

**TRAINING
in AFRICA:
best practices,
lessons learned
and future directions**

CONFERENCE
PROGRAM
and
SESSION
MATERIALS

DAY II

JHPIEGO, an affiliate of Johns Hopkins University, is a nonprofit corporation working to improve the health of women and families throughout the world.
www.jhpiego.org

JHPIEGO Corporation
Training in Reproductive Health project
1615 Thames Street
Baltimore, Maryland 21231-3492, USA

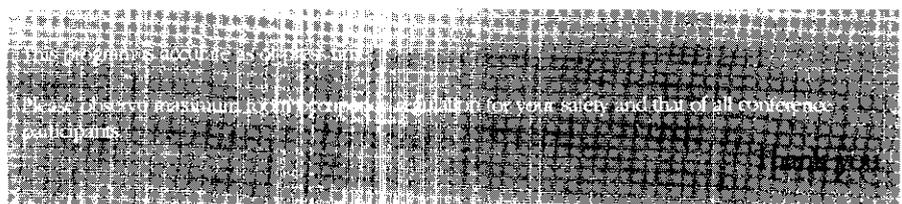
This conference program was made possible through support provided by the Service Delivery Improvement Division, Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-98-00041-00. The opinions expressed herein are those of JHPIEGO and do not necessarily reflect those of the U.S. Agency for International Development.

August 2003

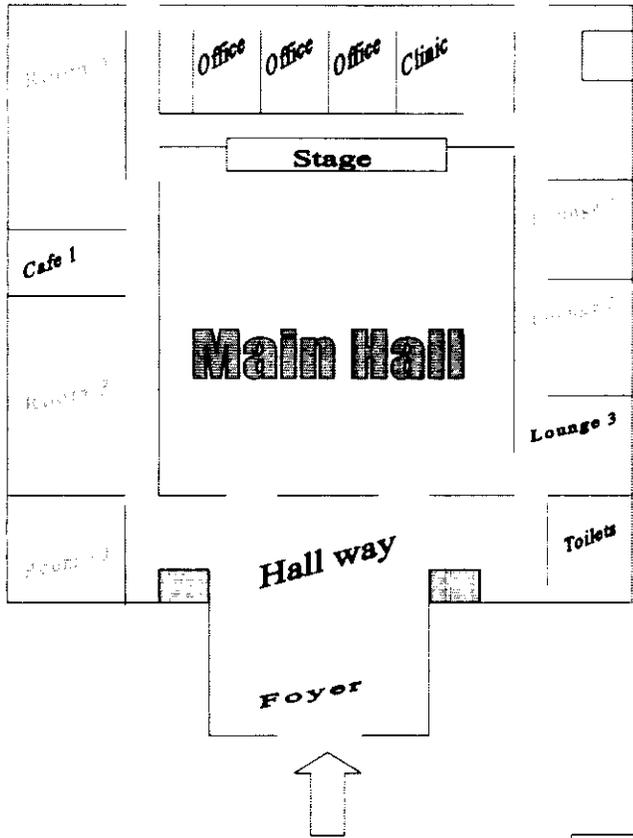
TABLE of CONTENTS

MAP of CONFERENCE FACILITY	i
DAY II AGENDA	ii
CONCURRENT SESSION MATERIALS	
* A Demonstration of Strategies/Techniques from the <i>Transfer of Learning Guide</i> : Using a Distance Learning Approach to Transfer Knowledge and Skills	1
* Individualized Training Achieves Competency with Limited Caseloads, Reduces Training Burden	11
* From Acquiring Knowledge and Skills to Being Able to Do the Job: Evolution and Current Status of Training Evaluation	27
* Design Your Audience into Your Training Program	41
* Decentralized Training and Supervision - Lessons from Ghana	53
* Beyond Training of Trainers: Lessons Learned in Developing High Quality Clinical Training Sites in Indonesia	67
* Business Planning Program: A Social Return on Investment	79
* Improving Understanding about Training in Africa through Operations Research	91
* Developing Effective Group and Individualized Learning Materials	107
* How to Build Partnerships: Models of Training Networks	117
* Tailoring Training and Ensuring Impact: Using the Performance Improvement Methodology	137
* Many Africas, One Training: Designing and Delivering One Intervention for Many Audiences	147
* "Client Profiles": Modeling Client-orientation while Tailoring Training to Local Needs	157
* The Best Practices Compendium: A Tool for Public Health Trainers	163
* Training to Create Adolescent-friendly Reproductive Health Services in Uganda	181
* Training Site Development - What are Ingredients for Success?	191

* Distance Learning: Lessons from the Field	203
" Ensuring the Effectiveness of Training by Using a Performance Improvement Approach	219
* Evaluation of Impact of Cascade Training Approach on Family Planning Services and Infection Prevention Practices	231
" Designing Counseling Training that Works	251
* Whole-site Training for Sustained Results: Egypt and Tanzania Experiences	255
* Training Clinical Decision-makers: Nurses and Cervical Cancer Prevention	271
* Use of Competency-based Assessment Tools in Clinical Skills Development	279
" Trainer Development for Decentralization of Postabortion Care Services: the Guinean Experience	297
* Licensed to Practice: Assessing Graduates of Strengthened Preservice Education	313
* Developing Effective Trainers for Sustainable Training Systems: Lessons Learned	315
* Training to Build Capacity for Long-term and Permanent Methods (LIPM) of Family Planning	331
" Move Forward with Teachback: A Unique Methodology for Training Trainers	339
* Combining Postabortion Care (PAC) Clinical and Structured On-the-Job Training (OJT) Skills for Sustained Results: Malawi Experience	341
" Importance of Training Sites in the Competency-based Training Approach	355
* Towards Adolescent-friendly Clinics - the Use of Values Clarification to Facilitate Change in Public Health Clinics	365
" Training for Home-based Care - Nurses, Community, Traditional Healers	381

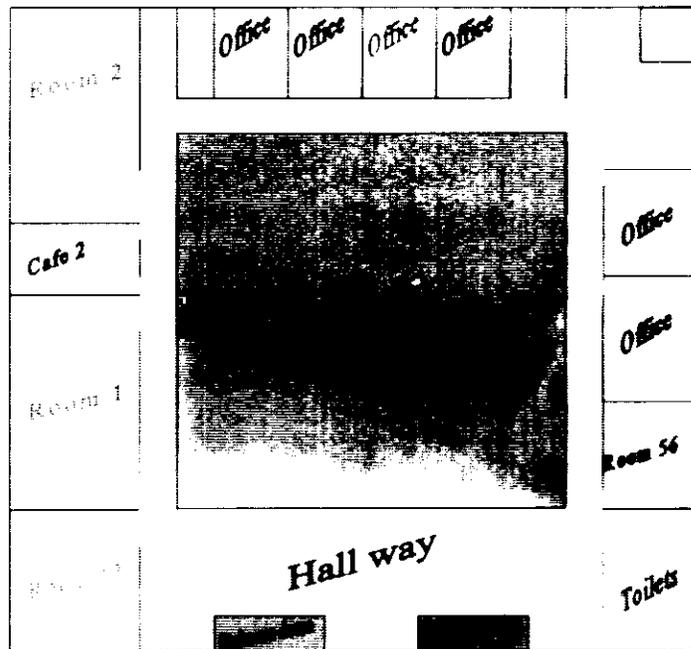


MAP of CONFERENCE FACILITY



GROUND FLOOR PLAN

FIRST FLOOR PLAN



DAY II AGENDA

9:00 AM - 10:30 AM

Concurrent Sessions

A Demonstration of Strategies/Techniques from the *Transfer of Learning Guide: Using a Distance Learning Approach to Transfer Knowledge and Skills*

Stembile Matatu

Intrah/UNC School of Medicine

Anne Otto

Intrah/LNC School of Medicine

The presentation will provide the participants with an overview of PRIME and JHPIEGO's *Transfer of Learning Guide*. The overview will highlight important features of the guide including the rationale, the important linkage between training and performance improvement and the user-friendly transfer matrix. Training and learning specialists from Intrah will share lessons learned during the design and implementation of a distance learning course to improve the knowledge and skills of nursing assistants/nurse aides in Uganda to deliver family planning and reproductive health services.

Room 4

Room 3

Individualized Training Achieves Competency with Limited Caseloads, Reduces Training Burden

Richard Hughes

Kamlesh Giri

JHPIEGO

Velepi Mtonga

Clinical Care & Diagnostic Services, Central Board of Health, Zambia

Competency-based training has become a standard for clinical training; yet achieving competency is a challenge when there is limited or erratic caseload. For both emergency procedures and low-volume procedures, caseload and client flow are issues. This can often be overcome by using an individualized training approach, as demonstrated in training programs for postabortion care (PAC) in Zambia and no-scalpel vasectomy (NSV) in Nepal. Individualized training, using a structured competency-based training package, enables training a few of providers in a flexible framework that **maximizes** the use of the existing **caseload** while **minimizing** the **burden** on trainers and training facilities.

Room 2

From Acquiring Knowledge and Skills to being Able to Do the Job: Evolution and Current Status of Training Evaluation

Rose Wabome

Jedida Wachira

Intrah

The presentation will review the evolution of training evaluation, from the genuine concern about the adequacy of venues, materials and trainers, and the appropriate acquisition of knowledge and skills by the trainees in early days, to performance evaluation. With diminishing budgets and increasing results-orientation of donor and implementing agencies, coupled with dramatic improvements in measurement methodologies and tools, the focus of evaluation has shifted to a more comprehensive assessment of external and internal influences that hinder or facilitate health workers' abilities to apply their knowledge and skills to particular jobs and their environments. Evaluations once reserved to special research initiatives can now be seamlessly carried out by almost any project management to find out whether training interventions have improved worker performance. However, with the shift to more comprehensive and impactful evaluation models, the advent of new paradigms (e.g., quality assurance, performance improvement) and concomitant interventions in the field, constraints in analysis and interpretation of data such as attribution and multicausality have challenged the field. A final word will be said about the applicability and dissemination of evaluation results for practical use in training-related programs, especially in the African context.

Lounge 1

Design Your Audience into Your Training Program

Gail Rae

Population Leadership Program

Designing your audience into your program means that your audience will be actively involved, energetic, and learning what they need to know. This session will teach you a technique that experienced trainers acquire, but don't often share. The best trainers 'intuitively' tailor their presentation to their audience and can 'go with the flow' while still achieving the training goals. How do they do it?

During this session, we will move from a focus on "how I will present" to "what they want to know". Your audience will appreciate the genuine interaction and you will increase your confidence as a presenter and facilitator of an exciting and respectful learning environment that has been successful in the African context. We will focus on what specific members of the audience bring to the session and how to build on their experience, their knowledge, and their stories - even though you never met them in your life.

DAY II AGENDA

Lounge 2

Room 13

Decentralized Training and Supervision - Lessons from Ghana

Nicholas Songogye Kanlisi

Patience Darko

EngenderHealth

The session will cover the process and lessons learned in the programming and implementation of a sustainable, scaled-up training system in Ghana:

- Steps for developing training capacity in a decentralized system, including training center development, trainer development and training management
- Building-in linkages between training and supervision to ensure that supervisors support trainees to either initiate service and/or improve already existing services
- Recognizing the importance of ownership – steps to ensure ownership of the program by counterpart organization and the effect of that ownership on success of the program.

Business Planning Program: A Social Return on Investment

Greg Rodway

Management Sciences for Health

The session focus is to introduce the Business Planning Program and the blended learning paradigm utilized by the program. This program utilizes face-to-face and e-learning methodologies to provide participating organizations with a technology that allows them to build expertise in such areas as: capturing and packaging breakthrough ideas, identifying target markets and marketing strategies, determining the best complement of staff to develop ideas and navigate financial aspects of a business plan. The Business Planning Program has been offered in Bolivia and is being adapted to Africa, where it will be implemented at the Centre for African Family Studies this March.

Main Hall

Beyond Training of Trainers: Lessons Learned in Developing High Quality Clinical Training Sites in Indonesia

Zabida Qureshi

University of Nairobi

In Indonesia, one of the strategies to achieve the Ministry of Health goal of increasing the numbers of births attended by skilled providers is to strengthen the skills of physicians and midwives through inservice training. In these efforts, it has become clear that a strong maternal and newborn healthcare training system requires not only well-trained trainers and well-supplied clinical sites, but also quality clinical settings in which trainees can observe, learn and practice a broad range of essential skills. Interventions include involving administrators into the planning process, mentoring hospital staff on an intensive, routine basis, and linking the clinical training sites to the preservice training institutes. Results from 2 years of activities at Budi Kemuliaan Maternity Hospital indicate that preparation of high quality clinical training sites requires complex inputs to strengthen skills in clinical decision making, mother friendly care, proper infection prevention practices, and prevention and management of complications.

Room 1

Improving Understanding about Training in Africa through Operations Research

Ity Osei

Harriet Birungi

Saiqa Mullick

Population Council

Operations research (OR) offers managers the opportunity to test and compare new training interventions on a pilot-basis. Undertaking OR studies to compare training approaches can be challenging, however, and this session will present examples of studies undertaken in Africa that test training in quality family planning services, and in routine and emergency antenatal care. Designing a study robust enough to draw valid conclusions while allowing the training interventions to be fully implemented, and collecting information on indicators that permit an assessment of the training interventions' effectiveness, will be the focus of the session.

11:00 AM - 12:30 PM

Concurrent Sessions

Room 4

Developing Effective Group and Individualized Learning Materials

Rick Sullivan

JHPIEGO

Mimunya Machoki

Kenyatta National Hospital

DAY II AGENDA

Effective materials for the participant and trainer are essential to the success of group and individualized learning interventions. Instructional designers and materials developers are continually challenged to design and develop materials that are easy to use, economical, based on measurable learning objectives and effective. In this highly interactive session, you will hear the lessons learned in Africa by one organization about the design and development of effective materials for group courses as well as for structured on-the-job training. Session content will focus on design of reference manuals, learning objectives, course schedules, outlines for group and individualized learning, and other components of effective learning packages.

Room 3

How to Build Partnerships: Models of Training Networks

Jacqueline Makokha

Regional AIDS Training Network (RATN)

To provide ideas about how partnership can be developed and sustained, several examples of training networks were collected from throughout the world. The networks include:

- Regional AIDS Training Network, East and Southern Africa
- AIDS Education and Training Centers, United States
- Public Health Training Network, United States and international
- Latin American and Caribbean Health Care Reform Initiative
- Getnet, South Africa

The presentation shows how each network is structured, staffed and funded. The examples are illustrative, but not prescriptive. They also show that one can design a network based on a relationship among partners from one model and a funding mechanism from another model.

Room 2

Tailoring Training and Ensuring Impact: Using the Performance Improvement Methodology

Rose Wabome

Jedida Wachira

Intrah

The presenters will describe how to improve training outcomes by coordinating training and non-training interventions designed to achieve desired performance. The presenters will briefly describe the performance improvement approach/methodology and then describe how this approach was used to improve performance in two Intrah programs: 1- to guide the design of the Safe Motherhood Initiative, DISH II Project, Uganda and 2- to improve primary health care service delivery, in the areas of family planning (FP) and sexually transmitted

infections (STIs), EQUITY Project, South Africa. Both programs utilized the results of a performance needs assessment to design, implement and evaluate a comprehensive strategy that used innovative training approaches in tandem with other targeted interventions to achieve the desired impact.

Lounge 1

Many Africas, One Training: Designing and Delivering One Intervention for Many Audiences

Maurzen Kuyob

Bob Rice

Jane Schueller

Family Health International

How do you design and deliver training curricula that accommodates a "world" of differences – yet is tailored to your participants' specific expectations and needs? A progressive case study format will focus participants at the "design and delivery" stages of curriculum development. Lessons learned from FHI's participatory *Research Ethics Training Curriculum*, packaged in a computer-based and Web-based format or as a "live" training package, will help participants see how design and delivery decisions can influence participants and the learning that takes place. Visual and content choices, field-testing, interactive attributes, as well as pre-training communication and post-training follow-up will be discussed.

Lounge 2

"Client Profiles": Modeling Client-orientation while Tailoring Training to Local Needs

Feddís Mumba

AMKENI Project

In designing a curriculum for integrated sexual and reproductive health (SRH) counseling, EngenderHealth faced the challenge of addressing the wide scope of counseling needs of individual clients, in the different SRH areas, and in varying cultures around the world. An approach that proved successful in field-tests was having the participants develop *client profiles* to reflect the realities of the communities and clients that they serve. These profiles became the basis of case studies and role-plays throughout the training. This approach supports client-centered services by focusing on the client as an individual, while tailoring the training to local needs.

DAY II AGENDA

Main Hall

The Best Practices Compendium: A Tool for Public Health Trainers

Susan Palmore

Lauren Pindzola

Advance Africa

In this session we are introducing a new training tool, the Best Practices Compendium. What is the Compendium? How can I use it in designing my training program? Why are best practices important? These are some of the questions that will be answered by brainstorming, role play and actual on-line use of this tool. Participants will gain the knowledge and skills necessary to use the Compendium to improve the interactivity and impact of their training program.

Room 13

Training to Create Adolescent-friendly Reproductive Health Services in Uganda

Stembile Matatu

Intra-C Consultant

The session will describe the innovative learning approaches used to train providers in the provision of adolescent friendly practices. As part of the needs assessment, the design team explored consumer expectations among adolescents and interviewed community leaders, health workers and parents to identify concerns that would need to be addressed in the training curricula or through non-training interventions. The findings of the needs assessment were used to develop activities that would help providers to change their attitudes towards adolescent sexuality by getting them to examine the effects these attitudes have on their adolescent clientele. In addition to changing provider attitudes the training addressed adolescent-specific reproductive health issues. The combination of training and non-training interventions improved provider performance, empowered adolescents and increased their access to reproductive health services.

Room 1

Training Site Development – What are the Ingredients for Success?

Anita Gibson

Kamlesh Giri

Maternal and Neonatal Health Program

Preparing sites to offer group-based and structured on-the-job training requires advance planning and coordination among government and NGO partners in addition to working with providers and managers at the selected site. This session will analyze experiences with establishing group-based midwifery training and structured on-the-job training for post-abortion care. Areas of focus will include: preparing staff to offer training while minimizing service disruption, understanding con-

siderations for training in a group-based setting, training interventions such as daily all-hands-on-the-job training, staff participation in the training and the role of the trainer in establishing a local group-based training process, and service delivery and monitoring programs.



Concurrent Sessions

Room 4

Distance Learning: Lessons from the Field

Nancy Kiplinger

Intra-PRIME

Distance learning helps overcome barriers to training healthcare providers in low resource settings including geographic distances and transportation costs, loss of services for long distances, providers are away for training, and the costs of the available for providers to receive training. Distance learning time between learning and applying learning is a challenge.

Distance learning can be effective in a variety of settings provided it is carefully designed and implemented and includes a strong learner support system. This presentation will describe a process to develop distance learning through the example of a PRIME innovation in Uganda.

Room 3

Ensuring the Effectiveness of Training by Using a Performance Improvement Approach

Wallace Hammum

Intra-UNC School of Medicine

Pauline Mububu

Intra-PRIME

This presentation will summarize best practices for designing and implementing training interventions as part of performance improvement initiatives. Using examples from the Intra's work in East and Southern Africa, presenters will describe lessons learned training practices, a combination of training interventions that work best in combination with non-training interventions to address performance on the job. The presentation will compare strategies and techniques found to be useful in ensuring training effectiveness by addressing performance factors that influence the application on the job of key knowledge, skills gained through training. The theme is that training can be enhanced when conducted within a performance improvement framework.

