provided through <b>classroom</b> activities (often associated with preservice education programs).
<b>Trainer</b>	Person who has knowledge and skills in a specified subject area and the ability and training to impart them to others. Trainers are proficient (expert) in the skills and activities in which they provide training. In addition, they have received specialized training and practice in training skills.
<b>Training</b>	Learning which deals primarily with obtaining the knowledge, attitudes and skills needed to carry out a specific activity (e.g., IUD insertion). Training should be based on the assumption that there will be an immediate application of the physical or mental skill(s) being learned.

**Training Package** Collection of materials used to conduct a course. Components of a training package include (but are not limited to) a reference manual; a course handbook for participants; a course notebook for the trainer; audiovisual and other training aids (e.g., videotapes, slide sets and anatomic models); and competency-based assessment instruments.

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# ASSESSMENT OF CLINICAL TRAINING SKILLS REFERENCE MANUAL

Please indicate on a 1-5 scale your opinion of the chapters and appendices.

5-Excellent 4-Very Good 3-Satisfactory 2-Needs Improvement\* 1-Unsatisfactory\*

CONTENTS	Easy to read	Need-to-know information	Samples	Usefulness in problem solving
<b>Overall Evaluation of Manual: Clinical Training Skills for Reproductive Health Professionals</b>				
<b>CHAPTER</b>				
1 An Approach to Clinical Training				
2 Creating a Positive Training Climate				
3 Using Audiovisual Aids				
4 Using Interactive Training Techniques				
5 Using Competency-Based Assessments				
6 Coaching in Clinical Training				
7 Combining Coaching with Other Clinical Training Techniques				
8 Conducting a Clinical Training Course				
<b>APPENDIX</b>				
A Checklist for Preparing for a Clinical Skills Training Course				
B Energy-Heightening Activities				
<b>GLOSSARY</b>				

\* Please comment on the back if you rated any chapter or appendix less than satisfactory.

## ADDITIONAL COMMENTS

1. What topics (if any) should be included in **more detail** to improve the manual?
2. What topics (if any) should be **reduced in detail** to improve the manual?
3. What topics (if any) should be **added** (and why) to improve the manual?
4. What topics (if any) should be **deleted** (and why) to improve the manual?
5. Did you receive this manual by attending a training course? If not, how?