DAY II AGENDA

Room 2

Evaluation of Impact of Cascade Training Approach on Family Planning Services and Infection Prevention Practices

Cathy Toroitich-Ruto

Family Health International

Findings of two trainings on evaluation of Family Planning (FP) and Infection Prevention (IP) training conducted using a Cascade approach in Kenya and Tanzania will be presented. The training programmes were aimed at addressing issues of rapid capacity building in FP and IP as well as efficient and effective transfer of knowledge, skills and attitudes among service providers in Kenya and Tanzania. The evaluation methodologies involved observations, interviews and structured questionnaires. Findings showed that the cascade approach yields a rapid multiplier effect in human resource capacity building and good transfer of FP and IP knowledge, skills and attitudes.

Lounge 1

Designing Counseling Training that Works

Gail Rae

Population Leadership Program

Counseling is a fundamental element of health service delivery so what counseling content and training methods have the most impact? Participants will explore key components of good counseling and the importance of four specific counseling content areas: knowledge, attitudes, behavior and context. Special attention is paid to what research says about self-efficacy, self-awareness and empathy.

Excellent counseling training also requires evidence-based best practices in training, such as using quality standards in curricula design, micro-skills training, modeling, supervised practice, peer review, self-assessment, positive reinforcement, using multiple learning approaches, and fostering a strong learner support system. This session includes lessons from life and research plus activities.

Lounge 2

Whole-site Training for Sustained Results: Egypt and Tanzania Experiences

Grace Engesia Wambua

EngenderHealth

Assessing and meeting the learning needs of all staff at the service site and applying learning to their work setting through Whole-site training creates institutional capacity and support, fosters problem-solving, and stimulates transfer of learning within the institution for wider, ongoing application of new skills. Egypt and Tanzania case studies illustrate the elements, process and benefits of Whole-site training approach, leading

to a common understanding of critical issues that engender behavior change and integration of new skills into routine services, strengthened teamwork, and enhanced chances of sustained capacity even when those initially trained are absent or reassigned.

Main Hall

Training Clinical Decision-makers: Nurses and Cervical Cancer Prevention

Sylvia Degamus

JHPIEGO

For the past two years the Cervical Cancer Prevention Program (CECAP) of JHPIEGO has been training nurse midwives and public health nurses in visual inspection of the cervix and cryotherapy. As part of this initiative, CECAP has developed methodologies to provide nurses with both procedural and clinical decision-making skills. Some of the novel aspects of this training include: independent clinical co-assessment by nurses and doctors, video review of clinical training and an innovative multimedia CD-ROM containing digital images of the cervix. Trainees achieve both procedural competence and confidence in making clinical judgments, enabling them to recognize and manage precancerous cervical lesions.

Room 13

Use of Competency-based Assessment Tools in Clinical Skills Development

Emmanuel Otolorin

JHPIEGO

Being able to measure learning progress satisfactorily and evaluate performance objectively are extremely important elements in the process of improving the quality of training. Traditional preservice education as well as inservice training in high and low-resource settings has not always addressed this issue. The end result of this is that students often exit from training institutions without the expected competencies for their future role in the community. This interactive session will share lessons learnt in the use of learning guides for clinical skills development and checklists for performance evaluation and supervision. The goal of training is to ensure that knowledge and skills learnt during training are transferred to the job.

Room 1

Trainer Development for Decentralization of Postabortion Care Services: The Guinean Experience

Yolande Hyjazi

Faculty of Medicine, Conakry

Tsigné Pleah

JHPIEGO

DAY II AGENDA

After the introduction of PAC at the maternities of the two Guinean teaching hospitals in 1999, expansion to the level of 9 regional and prefectural health facilities took place in 2001 and 2002.

The Guinean Ministry of Public Health, in collaboration with JHPIEGO, developed and implemented a training network to support the decentralization and sustainability of PAC services. This process included the development of national trainers, use of these trainers for PAC expansion activities, identification and development of regional trainers, and preparation of a regional training site.

This presentation will describe the process, results, and lessons learned from the process of decentralizing PAC training.

4:00 PM - 5:30 PM

Concurrent Sessions

Room 4

Licensed to Practice: Assessing Graduates of Strengthened Preservice Education

Susan Griffey Brechin

Kama Garrison

JHPIEGO

Traditionally, licensure or certification for a healthcare provider to practice has been based on written exams which emphasize knowledge rather than skills. Some clinical decision-making skills can be assessed in written form, but others cannot. A challenge of reforming preservice education to ensure competency-based training is defining formal assessment of student skills before graduation. At issue is the number of students to be assessed and the availability of faculty to perform the assessments. How many skills should be assessed? And how to do this efficiently?

JHPIEGO has adapted Observed Structured Clinical Examination (OSCE) to assess student skills. Using simulations and OSCE in an evaluation, allows for standardized observations of all students. Additionally, clients are protected when student competency in a skill isn't known. This workshop will also provide the opportunity to discuss the necessity and approach to increasing inter-rater reliability. This concurrent session will our expertise with these assessment methods and their implications. It will also review results for key questions (how competency-based training methods affect skill retention in a preservice setting, the relationship between a provider's experience practicing a specific skill and confidence and competence, determining acceptable performance of sentinel skills for providing FP and/or labor delivery services). Experiences and results from programs in Morocco, Ghana, Mali, Kenya and others will illustrate these concepts.

Room 3

Developing Effective Trainers for Sustainable Training Systems: Lessons Learned

Lunab Ncube

JHPIEGO

Mary Jonazi

Queen Elizabeth Central Hospital

Mathias Yameogo

Maternal and Neonatal Health Program

Sustainable training systems need trainers who can train providers (clinical trainers), train new trainers (advanced trainers) and design courses (master trainers). Each of these levels calls for unique skills, which require coursework and practice to master. JHPIEGO has developed a trainer development pathway that outlines the steps that will assist clinicians to make the transition from provider through each of these trainer levels. In this session, this process will be described and illustrated by 3 case studies: developing regional expert trainers in Africa; assure capacity building and sustainability; developing skilled attendants and clinical trainers in thirteen health centers in one district of Burkina Faso; and developing trainers in Malawi for in-service and preservice Reproductive Health training systems. Lessons learned will be highlighted.

Room 2

Training to Build Capacity for Long-term and Permanent Methods (LTPM) of Family Planning

Henry Kakande

IntraH Consultant

This presentation will describe a training approach used to build capacity for decentralized LTPM service provision. It will highlight the DHS II Project's successful experience in on-site training of multidisciplinary teams to create client interest and provide access to clinical services in outreach facilities for long-term and permanent methods of family planning including vasectomy, tubal ligation and Norplant. As a result of this team training approach involving visiting physician/nurse teams, state clinic providers and community health workers, LTPM clients increased almost six-fold in one year. This training approach was implemented after providers trained separately on 6 as teams in classroom clinical training approach was not successful in initiating LTPM services or attracting clients.

DAY II AGENDA

Lounge 1

Move Forward with Teachback: A Unique Methodology for Training Trainers

Michele Evering-Watley

Catherine A. McKinney

Cheryl Tryon

Cheryl D. Mayo

Centers for Disease Control and Prevention (CDC)

An important aspect of training trainers is to not only teach them the course content, but also enable them to gain the training skills necessary to teach the course to others. This session focuses on the Teachback training methodology which uses a systematic process for training trainers to teach others what they have learned. Attend this session and learn about this exciting and unique methodology and how it can be adapted to various courses for training trainers.

Lounge 2

Combining Postabortion Care (PAC) Clinical and Structured On-the-Job Training (OJT) Skills for Sustained Results: Malawi Experience

Joseph Ruminjo

Engender Health

The session will focus on best practices in training of trainers for provision of postabortion care. Drawing on results from Malawi, the session will document the value of using an individualized competency-based approach and structured on-job training (OJT) that utilizes humanistic methods such as anatomic models and actual instruments in simulated service delivery situations, in order to improve both trainer and provider performance and client satisfaction.

Main Hall

Importance of Training Sites in the Competency-based Training Approach

Paul Sossa

JHPIEGO

Well-developed training sites can be an excellent approach for transferring practical skills to reproductive health (RH) providers. The development of training sites should include:

- Preceptors with excellent coaching skills
- Anatomic models
- Appropriate teaching materials
- Adequate client load

Training sites offer providers resourceful practical training conditions. Providers can acquire mastery of required skills to provide quality RH services by the end of the training. This session will share lessons learned from using training sites to support the competency-based training approach in the Family Health and AIDS (FHIA) Project demonstration countries.

Room 13

Towards Adolescent-friendly Clinics - the Use of Values Clarification to Facilitate Change in Public Health Clinics

Melanie Pleamer

University of the Witwatersrand
Chris Hani Baragwanath Hospital

The attitudes of health care providers is one of the main barriers to young people seeking health care. In its work to facilitate change in public health clinics, the National Adolescent-friendly Clinic Initiative (NAFCI) has developed a Values Clarification process as part of its entry point training at clinics sites.

The presentation will describe:

- the values clarification approach as an important component for health care provider training;
- why and how it has been used as a key training strategy in the promotion of adolescent-friendly services;
- why and how all categories of staff have been included in the process;
- the usefulness of values clarification as a training approach with other aspects of sexual and reproductive health, lessons learnt and preliminary evaluation results.

Room 1

Training for Home-based Care - Nurses, Community, Traditional Healers

Felishela Gaspar

Ministry of Health Mozambique

With all 5 groups, we use a participatory methodology, including simulated training sessions, role play and dramatization. Training areas:

- information, prevention
- care of opportunistic infections and referral
- counseling

It is particularly important in a low resource setting for trainers to practice transmitting their newly acquired knowledge. This is a chance for further learning and correction of misconceptions in an informal atmosphere, where trainers feel comfortable to explore questions, doubts and fears.

Training of Traditional Healers and community volunteers have presented special challenges for which taking time to explore concepts of causation is mandatory.

**A Demonstration of
Strategies/Techniques from
the *Transfer of Learning Guide*:
Using a Distance Learning Approach to
Transfer Knowledge and Skills**

Stembile Matatu-Mugore

Reproductive Health Clinical Specialist
Intrah Consultant
94 Observatory Dr.
Woodhill
P.O. Box 60068
Pretoria 0076
South Africa
Phone: 27-12-908-3851
E-mail: mugore@mweb.co.za

Anne Otto

Assistant Clinical Services Advisor
Kampala, Uganda
Regional Office
P.O. Box 4958
00100 Nairobi
Kenya
Mobile Phone: 256-077-553341
Phone: 254-2-211820
Fax: 254-2-226824
E-mail: contact through Intrah Nairobi

A Demonstration of Strategies/Techniques from the *Transfer of Learning Guide*: Using a Distance Learning Approach to Transfer Knowledge and Skills

Stembile Maturu-Mugore
Reproductive Health Clinical Specialist, IntraH consultant

Anne Otto, IntraH consultant
Clinical Services Advisor, IntraH consultant



Transfer of Learning Guide

- Why does good training fail?
 - training was not the right "fix"
 - training is only part of the solution



Transfer of Learning Guide

- What factors affect performance?
 - job expectations
 - performance feedback
 - physical environment and tools
 - motivation
 - skills and knowledge

Organizational support is key to success!



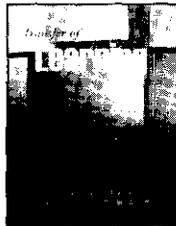


Transfer of Learning Guide

- What is the TOL process?
...an interrelated series of tasks performed by supervisors, trainers, learners and co-workers before, during and after a learning intervention in order to maximize transfer of knowledge and skills and to improve job performance...



Special Features of the Transfer of Learning Guide



- Case Study
- Transfer Matrix
- Action Plan



Case Study

- Highlights factors that may influence performance
- Illustrates how several interventions, training and non-training, must work together



**Key strategies:
During learning**

- Match training activities to intervention goals
- Give learners the time to learn



**Key strategies:
After learning**

- Provide on-going support and resources
- Monitor learner progress
- Make adjustments as needed



Apply transfer process...

- to any learning approach and combination (blended) approaches
- in various supervisory arrangements (on-site or visiting)
- in your next intervention design or re-design



What else?

- Available in English, French and Spanish
- Interactive, computer-based versions also available
- Help us evaluate the guide!



Learner Support: The Key to Transfer of Learning





Learner Support Systems

Infrastructure designed to facilitate learner achievements before, during and after the learning intervention

- learning materials and activities
- facilitators, peers
- administrative support



Featured Learning Intervention

Delivery of Improved Health (DISH)

Africa

Situation in Uganda

- Nurse aides/nursing assistants with little formal training
- MOH upgrading NA cadre's skills to provide essential health services
- DISH DL course
 - supplements FP content
 - DEP course offering

Africa

Transfer Strategies Used

	Before Learning	During Learning	After Learning
Supervisors	Oriented		Action plan
Tutor/mentors	Selection criteria		
Learners		Actively engaged	
Co-workers			

Africa



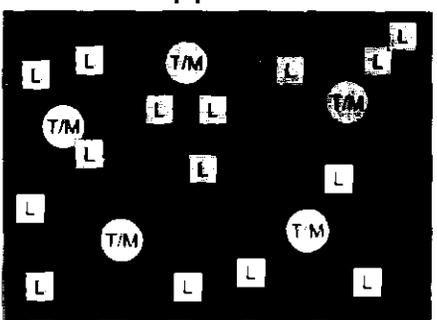
Course Design

- Highly-structured, 12-week, print-based distance learning course in family planning
- Tutor mentors, in-charges and co-workers involved in activities with learners

Africa



Learner Support in District



Africa



Tutor/mentor Support

- Orientation to course and targeted facilitator training
- Monthly support meetings
- DL coordinator based in district



Africa



Intervention Results

- Learners improved FP/RH knowledge and skills
- Training strategy/approach successfully re-purposed to train other cadres in different topic areas



Lessons Learned/Challenges

- Provide adequate learner support
- Provide training and on-going support to program organizers, supervisors and trainers
- Find better ways to link training interventions with non-training interventions and performance support systems

**Individualized Training
Achieves Competency with
Limited Caseloads,
Reduces Training Burden**

Richard Hughes

Associate Director,
ESA Region
Country Director, Zambia
JHPIEGO Corporation
Phone: 260-1-256255
260-1-256256
260-1-256257
Fax: 260-1-253839
E-mail: rhughes@jhu.edu

Velepi Mtonga

Acting Director
Clinical Care and Diagnostic Services
Central Board of Health, Zambia
Phone: 260-1-253179
Fax: 260-1-253173
E-mail: vmtonga@cboh.org.zm

Kamlesh Giri

Reproductive Health Advisor
JHPIEGO Corporation
1615 Thames Street, Suite 300
Baltimore, MD 21231-3492
Phone: 410-537-1900
Fax: 410-537-1470
E-mail: kgiri@jhpiego.org



Individualized Training
Achieves Competency with
Limited Caseloads,
Reduces Training Burden

JHPIEGO

Mr. Rick Hughes Country Director, JHPIEGO, Zambia
Dr. Kamlesh Giri RH Advisor, JHPIEGO, Baltimore
Dr. Velepi Mtonga Director, Clinical Care & Diagnostic
Services, Central Board of Health, Zambia

Objectives

- Describe the Individualized Learning Approach and its different applications.
- Discuss field experiences in using the Individualized Learning Approach to overcome different constraints:
 - Limited Case Load (NSV training in Nepal)
 - Emergency Setting (PAC training in Zambia)
- Apply lessons learned with Individualized Learning to various training situations.

Competency-Based Training

- What is the ultimate objective?
 - Service providers giving quality services
- What does that require of the trainee?
 - Technical Competence, and
 - Confidence to provide the service
- To achieve this, the trainee needs to apply her/his knowledge in practice, in a realistic setting and situation

Group Based Learning

- Train many participants at one time
- Fixed course schedule
 - Illustrated lectures
 - Observations
 - Demonstrations
 - Clinical Practice
- Participants and trainers are engaged full-time
 - Takes them away from normal duties of service provision

Achieving Competency

- Requires hands-on practice
 - Need enough client load for each participant to achieve competency, and confidence
- This can be a challenge where there is:
 - Low case load
 - Irregular client flow (e.g., emergency situations or infrequent procedures)

Solutions to Limited or Irregular Case Loads

- What are some possible solutions to situations in which there are limited case loads or irregular client flow?
- Here are some thoughts:
 - Increase the duration of training
 - Decrease the number of trainees
 - Alter the format to allow maximum use of cases when they present (fewer "missed opportunities")

Individualized Learning Approach

- Places the primary responsibility for "moving" through the objectives and related learning activities on the participant
- Does away with lectures and reduces the burden on the trainers
- Utilizes a flexible schedule, so that it is easier to make maximum use of cases when they are available

Individualized Learning Package

- Reference Manual
 - Contains the essential, need to know information related to the course objectives.
- Participant's Guide
 - Road map to guide the participant through the course
- Trainer's Guide
 - Contains the participant's handbook materials as well as answer keys and trainer's tips
- Supervisor's Guide (when needed)
 - Contains important information for the supervisor on the course content, management, & supervisory tasks
- Anatomic Models and Audiovisuals
 - Required for completing the various assignments

Comparing Group & Individualized Learning Packages

- Similarities
 - reference manual, anatomic models, audiovisual learning aids
 - pre- and post-tests, learning guides and performance checklists are the same
- Primary differences
 - course outline
 - structured learning activities
 - supervisor's guide

Comparing Group and Individualized Learning Courses

- **Group-based learning courses put the burden on the trainer**
 - trainer directs the participants' learning
 - illustrated lecture, demonstration, structured practice
 - course schedule designed to cover the material and skills in the time allotted
- **Individualized learning courses put the burden of moving through the course on the participant**
 - structured practice exercises direct participants' learning (knowledge)
 - trainer "supervises" their learning
 - trainer can focus more on the clinical teaching
 - course outline allows flexibility to maximize clinical teaching time

10

Advantages of Individualized Learning Courses

- **Putting the burden on the participant to move through the course reduces the burden on the trainer**
 - Trainers can continue to provide services
 - Enables a lower participant : trainer ratio
 - Diminishes trainer "burn-out"
- **Flexible schedule allows for maximum use of case load**
 - No fixed sessions – easier to adjust when clients are available
 - Participants can move at their own pace, and get to clinical practice stage earlier

11

Advantages of Individualized Learning Courses (cont.)

- **Flexible schedule allows for a variety of applications**
 - **On-the-job training**
 - Can be accomplished flexibly while continuing to perform normal functions
 - **Training staff from near-by sites**
 - Can be accomplished flexibly, by having the participant(s) come on a periodic schedule
 - **Training staff from far-away sites**
 - Can be done in a fixed time period, but still accommodating a small number of participants with minimal disturbance for the training site

12

Lessons Learned

- **Dr. Kamlesh Giri: Lessons learned from the Nepal NSV Individualized Learning Experience**
 - Low case loads
 - Maximum 2 trainees at a time
 - Manpower constraints at service & training sites
- **Dr. Velepi Mtonga: Lessons learned from the Zambia PAC Individualized Learning Experience**
 - Low case loads at all but a few sites
 - Irregular client flow & timing
 - Severe manpower constraints at service and training sites

13

Lessons Learned from the NSV Training Program in Nepal

- Competency Based Training (CBT) for family planning programs in Nepal started in 1994
- All family planning trainings were group-based, both in the public sector as well those conducted by NGOs
- Challenges for group-based training:
 - Trainers felt stressed in conducting numerous group-based trainings to meet the national training needs
 - Limited caseload especially for surgical procedures to achieve competency in given duration of time
 - "Compressed FP Season" for voluntary sterilization

14

Rationale for Introducing Individualized Training

- Relieve trainers from conducting theoretical presentations one after the other to meet the national training demand
- Relieve trainers from conducting theoretical training for very small number of participants (2 at a time)
- Trainers can continue to provide service while training is going on

Rationale for Introducing Individualized Training

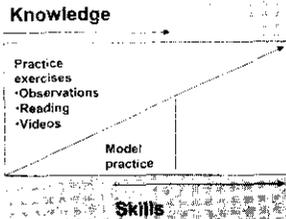
- Limited clinical staff in district health facilities
- Providers may spend less time away from work
- Create opportunities for larger facilities to train in-house providers using individualized training approach
- Provide opportunity for staff from satellite sites to be trained in clinical procedure

16

Individualized Training Approach

Individualized training for No-Scalpel-Vasectomy designed in 1999 and pilot tested the same year

Time distribution for training activity



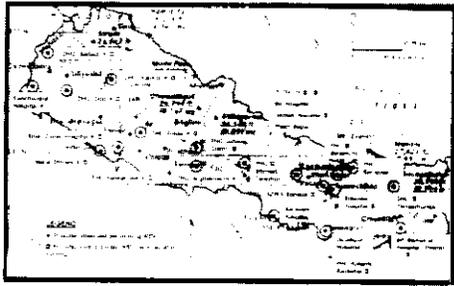
17

Evaluation Questions

- Trainers and participants' perspective on:
 - What are the advantages and disadvantages of individualized learning package?
 - Can trainers adequately maintain clinical responsibilities while conducting NSV individualized training?
 - Have NSV individualized training participants been providing NSV services post-training?

18

NSV Study Sites



Evaluation Study

- NSV providers trained **Sept '00-Sept '01 with Individualized Training Approach**
- 27 providers interviewed
 - out of 30 trained
- 18 actively providing services
 - 11 out of 18 provided services in outreach surgical FP services
- 6 active clinical NSV trainers interviewed
 - out of 7 total

Advantages Compared to Group-based Training

- | <u>Participants</u> | <u>Trainers</u> |
|--|--|
| <ul style="list-style-type: none">• 30% - equal clinical participation• 26% - learning style promotes self-learning• 22% - saved time on length of course - reduction mostly during knowledge acquisition part - potentially use more time for clinical exposure | <ul style="list-style-type: none">• Promotes self-learning• Enables trainers to provide needed clinical service in between meeting with participants (4%) and other administrative tasks• Allows for more time for clinical exposure |

Disadvantages Compared to Group-based Training

Participants

- 22% - difficulty on "self-learning"
- 15% - found the schedule to be "loose" – would have preferred a more restrictive schedule
- 42% - found no disadvantage to the training approach

Trainers

- Some participants not comfortable with self-learning
- 5/6 said – able to fulfill their clinical duties while using individualized approach for NSV

22

Additional Findings

- Differently qualified participants (e.g. MBBS versus MS or OBGYN) took different lengths of time for completion
- Some participants were able to leave training earlier when they complete training at a quicker pace
- Individualized Training relieved trainers of the "burn-out" from giving theoretical training to a small number of participants one after another

23

Summary: Lessons Learned in Nepal

- Approach allows flexibility to suit the length of training to individual needs
- Trainer able to balance time between training and service delivery
- Allows multiple training events one after another with small number of participants to allow for low caseload
 - Without undue stress to the trainers
 - With less disruption of regular service delivery at site

24

Summary: Lessons Learned in Nepal

- Approach can reduce training time for participants who are motivated and gain competency quickly
- Trainers should emphasize nature of individualized training approach to participants at the outset
 - Prepare participants for individual working style and schedule

Lessons learned from the PAC training program in Zambia

PAC Needs Assessment (1998):

- Some good news . . .
 - MVA introduced in 1990
 - All medical students trained in MVA
- . . . and some not so good news
 - Very limited availability of MVA due to lack of equipment
 - Not introduced in a constellation of PAC services

Background (cont)

- No linkage to FP or other RH services
- Poor infection prevention practices
- Legal limitations
- CBoH formed the National PAC Task Force, 1999
 - To introduce PAC services into 500 district clinics
 - BUT there was limited governmental and donor support
- Development of National PAC Strategy Plan
 - Phase I - National Training
 - Phase II - Provincial Training

PAC Individual Training Approach

- The National PAC Task Force adopted the PAC Individualized Learning Package and approach for its flexibility within a structured framework
 - Structured approach to achieve competency
 - Ability to train small numbers of providers to maximize use of client load
 - Therefore, quality competency-based training is possible at sites with lower case loads
 - Interest in building capacity for on-the-job training within institutions to enhance sustainability

28

Learning Approaches

- Phase I – Modified Individualized Approach
 - To establish the initial 3 National Training Centres
 - Individualized Training Package used for PAC clinical skills, but with a larger group of participants
 - ModCAL CTS used for clinical training skills
- Phase II – Individualized Learning Approach
 - for establishing 7 Provincial Training Centres

29

PAC Individual Learning Package Implementation

1. Used for training small groups of participants from remote sites
 - A few trainees are selected
 - Once their site is adequately prepared, they travel to the training site
 - Complete the PAC skills training in 2 weeks

30

PAC Individual Learning Package Implementation (cont.)

2. Used for on-the-job training of doctors and nurses within training sites
 - Should be following the 35 day course schedule
3. Trainees near the training sites (satellite sites) can use an intermediate approach, coming to the training site periodically (1 or 2 days / week)

31

PAC Individual Learning Package Implementation (cont.)

- Sites established with Individualized Approach
 - 7 quality PAC service sites established
 - 6 of these sites have also completed CTS and are conducting at least some OJT using the individualized training package
 - 4 more sites have completed initial PAC orientation and strengthening of underlying services, awaiting PAC clinical skills training and clinical training skills training

32

How has it worked? Lessons Learned

- ### Incorporation of nurses & midwives
- The recent enactment of the Nurses & Midwives Act 1997 allows midwives and nurses to be trained and to provide a wide range of services
 - Flexible approach makes it easier to train a mixed group
 - Physicians with more personal experience in PAC
 - Nurses and midwives with less clinical PAC experience

33

On-the-Job (OJT) vs 2 week Individualized Training

- Asked both trainers and trainees to compare:
 - The "true" OJT approach (35 day course schedule, on-site)
 - The "modified" 2 week individualized learning approach

34

Advantages of OJT

Trainer's Perspective

- Allows assimilation of materials by participant based on participant's pace
- Does not interfere with ward duties/service delivery
- Easier to follow-up, assess and give feedback
- Slow learners can still learn
- Ensures application of knowledge
- Easier to motivate trainee as rapport easily developed
- Easy to adapt
- Less stressful
- Transfer of knowledge higher

35

Advantages of OJT (cont.)

Trainee's Perspective

- Allows to do things at own pace
- Allows more practice and faster skill acquisition
- More attention given to trainee
- Emphasis on doing the correct things
- Makes you accomplish assignments and to read training materials
- Immediate feedback
- Enables to share feelings and ask questions freely
- Stationed in own environment therefore easy to adapt
- More time to understand issues
- Better acquisition of knowledge
- Less stressful
- Less competition for models and clients

36

Disadvantages of OJT

Trainer's Perspective

- Takes too long
 - staff movements
 - change of management
- Trainee robbed of free time
- Costly for trainee, especially if stays over lunch
- Can only train few trainees
- Trainees have no-one to compare and share ideas with
- Trainers on their own therefore no-one to consult with

Trainee's Perspective

- No-one to share ideas with
 - individual ideas vs group ideas
- Difficult for trainer & trainee to get together
- Disruption of sessions from work
- Needs a lot of time
- Needs more trainers for more students

Summary: Lessons Learned in Zambia

- OJT might be the best way to go, but . . .
 - Not all sites have adequate staff, trainers and client flow needed to do quality, structured OJT
 - Maintaining the momentum of OJT, to conduct and complete routine, ongoing training, is difficult
 - Asking staff to do OJT on top of full-time work without added incentives or extra time allocated can be difficult

Summary: Lessons Learned in Zambia

- Individualized training with a small group at a remote site works well
 - Small groups can still maximize practice using available client load
 - Retains some benefits of group learning dynamics
 - Flexible approach allows those who need more practice to get it
 - Burden on trainers is reduced over traditional group-based training
 - Allows training all sites, even those with low for group-based training, through decentralization and

Summary: Individualized Training – Pros

- **Shifts some burden from Trainer to Trainee**
 - Lessens "burn-out" of trainers
- **Allows trainers to continue to provide services**
 - Less disruption to the training site
- **Allows trainees to progress at their own pace**
 - Accommodate different cadre or learning styles and capacity
- **Progress to clinical practice more quickly**
 - Maximize available client load when cases are limited
- **Flexible schedule**
 - Maximize available client load when timing is unpredictable

40

Summary: Individualized Training – Pros (cont.)

- **Flexible approach**
 - On-the-Job Training
 - Satellite site training on periodic basis
 - Fixed duration training for further removed sites
- **Self-directed learning may improve ability to self-correct**
 - Putting more of the burden on the learner **MAY** better prepare them to go back and use the materials if they run into a problem or are unsure of themselves

41

Summary: Individualized Training – Cons

- **Not easily adapted for large groups**
 - Loses its advantages over group-based training
- **Materials must be well prepared and appropriate**
 - Practice exercises
 - Audiovisual aids
- **Trainer less able to make on-the-spot changes**
- **Requires discipline and motivation of both Trainer & Trainee**
 - Assumes principles of adult learning
- **Some benefits of group learning may be diminished**
 - Shared experiences, variety of points of view

42

From Acquiring Knowledge and Skills to Being Able to Do the Job: Evolution and Current Status of Training Evaluation

Rose Wahome

Program Officer
East and Southern Africa Region
Intrah PRIME
P.O. Box 4958
00100 Nairobi, Kenya
Phone: 254-2-211820
254-2-211821
Fax: 254-2-226824
E-mail: rwahome@intrah.org

Jedida Wachira

Regional Director of Programs
East and Southern Africa Region
Intrah
P. O. Box 4958
00100 Nairobi, Kenya
Phone: 254-2-211820
254-2-211821
254-2-230382
Fax: 254-2-226824
E-mail: jwachira@intrah.org

From Acquiring Knowledge and Skills to Being Able to Do the Job
 Evolution and Current Status of Training Evaluation

Rose Williams
 Program Officer for East and Southern Africa Region
 (Lead) PR ME

Ahmed J. Fom MC, PhD
 Associate Director for Research and Evaluation
 (Lead) The PR ME Project

Jedrej Wachira
 Regional Director of Programs for East and Southern Africa Region
 (Lead)

PR ME II
Africa
 For People & Country's Growth

Session Breakdown

- M&E model
- Working definitions
- Training monitoring and evaluation
- Performance evaluation
- Methodologies and tools
- Challenges and constraints
- The way forward

PR ME II
Africa
 For People & Country's Growth

M&E Model

Outcomes

PR ME II
Africa
 For People & Country's Growth



Working Definitions

- Monitoring
 - Assesses activities and outputs
 - Judges timeliness and adequacy
 - Looks at processes and outputs
- Evaluation
 - Measures results
 - Judges project/program success
 - Looks at effects and impacts



Training Monitoring



- Processes
 - Curriculum design
 - Participant selection
 - Venue/materials preparation
 - Use of training methods
 - Learner support



Training Monitoring



- Outputs
 - Number of courses conducted
 - Number and characteristics of people trained
 - Training quality
 - K's L1
 - Training effectiveness
 - K's L2

Training Evaluation

- Effects
 - Coverage
 - Range of services and methods
 - Client characteristics and satisfaction
 - Providers' performance on the job
 - Ks L3

PRIME II
Africa
The People, The Power, The Future

Training Evaluation

- Impact
 - CPR
 - MMR
 - HIV transmission rate
 - FP discontinuation and reasons
 - TFR

PRIME II
Africa
The People, The Power, The Future

Performance Evaluation

- Performance
 - Behavior
 - Skills
 - Competency
 - Proficiency
 - Quality of care (QoC)
 - Accomplishments
 - Client outcomes

PRIME II
Africa
The People, The Power, The Future

Examples of Indicators

- From the audience...

PRIME II
Africa
East Africa's Economic Future

Focus of Evaluation

Institutions/SDPs 	Providers 
Clients 	Population 

PRIME II
Africa
East Africa's Economic Future

Methodologies and Tools

- Methods
 - Institution-based
 - Facility-based
 - inventories
 - Providers
 - Clients
 - Population-based

PRIME II
Africa
East Africa's Economic Future



Institution-Based Methods and Tools

- Institution capacity-building
 - MSH's MOST (1996)
 - PRIME (T.R. #16, 1999)
 - USAID/CDIE (TIPS #15, 2000)
 - MEASURE/Evaluation (2001)
- Measuring capacity to
 - Design curricula
 - Maintain resources
 - Conduct and evaluate quality training



Facility-Based Methods and Tools

- Inventories
- Provider interviews
- Provider observations
- Self-assessment among providers
- Client and service statistics
- Client interviews



Inventories

- Used in Situation Analysis, QIQ, SPA and other methods/tools
- Looks at infrastructure, equipment, supplies, protocols and systems
- Assesses SDP conditions
- Complements data for QoC
- Used for minimum capacity, accreditation



Provider Interviews

- Looks at perceptions, attitudes, knowledge, practices and needs
 - Consumer orientation
 - Barriers and biases
- Assesses factors affecting performance
 - Recognition and incentives
 - Supervision and feedback



Provider Observations

- Direct and through simulated clients
- More objective than self-assessments
 - Optimal behavior
 - Intense observer training
- To observe:
 - Competency and proficiency
 - Interpersonal relations
- Complements QoC



Facility-Based Tool

TABLE OF QO INDICATORS

Indicator Number	Indicator	Client Exit Interview	Observation	Facility Audit
PROVOCN				
I-1	Does the provider provide training to the client?			
I-2	Does the provider provide counseling to the client?			
I-3	Does the provider provide information to the client?			
I-4	Does the provider provide support to the client?			
I-5	Does the provider provide referrals to the client?			
I-6	Does the provider provide information to the client?			
I-7	Does the provider provide information to the client?			
I-8	Does the provider provide information to the client?			
I-9	Does the provider provide information to the client?			
I-10	Does the provider provide information to the client?			
I-11	Does the provider provide information to the client?			
I-12	Does the provider provide information to the client?			
I-13	Does the provider provide information to the client?			



Self-Assessments

- Used for CQI/QA
- Empowers providers
- Uses relevant indicators because it is "internal"
- Less objective for program evaluation?
- Requires commitment and leadership



Client and Service Statistics

- Relatively unused
- Looks at number and characteristics of clients and services
 - Age, sex and marital status
 - Number of new services/methods
- Can assess quality of care
- Affected by reliability, quality and validity constraints



Client Interviews

- Exit interview responses proved consistent with observations
 - Counseling
 - Information
- Client interviews for other purposes
 - Tailoring services to needs



Population-Based Methods and Tools

- In-depth interviews
- FGDs
 - Users
 - Non-users
 - Discontinuers
 - Potential customers
- HIH surveys
 - WRA, men and adolescents



Lessons Learned, Advances, Challenges

Lessons Learned



Advances





Challenges



Lessons Learned

- No templates
 - Common principles
 - Unique situations
- Importance of baselines
 - Plan and budget
- Educate donors and counterparts
- Dissemination not a natural outcome

Advances in Design

- Evolution from classroom to workplace
- "What was learned?"
▼
"How was learning applied?"
▼
"What were the results?"

PRIME II
Africa
For People & People's Learning

Advances in Design

PRIME II
Africa
For People & People's Learning

Advances in Methodology

- Staggered control/comparison groups
- Multi-level analysis
- GIS
- Sampling alternatives/LQAS

PRIME II
Africa
For People & People's Learning



Challenges

- Limited evaluation mandates
- Non-integrated evaluation
- Attribution
 - Training alone may not account for results observed
- Sampling
 - Facilities/providers as units of measurement
 - More work and fewer numbers



Challenges

- Increased simultaneity of interventions
 - "Who did what?"
- Control groups are complex and rare



The Way Forward

- Improved collection of behavior-related data
- Increased use of client/clinic statistics
- Increased use of data linkages
 - Training ↔ outcomes
- Estimate population catchment from trained provider



The Way Forward

- Integrated evaluation agenda
 - Partnering of institutions/projects
 - Collaborative efforts to measure training effects and impact



From Acquiring Knowledge and Skills to Being Able to Do the Job

Evolution and Current Status of Training Evaluation

Amesha L. Ford, MEd, PhD
Associate Director for
Research and Evaluation
within the PRIME II Project

**Design Your Audience
into
Your Training Program**

Gail Rae

Manager

Professional Development

Population Leadership Program

529 14th St., NW, Suite 1030

Washington, DC 20045

Phone: 202-661-8021

Fax: 202-661-8029

E-mail: grae@popldr.org



Audience Space Design

By Gail Rae, Population Leadership Program

grae@popldr.org

(202) 661-8023

Audience Space Design means never again worrying about audience energy and involvement. This session will teach you a technique that experienced trainers acquire, but don't often share. The best trainers 'intuitively' tailor their presentation to their audience and can 'go with the flow' while still achieving the training goals. How do they do it?

During this session, we will move from a focus on "how I will present" to "what they want to know." Your audience will appreciate the genuine interaction and you will increase your confidence as a presenter and facilitator of an exciting and respectful learning environment. We will focus on what specific members of the audience bring to the session and how to build on their experience, their knowledge, and their stories -- even though you never met them in your life.



Create Space for Your Audience to Charge Ahead!

"More thought...needs to be given as to whether it is enough to put the client in the driver's seat, and whether a larger role for the client in terms of choosing whether to have the car in the first place and then also having a say in designing and engineering the car may also be needed for full empowerment."

--David Ellerman



Population Leadership Program



Why Bother?

The quickest and easiest way to design a seminar is to:

- 1 - Think of what you want to impart to your audience.
- 2 - Determine the relevant characteristics of your audience.
- 3 - Research appropriate material.
- 4 - Develop the course content.

Other considerations for course development.

Create Space for your Audience

Welcome audience contributions

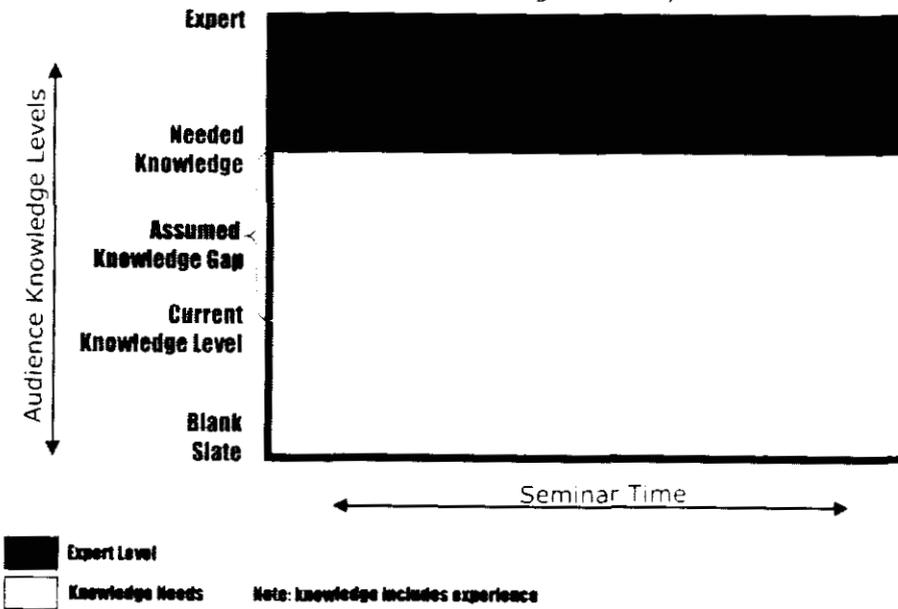
- **Make space for your audience.** Write it into your seminar structure. When this does not occur, the audience may still contribute, but are apologetic about it and act as if it is an interruption. Depending on the context – if there are no more than 40 participants, you can allow questions and comments during your talk.
- **How can I invite my audience in?** Recreate your talk into a discussion. Lay out your lecture notes in sequence. Look carefully at each topic on your list. For each topic, place a checkmark next to each item your audience knows something about. Even if you are sure they do not know what you are about to tell them, allow them first to set the stage. Allow them to see what the gap is between what they already know and what additional information you will give them.
- **Honor the knowledge your audience possesses.** Pose a question for them, ask them to discuss the topic and offer their suggestions.



Population Leadership Program
A Program of the Bill & Melinda Gates Foundation



Seminar Content Planning Model *Filling in the Gaps*

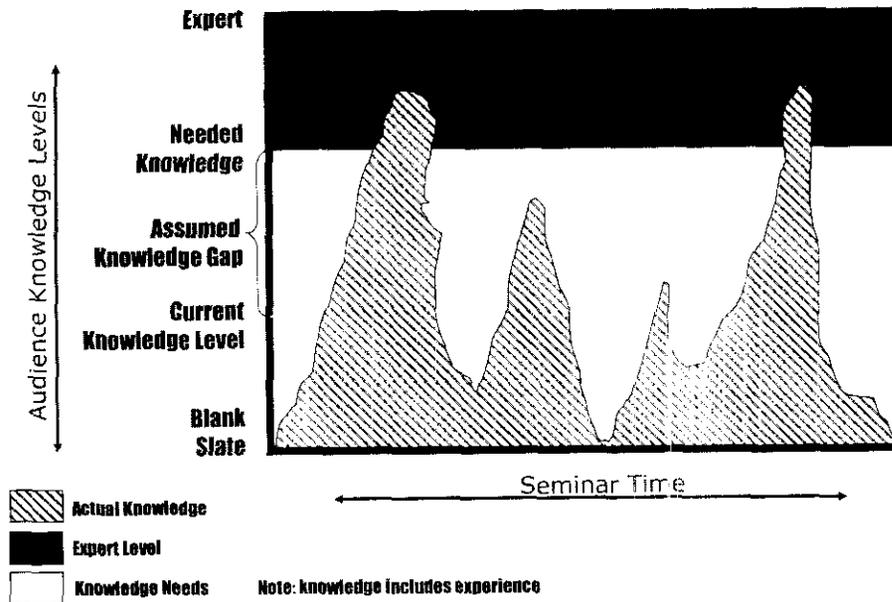


Let's Take a Look at this Design Model

List assumptions that this model is based on.

- 1.
- 2.
- 3.

Seminar Content Planning Model *Filling in the Gaps*



How does this model change our design process?

- 1.
- 2.
- 3.

Biases that Cause Trouble

- 1 – There is too much information to take time for the audience.
- 2 – The information need is so great; we might as well go for it.
- 3 – I have a dynamic personality and no one ever gets bored.
- 4 – I always allow for audience questions and comments.
- 5 – There is a Q & A session at the end of the seminar.

What are yours?



Population Leadership Program
A Division of the Institute for Global Health



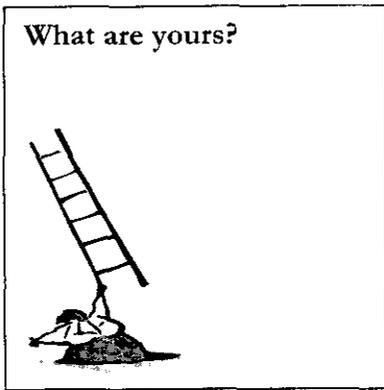
Space Principles

- Talk Less - Listen More
- The Art of Seminar Conversation
- It's Not About You!
- Invite 'Reality'
- Application, Application, Application
- Model Your Teachings

Session Objectives

List your current session objectives and then reframe them so that the audience could have written them.

Speaker-Focused Objective	Audience-Centered Objective
1.	
2.	
3.	



Meta-Objectives

No one speaks of these, but these are the objectives that speakers/facilitators keep to themselves. They can be very **lofty** like – Building rapport and trust, getting the audience energized, moving the audience to action. These are critical in directing the facilitator's intention and their speaking strategy.

Real Questions

Real questions are questions to which you do **not** have the answer. When you ask a real question, you need to listen to the answer in order to respond appropriately.

An example of a real question is:

- “What prevents you from using this technique in your local context?” or
- “How have you dealt with the _____ issue in your region?”

List 3 Real Questions that you can use to elicit useful information.

1. _____
2. _____
3. _____

Build and They Will Listen

What happens when you open yourself up to questions that you may not know the answers to?

Most public speakers, and facilitators like to control the conversation. They most often do this by creating a simulation of a conversation that controls participation, sometimes not allowing any more than a one-way interaction. But, and here is the secret – if you ask a question about a subject matter that you know, there is a high probability that the answers fall within a certain predictable range. And you can prepare for your role in providing satisfaction to the questioner.



Population Leadership Program
A Division of Public Health Institute



The Secret Plan for the Unknown

Use the 3 questions you just developed and brainstorm possible answers.

Question 1

Potential Answers

Question 2

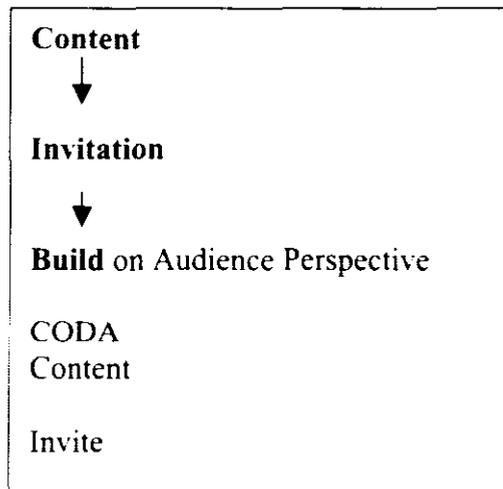
Potential Answers

Question 3

Potential Answers

The Great Build

Once you have listed possible answers to your question, you can plan your next section of seminar content. In this way, you are actually engaged in a 'dance' with your audience. And it goes like this...



From Linear to Space

Linear Content	Audience-Focused Content



Population Leadership Program
A Program of the National Endowment for Democracy



Session Strategy

Title -----

Objectives: At the end of the session the audience will be able to:

- 1.
- 2.
- 3.

Logistics:

Time	Content	Audience (Questions, Books, Supporting Materials)





Decentralized Training and Supervision - Lessons from Ghana

Nicholas Songogye Kanlisi

Program Manager
EngenderHealth/Ghana
25 Senchi Street, Airport Res. Area
PMB KIA
Accra, Ghana
Phone: 233-21-778-558
Fax: 233-21-775-396
E-mail: nkanlisi@engenderhealth.org

Patience Darko

EngenderHealth Ghana
25 Senchi Street, Airport Res. Area
PMB KIA
Accra, Ghana
Phone: 233-21-778-558
Fax: 233-21-775-396
E-mail: pdarko@engenderhealth.org





ENGENDERHEALTH

improving Women's Health Worldwide

INTRODUCTION

It is a pleasure to share with you the lessons learned during the scaling up of Minilap and Norplant services in Ghana through decentralized training and supervision. This presentation will only focus on the linkages between training and service delivery. Training is not an end in itself. In-service training is done in the hope that participants will acquire new skills and knowledge or improve existing skills and knowledge. But the ultimate aim is to provide quality services to clients. Training efforts must therefore keep the rights and needs of the client (the ultimate customer) in mind. The client is the direct recipient of the outcome of training interventions and programs. Providers are the intermediate and vital link to the client. Providers participate in training programs to develop or update their knowledge, skills, and change attitudes. In linking training to quality service delivery supervisors are a critical element. Supervisors facilitate the work of the trainees and ensure program progress. Therefore when training occurs with the involvement of the supervisor there is increased likelihood that the knowledge and skills acquired will be translated into service delivery.

The Objectives of the session

By the end of this session participants will be able to:

1. Describe steps in developing decentralized training capacity
2. Describe strategies used to link training & supervision
3. Articulate the roles of local counterparts and the importance of their ownership of the training program

Overview of scale up

I wish to start by giving you an over view of the scale up process and the context in which training was linked to supervision. This can be divided into two phases.

Phase 1: 1986 to 1993:

EngenderHealth introduced Minilaparotomy under local anesthesia for female sterilization in one teaching hospital in Ghana in 1986. EH conducted training for 5 service providers (with potential to do training) & directly supervised the initiation of services. EH awarded a subagreement to the teaching hospital to trained doctor Nurse teams in 15 selected hospitals in the Ashanti region. These started to provide services with direct supervision from EH. These demonstrated the practicability of providing Minilap under local anesthesia for female sterilization. Clients were able to come into the

clinic and get a minilap and walk back home without the need for hospitalization. This reduced the cost to the client.

Based on these modest successes, the MOH requested EH to scale up Minilap to all regions in Ghana. About the same period Norplant acceptability studies had just been completed FHI. MOH got interested and requested that Norplant be scaled up along side Minilap.

Phase 2: 1994 to 2002

The expansion phase was a result of countrywide assessment conducted by MOH to determine gaps in equipment and infrastructure needs.

Our strategy was to scale up training and service capability. We did this by establishing a national network of training and service sites capable of providing long term contraceptive services. We later developed sub-agreements with Regional Health Administrations that were supported through our USAID Cooperative Agreement. Two teaching hospitals were initially involved to manage and supervise training and trainees.

Five sites were subsequently developed as training sites and 210 sites as service delivery sites (105 sites providing Minilaparotomy and Norplant and 105 providing up to Norplant service).

An important part of the success of this program was the decision we took to scale it up nation-wide from the very beginning. This forced us to deal with program issues comprehensively. We set ambitious goals but not all were achieved. Notwithstanding, we believe the program did well.

QI systems were introduced. Counseling, COPE, Infection Prevention, Medical Site Visits and Facilitative Supervision are now in the scale up phase.

Steps for Decentralizing Training Capacity

1. Assessment and planning

As a first step, an assessment was conducted nation-wide to:

- Determine the level of infrastructure needs,
- Identify potential service delivery sites and trainees,
- Identify regional training sites,
- Develop and integrated training plans with the regional and district supervisors.

This assessment afforded us the opportunity to determine supervisory needs with local health managers. The assessment makes the managers think through where services should be initiated immediately and who goes for training first. Needs were therefore prioritized from the on set.

The regional and district service delivery systems provided us the vehicle to delivery training & services. Trainees were selected by the MOH Regional Director in conjunction with the District Director of Health Services and local hospital and clinic administrators and EH staff. Trainees return to their hospitals and clinics and provide long-term contraception. We expect to establish training sites in each Region. Currently, five sites were established as training sites.

2. Developing service capacity of training sites

We undertake to strengthen service delivery at selected training sites. Training sites are well equipped to ensure quality training and service delivery. In some cases we renovated and upgraded facilities to acceptable standards. A core of Family Planning Counselors was trained.

Clinical training sites serve as a model for future clinical practice. Providers perpetuate what is observed and learned there. Therefore the selection of a clinical training site must meet certain criteria:

- Meet accepted medical standards, be fully equipped and staffed to handle all immediate anesthesia related and surgical and procedure related complications.
- Must have adequate caseload to allow trainees to perform the number of cases needed to gain competency within a short period.
- Must be a good model for good service delivery, such as :
 - ✓ Infection Prevention practices
 - ✓ Counseling and informed choice
 - ✓ Choice of Methods
 - ✓ Client – provider relationships
 - ✓ Records management

In order to increase and sustain caseload outreaches were conducted to church groups and communities. In the hospitals themselves orientations were conducted to create awareness about the services. Linkages were developed with other clinics to refer clients for services at the training sites.

EngenderHealth intensified its medical monitoring and Quality Assurance activities to ensure the sites were meeting the desired standards. The skills of the service providers were monitored during Medical site visits and potential trainers identified.

3. Developing training capacity

As services became established at the potential training sites potential trainers were selected and sent for training in clinical skills. The trainers included doctors and nurses. The content of the training included training management and organization, clinical skills, Infection Prevention, and client provider relationships.

A TOT was also organized for counselors in training in Family Planning Counseling.

4. Conducting training of service providers.

Initially the trainers conducted all the training at the training sites for service providers in the region they are located in. As the program expanded more trainers in counseling and Norplant were identified and trained for each region. Training in counseling got decentralized to the regions with trainers from training sites providing back up. At the regional level EH assisted trainers with training plan development jointly with regional supervisors using the results of the assessment in step 1.

EH provided coaching and technical assistance in clinical and counseling training.

After the training trainers conducted post training follow up in conjunction with regional supervisor.

Strategies to ensure ownership and sustainability

During the course of scaling up we learned a number of lessons. The key among them is “understanding the existing health structures and utilizing them effectively”. Our program was successful because we studied the system and used it effectively. It has helped to eliminate several mistakes.

Design phase:

Pre- project assessment established gaps and infrastructure needs for 100 sites- Knowledge of the partner organization (i.e. MOH) and how things work there is important. It influenced the project administration.

We negotiated sub-agreements with the Regions and the Teaching Hospitals. We made sure the subgrantee i.e. Regional Health administrations and Teaching Hospitals are involved in the program planning process so that they can take ownership of the programs. This way, we received full cooperation from program managers. Managers identified service sites and providers for training. When funding was not available they pre-finance the planned activities. Managers showed interest in the implementation of the program. For example, statistics on the programs are now captured as part of routine service data.

Implementation:

Constant monitoring and supervision is another requirement to ensure program success. Monitoring and supervision must be facilitative and regular. This is the work of the managers and supervisors since they are involved in selection of sites and trainees. It was important to establish a reporting routine.

Constant communication with managers and service providers keeps you informed about changes that might affect the implementation of the program. It is also motivational to service providers especially monitoring visits.

Consistent funding and a stable political environment are critical success factors. Program scaling cannot be viable with “on and off” financial assistance.

Future challenges and strategies

As the program matures and the Ministries take ownership, the TA Agency should embrace the change in role and loss of control that comes with ownership.

There is going to be the challenge for the Ministries to maintain program quality as decentralized training and on-the-job training take place.

The TA Agency should develop strategy for updates and innovations in training and service delivery.

TA is still required, but in new areas as program evolves (long term strategy)

Key Conclusions:

Training is about service delivery. We must always have service system and needs in mind and link training strategy to those needs

Scaling up training capacity & Services requires a comprehensive long-term view. It cannot be done overnight and by outsiders –must be helped by those who understand the boundaries of ownership

Technical Assistance in support of this strategy is unglamorous, tedious and relentless-but entirely necessary.



Decentralized Training and Supervision- Lessons from Ghana

Dr. Nicholas Songogy Kanlisi
Program Manager



*Training in Africa: Best Practices,
Lessons Learned and Future Directions
Zambia, May 5-7, 2003*

Learning Objectives:

- Describe steps in developing decentralized training capacity
- Describe strategies used to link training & supervision
- Articulate the roles of local counterparts and the importance of their ownership of the training program

Overview of Scale-up:

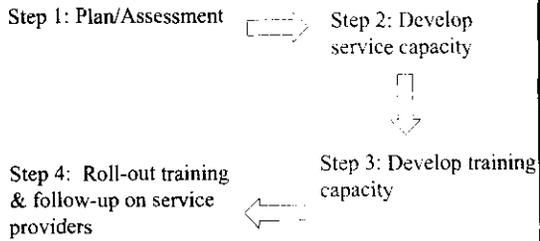
Phase 1: 1986 - 1993

- Outside training for initial providers (4)
- 1 training site
- 15 service sites
- EH conducted training & supervision directly
- Subagreement with training site

Phase 2: 1994 - 2002

- Outside TOT for 5 new training sites
- Regional Health Administration manages training & supervision through 5 training sites
- Subagreements with 10 regions & 2 teaching hospitals
- Service at 210 sites
 - 210 provided Norplant
 - 105 also provided Mimitap

Steps for Decentralizing Training Capacity:



Step 1: Assessment and Planning

- Identified potential training sites
- Identified potential trainees & service sites
- Developed integrated training plan with MOH supervision structure

Step 2: Developing Service Capacity of Training Sites

- Strengthening service delivery at training sites, including equipment and upgrades
- Conducted outreach to increase & sustain caseload
- Intensive EH medical monitoring and QA

Step 3: Developing Training Capacity

- Training of Trainers - clinical skills trainers
- TOT for counseling trainers –(decentralized more quickly)
- Joint (Trainers and Supervisors) training plan development and trainee follow-up

Step 3: Developing Training Capacity (2)

- Using assessment from step 1, service sites were selected and trainees selected for training roll-out
- Supervisors were oriented to the new services
- EH served as catalyst to facilitate links between Health managers and trainers

Step 4: Roll-out of Training and Follow-up of Service Providers

- Training sites conducted training with assistance from EH
- Trainers conducted post-training follow-up of providers in conjunction with regional supervisors
- Re-oriented supervisors to problem solving e.g. ensuring that trainees have needed resources

Strategies to Ensure Ownership and Sustainability

- Constant communication and dialogue between EH, training sites, and regional Health Managers
- Regional Health Managers take the lead in planning and organizing training – integrated into existing structure

Strategies to Ensure Ownership and Sustainability (2)

- Link training follow-up and supervision to ensure trainee can practice skills and initiate services
- Work with the existing health structures and utilizing them effectively

Challenges

- Embrace the change in role and loss of control by TA agency that comes with ownership!
- Challenge in maintaining quality as decentralized training and OJT training take place.
- TA is still required, but in new areas as program evolves (long-term strategy)

Achievements: 1994-Present

- **Training**
 - Minilap-284 DR Nurse teams
 - Counseling -1978 Nurses
 - Norplant insertion & removal -379 Nurses
 - Norplant insertion & removal - 77 Drs
- **Services**
 - Over 55,1920 clients served

Lessons Learned

- Understanding the existing health structures and utilizing them effectively
- Build linkages between training and supervision
- Select trainees who show interest
- Learning & Training as a Dr/Nurse team helps to overcome attitude problems

Lessons Learned (2)

- Scaling up training capacity & services requires the long view (\$\$). Cannot be done overnight and by outsiders - must be helped by those who understand the boundaries of ownership.
- TA in support of this strategy is unglamorous, tedious and relentless - but entirely necessary!

Beyond Training of Trainers: Lessons Learned in Developing High Quality Clinical Training Sites in Indonesia

Zahida Qureshi

Lecturer, Department of Obstetrics and
Gynaecology
University of Nairobi
JHPIEGO Consultant
E-mail: zqureshi@nbnet.co.ke

BEYOND TRAINING OF TRAINERS

Lessons learned in developing high quality clinical training sites in Indonesia

The Session

- Introductions/warm up
- Brainstorming
- Presentation
- Case studies
- discussion

Learning objectives

- Describe a comprehensive approach to strengthening clinical services and training
- Describe the importance of high quality training in maternal and neonatal health
- Understand the challenges of developing high quality clinical sites that meet the training needs of a large, low-resource country.



Demographic Health Data

- Population-201.4 million
- Neonatal Mortality Rate-25 per 1000
- Infant Mortality rate 52.2 per 1000
- Total fertility rate 2.8 children per woman

Demographic Health Data

- 4.5-5 million women give birth annually
- MMR-390/100,000 live births
- 18,000-20,000 women die annually
- Every hour 2 women die
- Up to 46% of deaths are due to PPH and 10% are due to complications of abortion.
- Estimated 60% of births attended by a skilled provider
- 72,000 midwives; 1240 ob/gyns

The Problem

- Lack of skilled providers
- Too few women seeking skilled providers at the time of birth

Background

- Indonesia –highest Maternal Mortality in South East Asia Region
- 1991-Safe motherhood programme started -community based midwives (54,000)
- 1995-improve performance of these midwives, strengthen quality of care, increase MNH services
- 1997-integrated RH framework

MNH-Global Program

- USAID funded-operates in 14 countries
- Indonesia is the largest Program
- Began in 1999 in Indonesia and is funded up to September 2004
- Implemented primarily in West Java-which has a population of 42 million and Maternal and Neonatal mortality rates nearly double that of the national average

MNH /MOH of GO Indonesia Goals

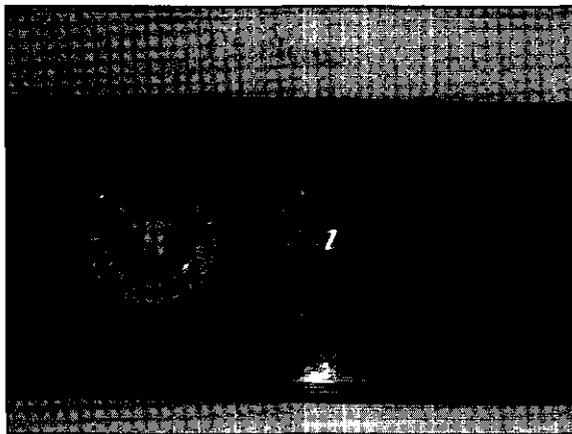
- Dedicated to ensuring the survival of pregnant women and their newborns

- Focus on interventions that have the greatest impact on reduction of maternal and neonatal mortality

- Key: promoting presence of a skilled attendant at birth

Site strengthening

- BUDI KEMULIAAN MATERNITY HOSPITAL FOUNDED IN 1917
- 120 BED HOSPITAL (undergoing renovation –present capacity 92 but new hospital will be 140)
- STAFF OF 430
- MIDWIFERY SCHOOL SINCE 1917



Site Strengthening

Assessment done in January 2000

■ **AREAS OF FOCUS**

- Technical and decision-making skills
- Organizational/management issues
- Mother-friendly and baby-friendly practices
- Infection prevention practices
- Documentation
- Equipment and supplies

Site strengthening

Staff commitment –administrators down to cleaners

- Midwifery school
- Service delivery unit

Knowledge based updates on evidenced based standards

Intense on-the-job mentoring

- Decision making
- Mother friendly care
- Infection prevention
- Documentation

Site strengthening

Equipment / supplies

- Delivery instruments
- IP supplies
- Protective wear
- Resuscitation equipment for mother and neonate

Site strengthening

- Ante natal clinic
 - Introduction of focused ANC
 - Infection Prevention practices
- Labour and delivery
 - Partograph
 - Clinical decision making
 - Emergency equipment and drill

Site strengthening

- Post natal unit
 - Rooming in (bedding in)
 - Counselling
 - Cord care
- Theatre
 - IP practices
 - Monitoring of patients

Site strengthening

- Process continued for 1 ½ years with periodic visits from Consultants – OB/GYN and midwives
- Skilled clinicians required
- Financial resources required
- Great deal of commitment from facility and visiting staff

**END RESULT- SITE READY FOR MNH
REGIONAL EXPERT DEVELOPMENT
WORKSHOP -JULY 2001**



Asia

Activities since then

- 200 midwives (91 from BK and 109 from other institutions) have undergone competency based training in "APN" basic delivery skills.
- Echo MNH course held October 2002-1st generation trainers conducted for 2nd generation participants
- MNH update/APN courses for 190 midwifery students from other provinces.
- I.P. Courses for 91 Midwives, 40 Nurses and 67 Nurse Assistants
- Changes in practice incorporated into Preservice midwifery curriculum and clinical practice

Lesson learnt#1

- MNH Skills cannot simply be incorporated into existing FP system
- Clinical decision making is more complex for MNH services

Lesson learnt #2

- To ensure quality training
Maternal and Health clinical
services must be strengthened
- Best practice in MNH training is
site preparation and not merely
training of trainers

Lesson learnt #3

- Clinical decision making is the
hardest skill to teach
- Trainers with good training skills
cannot be assumed to transfer
clinical decision making skills

Lesson learnt #4

- Strong leadership needed for
periodic internal monitoring
- External supervision and
monitoring- supportive
- Neither should be overwhelming*

Lesson Learnt #5

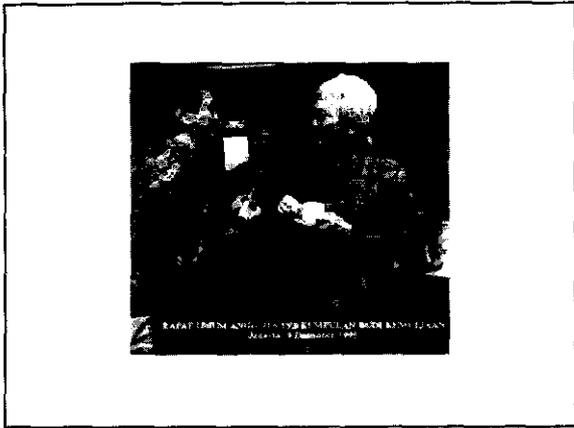
- Established standards are essential for sustainable training

Lesson learnt #5

- Is this really feasible?
- What are the alternatives?

Lesson learnt #6

- Ideal situation is that skills should be taught in pre-service environment
- Inservice training system is not the place for teaching basic MNH skills- too complex!



**Business Planning Program:
A Social Return on Investment**

Greg Rodway

Senior Program Officer
Management Sciences for Health
891 Centre Street
Boston, Massachusetts 02130-3400
Phone: 617-524-7766
Fax: 617-524-1363
E-mail: grodway@msh.org



Business Planning Program: A Social Return on Investment

The Art of Crafting a Business Plan for Social Return on Investment: The Application of a Blended Learning Program

"Ever have a breakthrough idea; an idea that could create all sorts of possibilities for increased coverage, better service, reduced suffering, or innovative management, only to find yourself unable to sell your idea to others?"

Purpose of the Business Planning Program:

Management Sciences for Health's (MSH) Management and Leadership Program has designed and delivered an integrated learning experience, entitled "The Art of Crafting a Business Plan for Social Return on Investment." This landmark program utilizes both face-to-face and electronic methodologies to provide participating organizations with a technology, that allows them to build expertise in such areas as: capturing and packaging breakthrough ideas, identifying target markets and marketing strategies, determining the best complement of staff to develop ideas, and navigating the financial aspects of a business plan, including social and some financial return projections. The tools, techniques, and worksheets supplied during this learning experience serve to simplify the complexities of the business plan, while helping the participants to balance their enthusiasm with facts.

The blended learning paradigm offers new opportunities for capacity building, cost effective scalability and real time coaching.

The pilot program has been successfully implemented in Bolivia, and is currently undergoing a number of enhancements prior to release in Africa in mid 2003.

Purpose of the Session

The purpose of this session is to introduce the Business Planning Program (BPP) and to share the experience of delivering the Program using a blended learning model.

I. The Need for Business Planning

NGOs are aware of the need to become more sustainable and less dependent on traditional sources of funding. Consequently, there is a demand for capability to identify and secure alternative funding opportunities.

At the same time, however, the best way to attract new funding streams is to offer new ideas in the form of breakthrough products and services.

The BPP is a rigorous process which encourages the development of "new thinking" through the development of capabilities that:

- Diversify funding streams & reduce risk
- Establish public/NGO-private partnerships
- Speak to the private sector using their terms
- Introduce new products and services that can make a difference
- Link investment money with results

The Business Planning Program assumes that money will follow good ideas, that intend to make a difference in the lives of the underserved.

II. Blended Learning as an Approach to Design

Blended Learning is defined as an educational method, which integrates traditional face-to-face (F2F) training with technological delivery systems. These systems include video and teleconferencing, Internet and email, CD-ROM and other technologies.

Blended Learning offers the opportunity to deliver high quality and effective training to a large audience.

Specific advantages include:

- Effectiveness – adult learners prefer to learn new techniques by being shown the process first then trying the process, with access to support if questions arise
- Scalability – can be ramped up more easily than traditional classroom based programs
- Cost – less overhead costs than traditional classroom based programs

III. The Program – Overview

The Goal of the BPP is to offer a business planning technology that will equip participating organizations to package and sell breakthrough ideas that generate primarily a social return on investment. However, this does not preclude the opportunity to develop new products or services, which deliver a financial return.

A number of key assumptions underlie the BPP:

- that money follows good ideas
- that the funder or investor wants his/her money to make a difference in the lives of the underserved
- that ideas generated by the organization *are more attractive* than those adapted by the organization

The primary objectives for the BPP are that at the end of the program each team be able to:

- State their organization's mission
- Articulate revolutionary ideas in the form of new products and services
- Assess the potential market and design a marketing plan for new products and services
- Identify a design and implementation team

- Estimate financial needs for design and launch
- Project the social return on the investment, and, if appropriate, the financial return on the investment.

The BPP is delivered as a series of Modules. Each of which addresses a concept listed above.

Each Module is structured similarly and comprises a series of inquiries, assignments, and reference materials and culminates with the submission of a complete section of the business plan. To co-ordinate the process each team names a "Team Captain" to oversee the completion of the assignments, and to communicate with the team's assigned Reviewer.

Summaries of Each Module

Module I: The Organizational Mission

This module provides the opportunity to show funders or investors what is interesting and unique about your organization and to draw them into the rest of your business plan. During this module, you will explore the strategic positioning and core competencies of your organization. You will begin by researching the history of your organization; you will then determine your organization's current scope in terms of product, service, market, and geographic coverage. After being introduced to the Delta Model, you will review your organization's current strategic positioning. Finally, you will identify the unique technical, management, and leadership competencies within your organization.

Module II: The Breakthrough Idea

This module will strengthen your ability to generate breakthrough ideas that will capture the attention of funders and gain their support. During this module, you will conceive, test, shape, and articulate breakthrough ideas that will lead to the development of new products or services. You will be introduced to the Strategic Mapping technology to help you generate breakthrough ideas to improve the health and welfare of your target population. After transforming these ideas into products and services, you will perform a selection process to determine the single new product or service that should be the focus of the business plan. Finally, you will learn how to enroll others and gain support for your ideas.

Module III: The Market and the Marketing Plan

In this module, you will show your funder or investor that the product or service you have chosen meets the needs of your target population, and that you will be able to effectively market the product or service to the population. The next step in the Business Planning Program is to undertake market research to make sure that your proposed product or service meets the demands of the target population. This module will show you how to conduct market research on your product or service and develop strategies to market it. Your research will help you to determine your potential market, the benefits the target population would expect from the new product or service, a reasonable price, and the quantity needed to meet potential demand. Once you have clearly defined the market for your new product or service, you will develop a

marketing plan that includes goals, marketing mix, promotional strategies, and activities and associated costs.

Module IV: The Design and Implementation Team

This module gives you the opportunity to show your funder or investor that you have a top-notch group of people working on your business plan, a team with the skills and experience required to develop and launch the new product or service effectively and efficiently, and ensure that it will have the greatest possible effect on the target population. In this module, you will focus on putting together a team capable of developing and launching the new product or service, according to a detailed schedule. This will include reviewing the roles and steps involved in designing and introducing the new product or service; proposing a team; drafting Scopes of Work for each member; and creating a Gantt Chart to plot the timeline for designing and introducing the new product or service.

Module V: The Financial Requirements

In this module, you will demonstrate to potential funders and investors that your organization is in good financial standing, and that you are capable of drafting a detailed budget that illustrates and explains the costs associated with the implementation of your business plan. Using the instructions and spreadsheets supplied in this module, you will review and summarize the financial health of your organization, and draft a budget detailing the costs of designing, launching, and marketing the new product or service.

Module VI: The Social Return Projections

This module will allow you to show your funder or investor that your idea will make a measurable improvement in the lives of your target population. During this module, you will learn how to project the social return on the investment your funder has made in the launch of the new product or service: to predict the measurable improvements in the health status, access to services, and quality of care that will result from the target population using your new product or service. You will learn to use various performance indicators and develop a plan to collect data that will show changes in baseline figures, demonstrating the success of the new product or service in contributing to your organization's mission.

Module Structure

The Modules are delivered on a CD-ROM. This technology was preferred over online delivery, as access to either Broadband or Narrowband Internet is problematic at present in most client countries.

Each Module comprises a number of components:

- Introduction
- Learning Objectives
- Deliverable/s

- Components

Introduction

The Introduction provides an overview of the purpose and scope of the Module.

As an example, the Introduction to Module I describes the Organizational Mission:

Introduction: *At this point in the Business Planning Program, you have been introduced to the Program overview and important program components such as the Pie of Ignorance model and the guided inquiry methodology.*

Purpose: *This module provides you with the opportunity to show funders or investors what is interesting and unique about your organization and to draw them into the rest of your business plan.*

Process: *During this module, you will explore the strategic positioning and core competencies of your organization. You will begin by researching the history of your organization; you will then determine your organization's current scope in terms of product, service, market, and geographic coverage. After being introduced to the Delta Model, you will review your organization's current strategic positioning. Finally, you will identify the distinctive technical, management, and leadership competencies within your organization.*

Learning Objectives

The Learning Objectives clarify the purpose of the Module.

Upon completing this module, you will be able to:

- *Describe your organization's history and mission*
- *Identify the current scope of your organization*
- *Characterize your organization's strategic position, using the Delta Model*
- *Assess the distinctive competencies within your organization*

Deliverable

The output from each Module forms an intrinsic part of the completed business plan.

Participants are given the technology and guidelines for studying, documenting and sharing each of the components of the Module. Following the face-to-face portion of the Module, participants return to their workplaces and generate the data and information that will allow them to complete each component of the Module.

An example of a deliverable is:

- *Within two weeks of the session, you will prepare Section I of your business plan, entitled "The Organizational Mission," submit a final version to your reviewer, and post it electronically.*

Components

Each Module is further segmented into a series of Components. Each Component comprises an Introduction as well as a series of Guided Inquiries and Assignments.

Component I: The Story behind the Organization

Often the most compelling section of a business plan is the story behind the organization: how it started, its purpose and social intent, the characteristics of the founder(s), and, of course, the early difficulties overcome by the organization. Good business plans focus on the people within the organization—their distinctive skills, experiences, and commitment to the success of the organization; the idea or business opportunity the organization seeks to pursue, along with a realistic understanding of the market and a good marketing plan; and a solid understanding of the financial structure of the organization and what additional funding is required to bring the new idea to the market.

You should begin the process of drafting the business plan with the history of your organization, presented in a lively way that will engage the potential funder or investor. This is your organization's best opportunity to "hook" the readers and inspire them to read more, with the hope that they will eventually provide funding for your idea or business opportunity.

Within the context of this learning program, you and your organization will be indistinguishable; that is, you and the members of your business plan development team will serve as ambassadors for your organization, always representing the organization's interests and values rather than your own. In that spirit, the program will begin with each participant presenting the story of his or her organization by completing the inquiry provided below.

Inquiry

1. *When was your organization founded? What were the vision and mission of your organization when it was founded? Have they changed? If so, what is the current vision? What is the current mission?*
2. *What are the characteristics of the founder(s)? Of the current leadership? How do the leaders motivate and inspire others?*
3. *What were some of the initial obstacles in setting up your organization? How were they overcome?*
4. *Describe some of the important events, outcomes, and areas of impact that have shaped your organization.*

Assignment

1. Arrive at the program opening prepared to present the story behind your organization. You are encouraged to use photographs, videos, posters, slides, and other media in your presentation.
2. Each presentation should be 10 minutes maximum and should include pertinent data and facts that help to describe the story behind your organization. Note: the shorter and more compelling, the better.
3. In addition, you should bring a **written summary** of the story behind your organization that corresponds to the inquiry above.

Learning Aids

A series of Learning Aids are provided on the CD-ROM. Included in this are sound files, Excel spreadsheets and Word documents.

The screenshot shows a CD-ROM menu with a table of contents on the left and a list of audio files in the center. The table of contents includes sections like 'Introducción', 'Objetivos de Aprendizaje', 'Producto', 'Componente I', 'Componente II', 'Componente III', 'Componente IV', and '¡Felicitaciones!'. The audio list includes 'El origen del Modelo Delta (2:22)', 'Cómo se aplica este modelo al sector en áreas de lucro y al sector público (4:06)', 'Mayor Producto o Servicio (1:08)', 'Soluciones Totales de Cliente (2:26)', 'Energía del Sector (1:22)', 'Las tres estrategias de estrategia (5:30)', and 'La importancia de una misión clara, estratégica, según el negocio (6:10)'. A small portrait of Professor Arnoldo Harz is also visible.

Figure 1 – Example of a Learning Aid

Resources / Terms and Definitions

Additional resources are provided on the CD-ROM to provide participants with tools to deal with the challenges, which arise in the course of the BPP. An example is the On-line Glossary:

IV. Launch Week

What is it?

Launch Week is an intensive six-day face-to-face introduction to the BPP. During Launch Week, each Module is introduced, including the Guided Inquiries and the Assignments. Some preliminary work towards completion of the Assignments is also undertaken. To maximize productivity of Launch Week, the participants are required to undertake pre-Launch Week preparation. Launch week concludes with the selection of the Team Captain, a review of their responsibilities, and the assignment of a Reviewer to each of the participating teams.

Requirements of Participants prior to and during Launch Week

1. Knowledge: an in-depth knowledge of the organization is required by those who attend Launch Week, including: the history, vision and mission, client needs, activities and financial performance of the organization (individual may have expertise in one area, but within the team all areas need to be covered). In addition, each team should have data about their target markets/clients/consumers.
2. Review: undertake a review of your organization that addresses the following:
 - Product Scope - what products are currently offered by your organization?
 - Service Scope - what services are currently available through your organization?
 - Market Scope - which segment(s) of the market is your organization currently targeting?
 - Geographic Scope - what geographic area(s) is your organization currently covering?
 - Financial Overview – reporting the organization's source of financial support – by funder - for the prior two years.

V. Facilitation at a Distance

After completion of Launch Week, the participants return to their respective organizations to complete the Modules, all of which are delivered on CD-ROM.

The beginning of each Module is prompted by a Module Management Memo that is sent by the facilitator via email, to the Team Captain.

During the development of each Module, the facilitators are available to each Team Captain via e-mail. To promote productivity, the facilitator reviews all the materials produced by the participants, and provides feedback directly to the team within a 24-hour period.

Members of the BPP teams are expected to devote 20% of their time on a weekly basis to complete the Modules. If time is not devoted to completing these processes, experience has determined that the business plan will be less than optimal.

Based on this time expectation, completion of the six modules is expected to take 12 weeks.

VI. Program Wrap Up

The final face-to-face component is the Wrap Up phase. This is a five-day engagement, during which a number of objectives are carried out, including:

- Finalization of the business plans
- Refinement of the elevator pitch
- Presentation of the elevator pitch during a closing ceremony attended by potential funders
- Review of the role of the Agent organization
- Establishment of a marketing plan
- Preparation of an Agent action plan
- Scheduling of facilitator training
- Transfer of training and marketing materials to Agent organization

VII. The Model for Sustainability

The BPP is delivered through a multilevel Distribution Paradigm. While MSH is responsible for the overall content of the BPP, Agents are accredited to offer the program to third parties (i.e. clients).

The Distribution Paradigm is as follows:

MSH enables the business planning technology:

- Owns and develops the technology
- Liaises with Agents to strengthen the business planning technology
- Coordinates the development of the technology – i.e. version control

Agent facilitates the business plan:

- Receives program as a team following face-to-face orientation
- Works with Client to refine the business plan
- Liaises with MSH to strengthen the business planning technology
- Uses MSH as a repository for support

Client develops the Business Plan:

- Initial idea
- Receives BPP training from Agent
- Works with Agent to develop the business plan

Consequently, the BPP can be seen as a two level opportunity for the Agent: - providing a service the Agent can offer to other organizations and also the use of the BPP to improve the business planning capability within the Agent's organization.

For the client, the goal of the BPP is to improve business planning capability, so that the client organization is more likely to attract the desired social investment.

VIII. The Demand and Potential Investors

To date, demand for access to the BPP has arisen in Latin America, the Caribbean and Africa. To facilitate this demand MSH is considering increasing the number of languages supported by the BPP to four. Currently, the BPP is available in English and Spanish and consideration is being given to Portuguese and French versions of the program.

Experience arising from Bolivia indicates that there is a “market” for well-developed business plans. While locally based donors have made the funding offers in Bolivia, there is also an increasing number of Internet based social investment facilitators, for example Developmentspace.com. These organizations operate web portals that connect social entrepreneurs with non-traditional donors. “Graduates” of the BPP consequently have the flexibility to pursue a variety of funding sources.

IX. Impact on Potential Investors

Key findings regarding the **program’s impact** on participating organizations include:

A transformation of attitudes and concepts:

- Participants are more client focused
- Participants have adopted a more active attitude within their organization - generating ideas based on the target populations’ needs
- Participants think in terms of products and services instead of projects

Improved internal processes and systematization of information

- Participants have a greater understanding of their own organization
- Participants are able to articulate their organization’s mission more clearly to others

Strengthened organizational teams

- Participants are able to propose solutions to problems and make decisions in coordination with their directors

Application of new skills and concepts

- Participants are applying the program methodology to other areas of their work
- Participants are using new terminology and have adopted business language

Conclusions

The use of Blended Learning as the facilitative process within the BPP provides a number of advantages over classroom training or complete virtual delivery. The combination of face to face training with virtual facilitation provides flexibility, scalability and effectiveness.

Improving Understanding about Training in Africa through Operations Research

Ivy Osei

Health Research Unit
Ghana Health Service
P.O. Box GP 184
Accra, Ghana
Phone: 233-21-230220
E-mail: ivy.osei@hru-ghs.org

Harriet Birungi

FRONTIERS in
Reproductive Health Programme
Population Council
Nairobi, Kenya
E-mail: hbirungi@pcnairobi.org

Saiqa Mullick

FRONTIERS in
Reproductive Health Programme
Population Council
Johannesburg, South Africa
E-mail: smullick@pcjoburg.org



Improving Understanding About Training in Africa Through Operations Research

Ian Askew
Harriet Birungi
Placide Tapsoba
Saiqa Mullick

Structure of Presentation

- Brief overview of OR approach to understanding training in Africa
- Family planning example (Uganda)
 - Harriet Birungi
- Safe motherhood example (Ghana)
 - Placide Tapsoba
- Antenatal care example (South Africa)
 - Saiqa Mullick
- Summary of common themes
- Group discussion

Why Use an OR Approach?

- Small-scale, pilot-testing of innovative training approaches
- 'R&D' investment to prevent possible costly mistakes
- Compare alternatives
- Systematic measurement and documentation
- Can go beyond provider level outcomes
- Determines effectiveness as well as feasibility
- 'Objectivity' of researcher

What Is an 'OR Approach'?

- Prospective
- Controlled intervention and environment
- Quasi-experimental design
- Scientific rigour
 - Sampling
 - Indicators and data collection instruments
 - Analysis
 - Ethical procedures
- Programmatic recommendations

Evaluating the Effect of Improving Quality of Client-Provider Interactions



Improving Provider Competence

- 3-day refresher training for staff already trained through 6-week integrated RH course
 - Introduction to FP services
 - FP methods available
 - Counseling
 - Screening for FP methods
 - Providing FP methods
 - Managing side effects and complications
 - STI/HIV/AIDS
 - HMIS

Supportive Interventions

- Comparison sites ('readiness' only)
 - Update policy guidelines and service standards
 - Ensure availability of minimum equipment and supplies
 - Improve clinic environment
 - Increase availability of IEC materials
 - Improve the HMIS
 - Build capacity for facilitative supervision
- Experimental sites (Yellow Star Programme)
 - As above plus:
 - Build capacity for strategic planning
 - Improve provider motivation
 - Raise clients' awareness of rights to quality care

What Is the Quality of Care Scale?

- Measures interpersonal relations and information exchange
- Derived from literature and experience
- Provided baseline measure and change over time
- Compared quality produced through different interventions
- Informs decisions on provider training

Content Areas of the Scale

- Interpersonal relations
- Need diagnosis
- Method choice
- Contraindications
- Use instructions
- Possible side effects
- Alarm signs
- Follow-up instructions
- General satisfaction

How Was the Scale Generated?

- Indicators developed for each content area
- Indicators measured through client exit interview and observation of client-provider interactions
- Scale consists of 22 indicators
- Equal weight assumed for content areas and indicators

Examples of Indicators

Interpersonal relations

1. How were you treated by the provider? (*Very well = 1; not well = 0*)
2. Did you feel that the provider cared about your health? (*Yes = 1; No = 0*)
3. Did the provider seem annoyed to you? (*No = 1; Yes = 0*)

Need diagnosis

1. Provider asked or client stated desire to have children (*Yes=1; No = 0*)
2. Provider asked or client stated partner's attitude toward contraception (*Yes = 1; No = 0*)
3. Provider asked or client stated previous use of any method (*Yes = 1; No = 0*)

Generating the Scores

- Scores for new FP clients only included
- Values for each indicator (0,1) summed and averaged to give a mean content area score
- Total score is the mean sum of all 22 indicators (0-22)
- Mean scores compared over time and between groups using $p < .05$

Methodological Issues

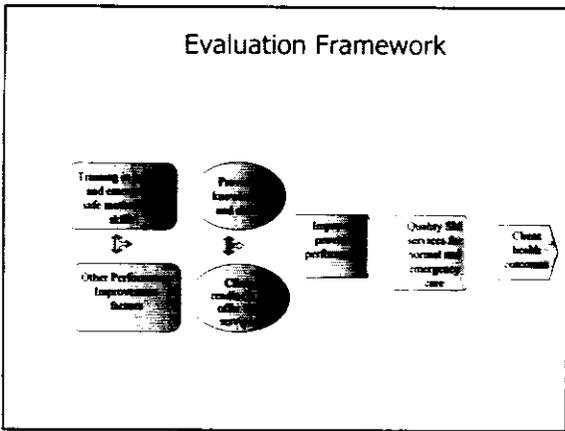
- Equal weightings assumed for content areas and indicators – need for sensitivity analysis
- 6 CPI per provider - is sample size sufficient?
- Quality of CPI measured at provider level
 - Representative of general clinic experience?
- Attribute results to provider training, YSP programme – but role of supportive interventions?
- Was intervention implemented equally intensively?

Improving the Ghanaian Safe Motherhood Programme:

Comparing the Cost-effectiveness of Two Provider Training Approaches

Which Training Approach Works Best?

- 3-week residential safe motherhood clinical skills update training course
 - Integrated LSS and PAC services training
 - RRT members with Master Trainers
- Self-Paced Learning in safe motherhood
 - Competency-based training
 - Self-directed learning with support system



- ### Outcomes for ANC, Labour, Delivery and PAC Services
- Baseline and endline facility surveys:
 - Provider knowledge
 - ✓ Provider interview
 - Provider skills
 - ✓ CPI observations
 - ✓ Simulated scenario questions
 - Clinic readiness
 - ✓ Inventory
 - Quality of safe motherhood services
 - ✓ Provider interview, observations, client interview

- ### Health Outcomes of Antenatal Clients and Medical Outcomes of Deliveries
- Outcome of each service observed
 - Health centers: working hours for one week
 - Hospitals: 24 hour observations
 - Service statistics
 - Are relevant health outcomes recorded
 - Quality of record keeping

Sampling

- (non-) Randomization process
 - By district
 - Clinics within same district?
 - Provider selection within clinic
- Measure provider or facility performance?
 - Attribution of effects of training and other PI interventions to provider or clinic performance?
- Client health outcomes
 - Duration of service statistics included

Measurement

- What is an appropriate way to evaluate the effect of safe motherhood training on provider knowledge and skills?
 - Individual interviews
 - Observations of consultations / procedures
 - Case scenarios
 - Provider self-reporting?
- By type of service?
 - Routine consultations
 - Standard procedures
 - Emergency procedures

Indicators

- Mean summary score index created to measure and compare provider knowledge and skills in each group
 - Assumption of equal importance through non-weighting each indicator
 - But some issues are more critical than others
 - ✓ Critical life saving more than an ordinary procedure
- Should a 'critical steps' index be set?

Standard of Competence

- Should standards for knowledge or skills competency be set?
 - What should be the level of such scores?
 - How set and by who?
 - What to do with providers having a low score or fail the test?
 - ✓Do more training?
 - ✓Re-assign to other duties?
 - ✓Ethics of continuing if low score

Role of Other P.I. Interventions

- Can provider training be effective without other interventions?
- If no, what to do if not possible to implement total package?
- Evaluate total package or training separately?

What Should Be the Basis for Programmatic Recommendations?

- Provider performance
 - Knowledge?
 - Skills?
- Acceptability of models to providers / supervisors?
- Cost per provider trained?
- Effect on service quality?
- Impact on health outcomes?
- Cost-effectiveness
 - But which c-e ratio?

Other Methodological Considerations

- Ethical practice when observing a dangerous practice (especially emergencies)
- Judging performance when few cases available (what is minimum?)
- What if some outcomes decline?
- Resources required to collect data – is it worthwhile?

Training Providers to Involve Men in Maternity Care



Goals of the MiM Study

- To determine the feasibility, cost and impact of involving men in ANC and PNC
- To evaluate the impact of involving men in group couple counseling sessions with their pregnant partners

The Interventions

1. Training clinic staff
2. Development and use of IEC materials
3. Group couple counseling sessions
4. Development and use of a management information system
5. Monitoring and supervision

Implementing Training of Clinic Staff

- Data collected through diagnostic research
- Working group of key stakeholders formed
- Training curriculum sub-group created
- Comprehensive curriculum developed
- One week trainers workshop held
- Three week training for all nurse cadres
- Each nurse exposed to 40 hours of training
- 65 nurses trained in six clinics

Training Modules

- Quality of care
- Basic counseling skills
- Sexual health
- Sexually transmitted infections
- Involvement of men in maternity care
- Pregnancy
- Preparation for delivery
- Post natal care
- Infection control

Challenges to Designing and Implementing Training (Content)

- Introducing new concept (male involvement)
- Introducing new service (couple counseling)
- Ensuring all aspects are included
- Handling controversial issues
- Balancing content with time available

Challenges to Designing and Implementing Training (Process)

- Removing nurses from service for training
- Ensuring the appropriate staff are trained
- Mix of nurse cadres of nurses in training
- Cascade training may dilute quality
- 'Brain drain' of nurses

What Outcomes Were Measured?

- Client knowledge
 - FP, STI/HIV, dual protection, pregnancy/childbirth
- Client / partner behaviour
 - Male participation in service
 - Interpersonal relations and supportive roles
 - STI prevention and male symptoms
 - Infant care
 - Postpartum FP
- Not measured but should have been:
 - Provider knowledge
 - Provider practice

Data Collection Methods

- For providers
 - Focus group discussions
 - Supervisory tool
 - Client records
- For clients and partners
 - Baseline interviews on first ANC visit
 - Endline interviews at home six months postpartum

Evidence that the interventions took place

- Supervisory tool
- Clinic registers
- Client questionnaires:
 - Exposure to IEC materials
 - Exposure to couple counseling sessions
 - Inter-couple discussion on key issues

Challenges to Evaluating MiM Training

- Attribution to provider training not direct for client level outcomes
- Client-level data collection can be costly and time consuming
- Difficult to follow-up clients in mobile populations
- Recall bias over time
- Staff turnover

Lessons Learnt

- Variety of research methods needed for design, development, implementation and evaluation of training
- Provider training could have limited impact if supporting infrastructure is not adequate
 - E.g. training should have included delivery hospital nurses
- Process and output measures of training important to be able to understand impact
- Package of interventions means difficult to attribute outcomes to staff training

Some Common Themes

Evaluation design issues

- Desirability/feasibility of randomization
- Attribution of training as component of a package
- Providers vs. clinic level output measures
- Service vs. client behaviour / status outcomes
- Sample sizes
- Different ways of measuring same indicator
- Summary indexes – creation and weighting

More Common Themes

Interpreting / using findings

- Ethical handling of dangerous practices
- Judging provider performance
 - standards or significant improvements
 - Which outcome measures to make decision
- Dealing with non-improvement
- Dealing with decline
- Getting evaluation results used
 - overcoming inertia
 - Institutionalizing better practices

Developing Effective Group and Individualized Learning Materials

Rick Sullivan

Director
Learning and Performance Support
JHPIEGO Corporation
1615 Thames Street, Suite 300
Baltimore, MD 21231-3492
Phone: 410-537-1931
Fax: 410-537-1476
E-mail: rsullivan@jhpiego.net

M'imunya Machoki

Lecturer: ObGyn
Kenyatta National Hospital
Department of Obstetrics and Gynecology
P.O. Box 28207
Nairobi, Kenya
Phone: 725505 or 726672
Fax: 716177
E-mail: mmachoki@africaonline.co.ke



Developing Effective Group and Individualized Learning Materials

JHPIEGO

Rick Sullivan
JHPIEGO Corporation

Objectives

- Identify the components of an effective learning package.
- Apply lessons learned from JHPIEGO's experience in designing and developing group and individualized learning materials.

2

A Pause for Brainstorming

- Talking with your neighbors, discuss the **worst** materials you have used as a course participant and as a trainer.
- Then talk about the **best** materials you have used as a course participant and as a trainer.
- Let's share.

3



Instructional Design Process

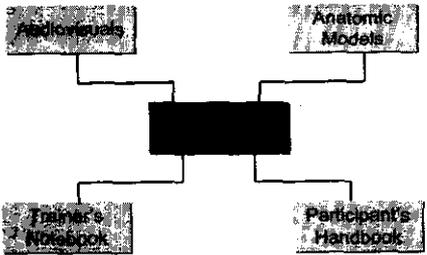
- Analysis
- Design
- Development
- Implementation
- Evaluation

- Let's look at the instructional design process.
- What approach do you use for instructional design?

4



Group Learning Package



5



Reference Manual

- Contains the essential, need to know information related to the course objectives.
- Serves as the "text" for the participants.
- Serves as a "reference source" for the trainer.
- Supplemented with country specific information.
- Used by the participant after training as a *reference source on the job*.

6

Participant's Course Handbook

- Road map to guide the participant through the course and contains:
 - Course syllabus (see sample)
 - Course schedule (see sample)
 - Exercises
 - Pre-test
 - Clinical learning guides and performance checklists
 - Course evaluation

7

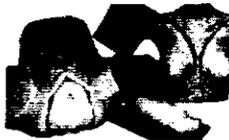
Trainer's Course Notebook

- Contains the participant's handbook materials as well as the following:
 - Course outline (see sample)
 - Post-test
 - Answers to the pre- and post-tests
 - Answers to the exercises
 - Performance checklists
 - Supplemental information for the trainer (e.g. warm-ups)

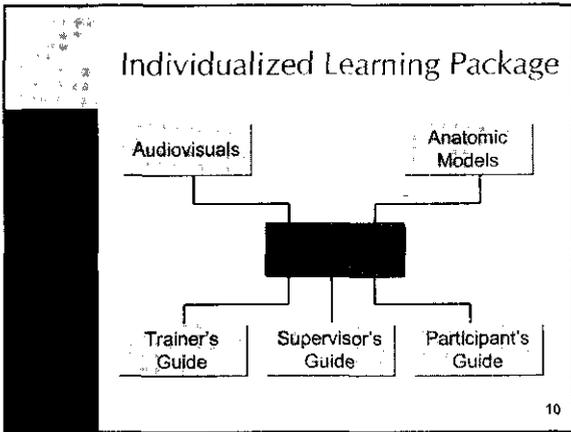
8

Anatomic Models and Audiovisual Learning Aids

- Anatomic models (e.g., pelvic, condom, breast, childbirth simulator)
- Videotapes
- Jobs aids (e.g., pregnancy wheel)
- PowerPoint presentations
- CD-ROM with content images (e.g., cervical cancer)



9



Comparing Group and Individualized Learning Packages

- Reference manual, anatomic models, audiovisual learning aids, pre- and post-tests, learning guides and performance checklists are the same.
- Primary difference is in the course outline as the participant is now primarily responsible for "moving" through the objectives and related learning activities (see sample outline).
- In some packages, there is a need for a supervisor's guide.

11

Lesson Learned #1

- **Design and development of learning materials must be based on an instructional design process.**
 - Review existing processes and adapt a process that fits your organization.
 - Orient and train key staff to use the process.

12

Lesson Learned #2

- **Develop clear learning objectives to define the knowledge and skills participants are expected to learn.**

- Write objectives using a standard format
- Develop objectives at appropriate levels of the knowledge or cognitive domain
- Develop objectives to reflect the appropriate levels of the skill or psychomotor domain

13

Lesson Learned #3

- **Authors writing the reference manual must be subject matter experts (SMEs) and fully dedicated to writing.**

- Authors work as part of a writing team
- Need a lead SME
- Authors need to work closely with the instructional designer (also on the team)
- Authors and editors must be involved from the beginning of the design process

14

Lesson Learned #4

- **Write materials at an appropriate reading level.**

- Keep target audience in mind
- Keep sentences short
- Avoid multi-syllable words (like multi-syllable)

15



Lesson Learned #5

- **Keep the design of the reference manual simple.**
 - Use lots of white space.
 - Use simple line drawings for graphics.
 - Use bullet lists.
 - Send reviewers a version that is as complete as possible.

16



Lesson Learned #6

- **Build knowledge and skill assessments into the courseware.**
 - Pre- and post-tests
 - Learning guides
 - Performance checklists
 - Guidelines for administering knowledge and skill assessments

17



Lesson Learned #7

- **Participants must be able to keep a copy of the course materials following the course.**
 - Use as a problem-solving tool on the job.
 - Refer to for updates as needed.
 - Share information with colleagues.

18

Lesson Learned #8

- **Content in the reference manual must be separate from training methodologies and approaches.**
 - Develop one manual and use it in a variety of training settings (e.g., PAC manual, IUD manual)
 - Participants do not need all of the training information.
 - Design the course and supporting courseware after the reference manual is finalized.

19

Lesson Learned #9

- **Trainers need a detailed outline of how to conduct the course.**
 - Most trainers are not instructional designers.
 - Helps ensure a variety of training methods are used.
 - Trainer can modify, but needs a place to start.
 - Improves trainer's time management.
 - Helps ensure standard delivery of training.

20

Lesson Learned #10

- **Trainers must be SMEs, trained in training skills and must be oriented as to how to use the course materials.**
 - Skill standardization and knowledge update
 - Classroom and clinical training skills
 - Practice using the course materials in presentations, demonstrations, coaching, etc.

21

Lesson Learned #11

- Trainers need to **"personalize"** content to make it fit their individual training style.
 - Avoid too much detail for the trainer (e.g., Say "xxx").
 - Personalize (i.e., notes, AV reminders, questions, activity steps) the same reference document being used by the participants.
 - Separate reference manual to create a folder system with one folder per chapter or session.

22

Lesson Learned #12

- Those responsible for the course design and materials development should have some level of involvement in the pilot test of the course.
 - When possible, should be present to observe.
 - Talk with the trainers and, if possible, the participants.
 - Review results of any knowledge and skill assessments.
 - Review course evaluations.
 - Revise the course design and materials accordingly.

23

Summary

- Questions regarding the lessons learned from developing group and individual learning materials?
- Please complete your session evaluation.

Thanks for coming!!!

24

How to Build Partnerships: Models of Training Networks

Jacqueline Makokha

Network Coordinator
Regional AIDS Training Network
(RATN)

P.O. Box 16035 00100 GPO

Nairobi, Kenya

Phone: 254-2-271-6000

254-2-272-4634

254-2-272-6705

Fax: 254-2-272-6626

E-mail: jackiem@ratn.org



How to Build Partnerships: Models of Training Networks

Presenters

Jacqueline Makokha
Network Coordinator, Regional AIDS Training Network (RATN)
Nairobi, Kenya

Ann Downer, EdD
Director, International Training and Education Center on HIV (I-TECH)
University of Washington
Seattle, USA

Overview of Session

Purpose: to provide ideas about how partnership can be developed and sustained. Several examples of training networks have been collected from throughout the world and described in this document. The networks include:

- Regional AIDS Training Network, East and Southern Africa
- AIDS Education and Training Centers, United States
- Public Health Training Network, United States and international
- Latin American and Caribbean Health Care Reform Initiative
- Getnet, South Africa

The workshop allows time to study how each network is structured, staffed and funded. The examples are illustrative, but not prescriptive. They show that one can design a network based on a relationship among partners from one model and a funding mechanism from another model.

Learning Objectives: This session will help professionals to create training partnerships by making decisions about:

- which partners could be included in a network;
- what partners can contribute to a network; and
- how training can be financed.

Methodology: The session is divided into three 30-minute segments.

- Presentation of the 5 training networks.
- Questions & Answers. Participants may discuss the examples or ask questions of the presenters.
- Exercise. Participants will work in small groups to discuss the strengths and weaknesses of the different partnership models and how they could be applied in their particular geographical or technical area.

1. Secretariat Model -- RATN

The Regional AIDS Training Network (RATN) is a network of training institutions in the Eastern and Southern Africa (ESA) region. The Network is managed through the University of Nairobi and the University of Manitoba, with its Secretariat based in Nairobi, Kenya.

The objectives of RATN are:

- To assist member institutions to identify, develop and improve courses;
- To enhance program delivery and related services in order to meet the specific needs of the region;
- To link training institutions and facilitate regional collaboration in the management of STDs/HIV/AIDS;
- To provide a wider resource base, dissemination of information to members so that they can improve quality and effectiveness of their services in individual countries and the region;
- To facilitate exchange of skills, expertise and technologies among training institutions;
- To liaise with the donor community & mobilize funds, technical assistance and other resources to increase the impact of training programs/activities.

Website: <http://www.ratn.org>

Structure

RATN carries out the following activities through its Secretariat in Nairobi:

- Sparks and coordinates forums for experts meetings on training needs and development of courses;
- Initiates and conducts regional surveys to assess new developments and needs in training;
- Produces a quarterly newsletter on training and related issues;
- Stimulates extension programs for follow-up of ex-course participants;
- Keeps a database of training institutions, resource persons and ex-course participants;
- Produces a course calendar on regional courses;
- Mobilizes resources from donors to support participants to regional courses;
- Undertakes regional and international advocacy activities on behalf of its membership.

RATN is a network of training institutions coordinated through a secretariat and guided by a steering committee.

The Network Steering Committee, composed of representatives of partner institutions, donor agencies and implementing agencies such as UNAIDS, is responsible for the overall policy and direction of the Network while the Secretariat is responsible for its daily operations.

Network Membership

The Network has the following categories of membership:

- **Partner Institutions:** This group of regional training institutions form the core of the Network. They comprise of institutions that prepare and deliver courses and participate in other Network activities.
- **Associate Institutions:** These comprise of institutions that are involved in other areas of prevention and control of STDs/HIV/AIDS activities such as; Ministries of Health, National AIDS Control Programs, other networks working in the region, development agencies, the

donor community, and others that are interested in the Network's information, communication and extension activities.

- **Other Members:** Other categories of membership include ex-course participants, researchers/experts and others who are interested in the Network activities.

There are currently no membership fees; however, RATN is planning to charge fees for specific services.

Training

Most of the trainings associated with RATN are courses, but the courses are offered at partner institutions. RATN's role is to develop the courses by conducting a needs assessment and/or convening an expert committee to develop the curriculum. Partners are then invited to submit a proposal with their institutional capabilities and one or more of the partners are selected to offer the course.

The course calendar includes courses on 16 topics ranging from Advocacy Skills to Laboratory Management to Training of Nurse Trainers in STIs. The trainings last from 2 to 5 weeks. Many courses include clinical training; for example a 3-week course might include 1-week of clinical training.

Staff

Staff positions at the secretariat are listed below:

Position	FTE
Co-Directors	2
Course Coordinator	1
Network Coordinator	1
Project Manager	1
Resource Center Assistant	1
Computer Network Administrator	1
Information Officer	1
Data Entry Clerk	1
Secretaries	2
Office Assistant	1

In addition to the secretariat, there is a volunteer contact person for RATN at each of the partner institutions. Whenever possible, RATN funds travel for the staff at partner institutions who participate in a needs assessment or serve on an expert committee.

Funding

RATN secretariat's annual budget is estimated to be \$600,000. RATN's activities and staff are funded by several donors and universities, including:

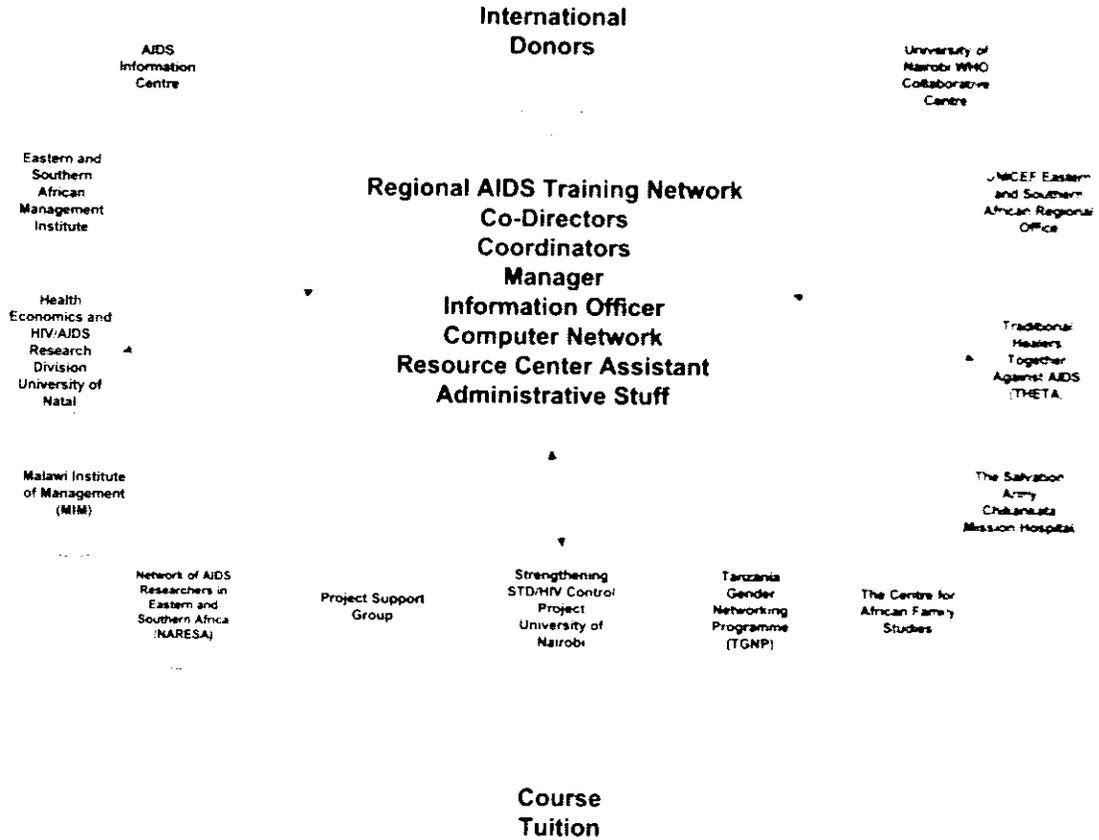
- Canadian International Development Agency (CIDA)
- Swedish International Development Agency (SIDA)
- The World Bank
- Flemish Interuniversity Council (VLIR)
- UNAIDS
- WHO

- UNICEF
- University of Nairobi
- University of Manitoba
- Family Health International - Impact Project
- United States Health Resources and Services Administration (HRSA)

As shown on the RATN Financial Model below, RATN does not finance the courses offered at the partner institutions and has only limited funds for scholarships. The courses are funded by tuition, which is collected by the partner who offers the course. Donors may also channel the funds through RATN to the institution offering the course. Course revenue averages \$50,000 per course. Tuition ranges from \$1,500 to \$2,500 and enrollment ranges from 12 to 30 participants. In addition to tuition, participants must find funding from their employers or other donors for travel to the course, and the participant or their employers bear the cost of time away from work.



RATN Financial Model



2. Independent Centers Model -- AETC

Based in leading academic centers across the United States, the AIDS Education and Training Centers (AETCs) offer clinical education and consultation covering up-to-date information on the transmission, treatment, and prevention of HIV/AIDS. The education is provided in a variety of formats including workshops, hands-on supervised clinical training, and specialty conferences. The AETCs use nationally recognized faculty and HIV researchers to develop, implement, and evaluate the education and training offered. The AETCs' medical faculty also provide timely clinical consultation in person, or via the telephone or internet.

The AETC network is made up of regional centers that conduct clinical training on HIV/AIDS issues and national resource centers that support the regional centers.

The AETC program was designed to improve dissemination of new information to U.S. HIV/AIDS care providers to ensure that they are well-trained and educated about state-of-the-art care and treatment. The AETCs offer front-line healthcare providers including physicians, nurses, physician assistants, dentists and pharmacists the latest in AIDS education and training so that they can give their patients the best care possible. The AETCs serve all 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, and the six U.S. Pacific jurisdictions.

Website: <http://www.hab.hrsa.gov/educating.htm>

Structure

The AETC program currently supports a national network of regional centers that conduct the education and training programs. The AETCs consist of 12 university-based programs, and one hospital-based center. Considerable flexibility and creativity have been maintained in AETCs regional programming so that changes in the socio-economic, cultural, and clinical aspect of the epidemic are rapidly reflected in the training program.

Several national, cross-cutting components of the AETC program support and complement the regional training centers. These include the National Minority AETC, the National Resource AETC, the National Evaluation AETC, and the National HIV/AIDS Clinicians' Consultation Center. The Minority AETC benefits minorities who are disproportionately affected by HIV/AIDS. The Center offers clinical consultation and support to minority providers, builds networks among these clinicians, and expands educational resources to increase the number of minority clinicians providing quality care to HIV-positive individuals. The Resource Center is a web-based HIV/AIDS training resource that supports the regional AETCs through coordination of HIV/AIDS training materials and rapid dissemination of advances in treatment. The Evaluation Center is responsible for program evaluation activities, including assessing effectiveness of the AETCs' education, training, and consultation activities. The National HIV/AIDS Clinicians' Consultation Center provides health care providers with a national resource to obtain timely and appropriate responses to clinical questions related to treatment of persons with HIV infection and/or possible health care worker exposure to HIV and other blood-borne pathogens.

Northwest AIDS Education and Training Center (NW AETC)

Each of the 12 regional centers in the United States is unique, so there is no single model of an AETC regional center. All AETCs must however, have a Minority AIDS Initiative program that builds organizational and clinical capacity. We offer information below on training at the Northwest AETC (NW AETC), as well as information about its staff and funding. The model

focuses on the state programs; NW AETC is also home to a Minority AIDS Initiative program and a Palliative Care program, which are briefly described below.

Training

NW AETC devotes most of its resources to workshops and preceptorships instead of lectures because more intensive trainings are more effective. Trainings by NW AETC are primarily categorized as levels II and III from the following categories:

- I. Didactic. These lectures are geared to 2 types of audiences: 1) experienced, high volume providers who need an update on the latest information, and 2) inexperienced providers who need motivation to treat HIV/AIDS patients and develop HIV/AIDS expertise.
- II. Workshops. These courses are generally 4 hours long and teach specific skills such as: 1) how to perform a risk assessment, or 2) how to co-manage an HIV/AIDS patient with more experienced clinician.
- III. Preceptorship. This is a 1-2 day activity in which a provider will observe the trainer in practice at a clinic.
- IV. Consultation. A trainer visits the provider's clinic for a day and attends patient visits with him/her or reviews medical charts with him/her.
- V. Technical Assistance. This activity is directed at the organization.

In FY 2002, the NW AETC provided training to 2224 people in 5 states. Staff provided 504 hours of training during 156 sessions. A training session lasted 3 hours and 15 minutes on average.

Staff

The NW AETC is structured with a regional staff located at the University of Washington (UW) and staff in each of the 5 states included in the region: Alaska, Idaho, Montana, Oregon and Washington. Some regional staff work on one program, while others work on multiple programs. The state program is structured with a regional staff at UW and at least one coordinator in each of the five states. The regional staff leads training programs in specific fields, as well as overseeing and administering the program. The Minority AIDS Initiative program is structured with a regional staff at UW, and training coordinators at four sites. The Palliative Care program has staff only at UW. Staff positions for all three programs on at the regional office are listed below:

Position	FTE
Principal Investigator/Clinical Director/Educator	0.5
Program Director	1
Medical Program Director/Educator	0.6
Pharmacy Educator	0.25
Dental Director/Educator	0.35
Corrections Program Educator	0.2
Program Manager	3
Program Coordinator	3
Evaluator	1.5
Data Analyst	1

NW AETC has several additional regional medical educators for both the state program and Minority AIDS Initiative program who are consultants or UW employees.

For the state program, staff at the state office is responsible for conducting training needs assessments, and the planning and implementation of training for health professionals in that state. Most state coordinators are hired through a contract with a Ryan White Title II agency.

(state health department) or a Ryan White Title III clinic. For the Minority AIDS Initiative program, the training coordinator is hired through a contract with a minority, community-based organization, a tribal college or a Ryan White Title III clinic.

Funding

The NW AETC has an annual budget of about \$2.2 million for FY 2003, which is funded by the United States Health Resource Services Administration (HRSA). As shown below, the State Program Financial Model is decentralized. Each state coordinator has his/her own budget and HRSA requires that each state receive at least \$150,000 per year. The Minority AIDS Initiative program and Palliative Care programs are more centralized.

The NW AETC does not charge for training, but other regional centers recover some expenses by charging for courses. In FY 2002, the average cost per person trained was about \$944. For the state program, participants are responsible for travel expenses. For the Minority AIDS Initiative, travel funds are available for participants. For both programs, participants or their employers bear the cost of time away from work. Foregone earnings in the United States are a substantial expense for a medical practice, so every effort is made to minimize the amount of time away from work.



NW AETC State Program Financial Model

HRSA

Regional Office

PI

**Program Director
Regional Educators
Manager
Coordinator
Evaluator**

**AK
State
Office**

**ID
State
Office**

**MN
State
Office**

**OR
State
Office**

**WA
State
Office**

3. Partners Model -- PHTN

The mission of the Public Health Training Network (PHTN) is to develop a public health workforce in the United States that is able to quickly apply current and relevant knowledge to public health issues.

PHTN is a distance learning system that "takes training to the learner" by using a variety of instructional media ranging from print-based to videotape and multimedia. Formats include:

- Print-based self-instruction;
- Interactive multimedia (e.g. CD-Rom, Web-based);
- Videotapes;
- Two-way audio conferences; and
- Interactive satellite videoconferences.

PHTN develops partnerships with existing institutions and uses distance learning systems to "take training to the learner".

Website: <http://www.phppo.cdc.gov/PHTN>

Structure

The PHTN is a network of public, private, academic, and business organizations. These partners include the Association of Schools of Public Health, Association of State and Territorial Health Officials, Association of Teachers of Preventive Medicine, National Association of City and County Health Officers, Public Health Foundation, Veterans Administration, state and local health departments, and others. The partners support PHTN activities such as:

- Assessing the training needs of the public health workforce;
- Training development and delivery;
- Evaluating individual training products and PHTN as a whole; and
- Accreditation of programs.

Since September 11, 2001, several new partners have joined PHTN, including the American Hospital Association, American Medical Association, the American Osteopathic Association, Association of American Medical Colleges and the National Medical Association.

Products

PHTN's offerings are produced collaboratively by instructional specialists housed at the Centers for Disease Control and Prevention (CDC) and content specialists who work at one of CDC's centers, institutes and offices or at one of the public health partners. A CDC scientist proposes a course topic to PHTN and then PHTN helps to design and develop the offering. The center/institute/office is responsible for developing the course content. Other public health partners may also propose course topics, but they are encouraged to develop it with a CDC center/institute/office.

PHTN courses cover a range of topics, because of the broad spectrum of public health priorities. It serves all of CDC's centers, institutes and offices at CDC and public health partners may also produce satellite broadcasts that are listed on the PHTN website. For example, a November/December 2002 schedule of satellite broadcasts includes:

- A six-part satellite conference series on "Crisis and Emergency Risk Communication"
- Live broadcast of a session from the America Public Health Association meeting
- "Schizophrenia: How do we improve long-term outcomes?"
- "Asthma triggers and medications"
- "2002 STD Treatment guideline update"

Since 1993, PHTN programs have reached over 4 million public health professionals in the United States. PHTN trained more than 2.2 million people in 2001 through 196 live satellite broadcasts, and 99 video, print, computer-based and web-based programs. In 2001, 59 percent of the participation was associated with the "CDC Responds" series about bioterrorism. PHTN programs also serve public health professionals in 25 North American, African, Caribbean, Eastern European, and Mediterranean countries.

Staff

The PHTN is centrally led and supported by CDC's Division of Professional Development and Evaluation within the Public Health Practice Program Office. The CDC staff includes specialists in instructional design, field operations, learner support, graphic design, and television production.

The PHTN also includes state distance learning coordinators in the department of health of each state. The coordinators are employees of their respective states.

Funding

The PHTN has separate funding mechanisms for staff and course development. Staff within the Division of Professional Development and Evaluation is funded directly by CDC, whereas course development is funded by CDC centers, institutes, and offices as part of their budget allocation from the U.S. Congress. The center/institute office may also give funds to PHTN to help develop a course and to build infrastructure.

In some cases, CDC charges for courses, whereas in others the courses are free. Continuing education credits are available for many courses. Trainees or their employers bear the cost of time away from work.



PHTN Financial Model

Centers for Disease Control and Prevention (CDC)

Public Health Practice
Program Office

Division of Professional
Development and
Evaluation/DPDE

PHTN Staff

CDC Centers

Offices

Institutes

Partners
(Public Health Associations, etc.)

Distance Learning

Coordinators from State
Departments of Health

State Governments

Other U.S. Government Agencies

4. Regional Model -- LAC HCR Initiative

The Latin American and Caribbean Regional Health Sector Reform (LAC HSR) Initiative provides support to national reform processes to promote more effective basic health services. It uses a participatory approach, working in partnership with key decision-makers in the region to build capacity to access health sector problems and to design, implement, and monitor reforms. The Initiative supports activities in 14 countries, including: Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, and Peru.

The LAC HSR Initiative supports health service reform in the region through partnerships and an information clearinghouse.

Beneficiaries of the LAC HSR Initiative include ministries of health, ministries of finance, central banks, social security institutes, private voluntary organizations (PVO), non-governmental organizations (NGO), local government, private-sector health care providers and insurers, professional societies, universities and research institutes, and donor organizations in LAC and elsewhere.

In 1994, governments in the region expressed a need for a network to support health reform through analysis, training, and other capacity-building measures. Those needs were presented in the Section 17 of the Action Plan approved by heads of state at the Summit of the Americas in Miami in 1994. The LAC HCR Initiative was launched in July 1997, and continues to be supported by the Bureau for Latin America and the Caribbean, U.S. Agency for International Development (USAID/LAC), with some co-financing from the Pan American Health Organization (PAHO).

The Initiative seeks to promote more effective implementation and assessment of health reforms and health system performance. The regional efforts of the Initiative support informed decision-making on health financing, organization and management of health services, and human resource/workforce issues. The LAC HSR Initiative emphasizes teamwork and participatory design and implementation. USAID and the Initiative's implementing partners seek ideas from a broad range of people and institutions engaged in health reform to develop partnerships that build and share knowledge across the region.

Since 1997, the LAC HSR Initiative has made significant contributions to strengthening reform processes at the regional level. Most notably, the Initiative supported the introduction of a standardized approach to estimating national health expenditures, called National Health Accounts (NHA), in eight countries in LAC. A regional network for country teams involved in developing NHA was established and maintained until 2000. Regional efforts at obtaining standardized, quantitative information on sources and uses of health financing have led to increased awareness of inequities in health financing and complexities of managing the link between provision and payment for services.

The revised LAC HSR is currently being implemented from 2001 to 2006. The first phase, 2001-2003 will consolidate and extend the impact of previous Initiative activities, products and tools, and identify and begin testing new areas and topics in health reform and systems performance. Priority will be placed on providing follow-up and greater in-depth consultation and exchange in order to contribute to health reform objectives of greater access, equity, efficiency, quality, and sustainability of health services. The subsequent phase, 2003-2006, will focus on more effective implementation and assessment of health reforms and health system performance in target countries in LAC.

Website: <http://www.americas.health-sector-reform.org>

Structure

The LAC HSR Initiative currently has five implementing partners, including PAHO and four Cooperating Agencies (CAs). CAs are organizations which have current contracts or cooperating agreements with USAID. The Initiative's four CAs include: 1) Partners for Health Reform Plus (PHRplus) Program; 2) Management and Leadership (M&L) Program; 3) Quality Assurance and Workforce Development (QA/WD) Program; and 4) Rational Pharmaceutical Management Plus (RPM+) Program. The Initiative is coordinated through a steering committee with representatives of USAID and the implementing partners, and guided by a technical advisory group.

Activities

The regional activities of the LACHSR Initiative are organized around three cross-cutting intermediate results areas:

1. Increased use of Initiative tools, approaches, and technical materials.
2. Increased availability and improved quality of information.
3. Increased communication, dialogue, networking, experience sharing, and institution building around common concerns and themes.

In addition, since October 2002, the Initiative focuses on three thematic areas of activities: health financing; organization and management of health care delivery; and, human resources. Within these areas, emphasis will be on:

- Development, adaptation, and modification of tools and methods for improving implementation of health reforms.
- Upgrading of the Initiative website into a proactive platform for sharing experiences and disseminating information.
- Conduct of operations research, cross-country comparisons and assessments;
- Synthesis of country experiences.
- Conduct of workshops, seminars, and study tours around specific, focused themes.
- Activities related to institution building through support of regional training activities in health reform and in utilizing LAC expertise on health reform in South-South exchanges and technical assistance.
- Strengthening networks within the region involved in implementing health reforms.

The Initiative has produced nearly 60 major publications, of which one-third are tools, approaches, and methods for strengthening the design, monitoring, and evaluation of health reform in the region. These include:

- A methodology for monitoring and evaluating health sector reform in LAC.
- Guidelines for promoting decentralization of health systems.
- A policy analysis toolkit.
- Guidelines for enhancing the political feasibility of health reform.
- Provider payment primer and prospective payment tools.
- Approaches for partnerships between the public and private sector.
- Social health insurance assessment tools.

The Initiative has sponsored 20 regional exchanges addressing topic such as NHA, NGO contracting, decentralization, health reform and HIV/AIDS, leadership and health reform, hospital reform, social insurance, policy and research linkages, and provider payment mechanisms. A total of 851 participants have participated in these events, covering all of the Initiative's target countries.

Staff

The LAC HSR Initiative has no permanent paid staff. Staff at USAID/LAC Regional Sustainable Development Office, Population Health and Nutrition Team (USAID/LAC/RSD-PHN) provides oversight, guidance, and management of the Initiative. Staff from the implementing partners based in Washington, D.C., and Boston are assigned to work on coordination and technical functions of the Initiative.

Population Health and Nutrition Staff in USAID missions and PAHO regional and country-level offices help to coordinate and facilitate activities of the Initiative as part of their regular job responsibilities. Representatives of ministries of health, social security institutes, NGOs, private-sector organizations, and other agencies in the LAC region, participate as part of their job responsibilities.

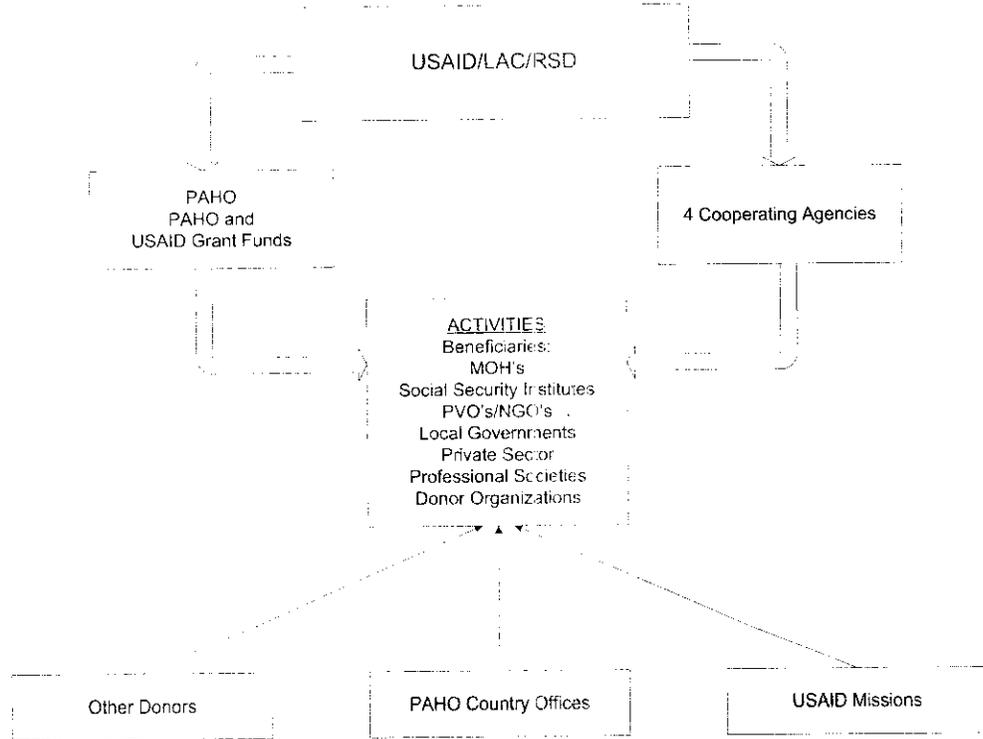
Funding

The LAC HCR Initiative is financed by the USAID/LAC/RDO-PHN. Since 1997, USAID has obligated approximately \$US 1 million per year for the Initiative, which is divided among the implementing partners through various mechanisms. USAID has a grant agreement with PAHO, which requires counterpart funding of the Initiative. PAHO's own contribution to the total budget of the Initiative represents approximately one-fifth of the total. USAID/LAC/RSD-PHN provides "field support" buy-ins to the other four CAs whose primary contracts or cooperative agreements are with USAID's Bureau for Global Health. These four CAs may also contribute to the Initiative by using core funds to support specific activities, such as studies and development of tools.

The Initiative's workshops and other activities are generally free to participants from the LAC region. Because the Initiative seeks to create collaboration among donors and other organizations in the area of health reform in LAC, travel, accommodations, and per diem costs of participants have been funded through the Initiative's implementing partners, as well as USAID missions, PAHO country offices, the World Bank, and the Inter-American Development Bank. Participants or their employers bear the cost of time away from work.



LACASR Financial Model



5. Consultant Model -- GETNET

The Gender Education Training Network (GETNET) is a South African NGO that offers gender training through a pool of skilled gender trainers. Services contribute to addressing the need for skills, expertise and capacity to effect gender sensitive policies, practices and cultures within institutions and organizations. GETNET believes that relevant skills and expertise are crucial to the quality, pace and scale of change towards gender equality.

GETNET has a small staff and uses a pool of skilled trainers to deliver training.

Building partnerships and sharing knowledge are core principles that support GETNET's objective of developing critical dialogue. This dialogue leads to the development of indigenous theoretical frameworks and methodologies. These indigenous frameworks and methodologies, in turn, ensure that strategies to achieve gender equality are effective and that the impact of gender training is lasting.

Website: <http://www.getnet.org.za>

Structure

GETNET was established in 1995 as an independent, non-profit, membership-based organization in South Africa's NGO sector. GETNET's work is guided by a board of directors. A small, full-time staff maintains the administration, implements operations and coordinates a panel of trainers who act as consultants. The trainers work throughout the Southern African Development Community (SADC) region.

Training

Most training is in the form of workshops that last three to five days. GETNET has developed the following four key modules for workshops:

- Gender education and awareness raising
- Organizational development and transformation
- Mainstreaming gender equality in organizations
- Gender analysis of policy

GETNET encourages clients to support a needs assessment in advance of workshops to be sure that the training provides the skills necessary for a clients' particular environment or problems. In 2001, GETNET appeared to offer about 1 workshop per month.

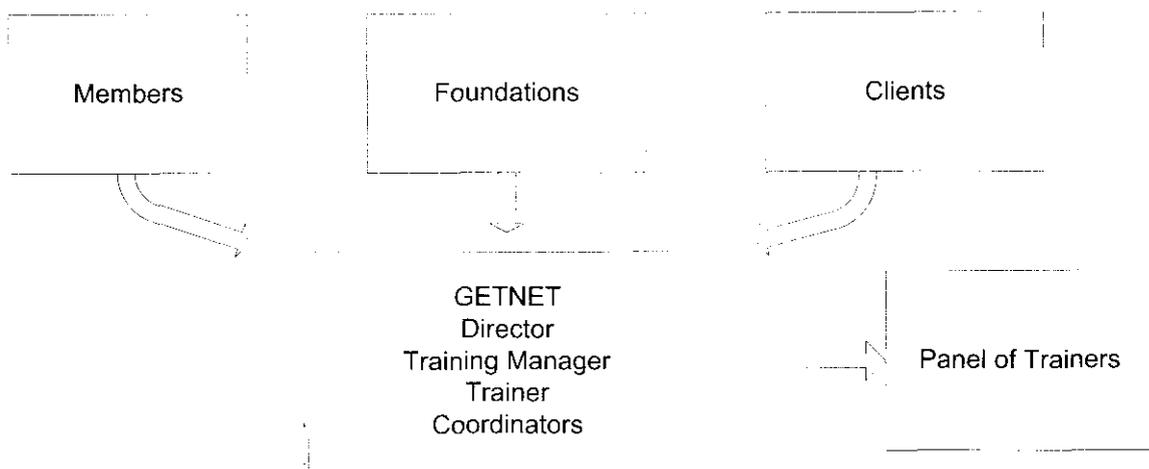
Staff

The full-time staff of GETNET includes at least four positions: director, training manager, trainer and coordinator.

Funding

As shown on the GETNET Financial Model, funding for GETNET appears to come from 3 sources: 1) membership fees, 2) foundation grants, and 3) consultancy fees.

GETNET Financial Model



Tailoring Training and Ensuring Impact: Using the Performance Improvement Methodology

Rose Wahome

Program Officer
East and Southern Africa Region
Intrah PRIME
P.O. Box 44958
00100 Nairobi, Kenya
Phone: 254-2-211820
254-2-211821
Fax: 254-2-226824
E-mail: rwahome@intrah.org

Jedida Wachira

Regional Director of Programs
East and Southern Africa Region
Intrah
P. O. Box 44958
00100 Nairobi, Kenya
Phone: 254-2-211820
254-2-211821
254-2-230382
Fax: 254-2-226824
E-mail: jwachira@intrah.org



Tailoring Training and Ensuring Impact: Using the Performance Improvement Methodology

Jedida Wachira, ESA Director of Programs, Intrah
Rose Wahome, ESA Program Officer, Intrah

Africa
For Partners in Learning & Growth

Session Agenda

- Orientation to the performance improvement process
- Review two cases (EQUITY and DISH)
- Impact
- Lessons learned
- Guided discussion

Africa
For Partners in Learning & Growth

Global Trend

SHIFT

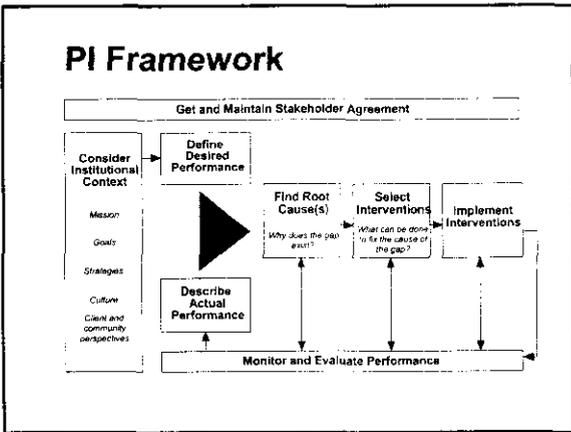
Africa
For Partners in Learning & Growth

Why the PI Approach and Tools?

Despite a series of training activities, reports from clinics show:

- gaps in performance
- inconsistent and /or low performance





The Situation

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none"> ▪ DOH challenge to provide PHC ▪ Epidemics of TB, HIV/AIDS, STIs ▪ Lack of resources ▪ Poor infrastructure ▪ Clinic staff lack necessary skills ▪ Clinics poorly designed 	<ul style="list-style-type: none"> ▪ Challenge to make motherhood safe ▪ Clients perceive low-quality services ▪ Clients lack knowledge of antenatal health ▪ Late/no antenatal care; postnatal focus on infant ▪ Facilities poorly equipped



Stakeholder Agreement

South Africa/EQUITY	Uganda/DISH
<p>Meetings with:</p> <ul style="list-style-type: none"> ▪ DOH training coordinator ▪ PHC training team ▪ district manager ▪ community health managers ▪ supervisors ▪ clinic staff 	<p>Meetings with:</p> <ul style="list-style-type: none"> ▪ MOH leadership at national, district, sub-district levels ▪ DISH Project partners ▪ health unit staff ▪ clients, CORPS, community leaders
<p>Agreements on: approach, purposes and outcomes</p>	

The Goals/Objectives

South Africa/EQUITY	Uganda/DISH
<p>Use model clinics to explore, identify, create and apply performance solutions to TB, STIs, HIV/AIDS, child health and FP</p> <ul style="list-style-type: none"> ▪ training/supervision ▪ service quality 	<p>Increase utilization of MH services:</p> <ul style="list-style-type: none"> ▪ assisted deliveries ▪ quality facilities ▪ birth plans <p>Improve client knowledge of:</p> <ul style="list-style-type: none"> ▪ pregnancy risk ▪ ante-/post-natal care

Desired Performance

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none"> ▪ 85% of new and 80% of re-treatment adult TB patients will complete treatment according to standard ▪ All adult patients presenting at clinic with chronic cough will be screened for TB and have two sputum tests 	<ul style="list-style-type: none"> ▪ MH providers will access and comply with RH-MCH guidelines for: <ul style="list-style-type: none"> - goal-oriented ANC - intra-partum care - postnatal care ▪ 80% of pregnant women attend antenatal clinic 4 times and have assisted delivery

Actual Performance

South Africa/EQUITY	Uganda/DISH
4 of 5 clinics reported no cases of TB; one clinic reported one case	< 20% of clients are assisted at delivery in health facilities

Africa
New Practices in Training & Learning

Performance Gap

South Africa/EQUITY	Uganda/DISH
95-100% gap in identifying, treating and reporting TB cases	60% gap in number of clients opting for assisted delivery in health facilities

Africa
New Practices in Training & Learning

Root Causes of Gap

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none"> ▪ Patients not coming to clinics ▪ No DOTS program ▪ Patients not properly counseled ▪ Providers lack knowledge of TB management and control guidelines ▪ Job expectations not clear 	<ul style="list-style-type: none"> ▪ No education for clients about risk ▪ Inadequate clinic staff supervision ▪ Services inaccessible ▪ Limited supplies and equipment ▪ Economic constraints

Africa
New Practices in Training & Learning

Non-Training Interventions

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none">▪ Organizational support<ul style="list-style-type: none">- support supervision▪ Environment/tools<ul style="list-style-type: none">- adapt space practices- change sputum collection transport▪ Job expectations<ul style="list-style-type: none">- community education- community mobilization- job description	<ul style="list-style-type: none">▪ Organizational support<ul style="list-style-type: none">- DHT HSD teams- focal person- community volunteers▪ Environment/tools<ul style="list-style-type: none">- drugs supplies- assessment tools▪ Job expectations<ul style="list-style-type: none">- design implement plan- national guidelines- Yellow Star standards

Training Interventions

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none">▪ Knowledge/skills<ul style="list-style-type: none">- Supervisors trained to design interventions and offer on-the-job training support- Supervisors/managers conduct targeted training for providers- Community health volunteers trained in DOTS	<ul style="list-style-type: none">▪ Knowledge/skills<ul style="list-style-type: none">- PI training for trainers, supervisors and focal persons- Self-instruction OJT in Safe Motherhood- Ongoing on-the-job support mentoring- Training in life saving skills and PAC for midwives- Community resource persons oriented

Complementary Interventions: Successes and Challenges

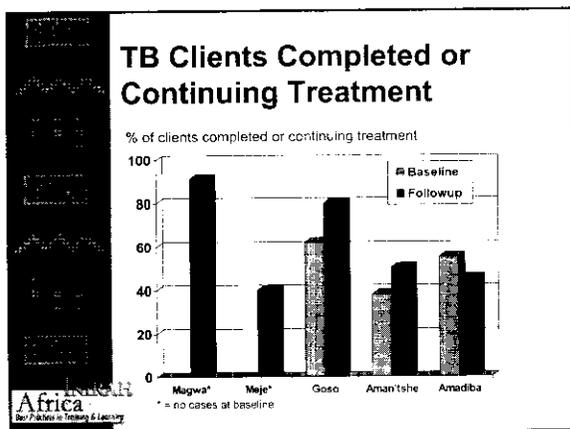
Training interventions not likely to be effective without non-training interventions

- support of supervisors critical
- broad organizational/community support required
- equipment, supplies and changes in the environment needed
- clear expectations essential

Results

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none"> ▪ More suspected cases of TB identified ▪ More clients treated according to protocols ▪ More TB patients completing or continuing treatment 	<ul style="list-style-type: none"> ▪ 10-15% increase in deliveries at health units ▪ Improved antenatal care ▪ Increased postnatal services ▪ Improved service quality ▪ Increased use of birth plans

Africa
Best Practices in Training & Learning



Challenges

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none"> ▪ Regular schedule of support visits ▪ More TB cases; staffing same ▪ Reliable transport and drug supply ▪ Accurate record-keeping ▪ Other services require quality improvements 	<ul style="list-style-type: none"> ▪ Integration of site-based PIA with routine processes ▪ Involvement of in-charges and supervisors in interventions ▪ Regular schedule of support visits ▪ Staff work loads increased ▪ Sustainability

Africa
Best Practices in Training & Learning

Lessons Learnt/Reinforced

South Africa/EQUITY	Uganda/DISH
<ul style="list-style-type: none">• PI can be used to solve problems• No on-site PI expert required• Clinics can be linked with communities• Clinic staff monitored service quality	<ul style="list-style-type: none">• Comprehensive strategy required more time and resources• District leadership support essential• Project facilitation critical to success• Trainers needed more support

Guided Discussion Questions/Answers



**Many Africas, One Training:
Designing and Delivering
One Intervention for Many Audiences**

Maureen Kuyoh

Deputy Director
Africa Regional Office
Field Programs
Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709
E-mail: mkuyoh@fhi.or.ke

Bob Rice

Director
Field Programs
Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709
E-mail: rrice@fhi.org

Jane Schueller

Associate Director
Field Programs
Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709
E-mail: jschueller@fhi.org



**Many Africas, One Training:
designing and delivering one intervention
for many audiences**

Lesson learned designing and delivering
*The Research Ethics Training Curriculum
(RETC)*

Maureen Kuyoh

Jane Schueller

Bob Rice

Family Health International (FHI)



Objectives

Participant will be able to:

- Identify design and delivery elements that facilitate participant engagement in the learning process.
- Design curricula that can easily be adapted by the trainer to the training delivery situation.
- Tailor training curricula to the needs of specific audiences.



Session Design

- A progressive case study will be used to consider design and delivery aspects for a training intervention or curriculum.
- The facilitators will base experience on a well-received training curriculum, *The Research Ethics Training Curriculum (RETC)*.
- Participants will be expected to be **creative**, be **open-minded**, and be **innovative**.



Expectations

- You will participate!
- Facilitators will be resources for you.
- Cell (mobile) phones will not ring.
- We will begin and end on time.
- No smoking.
- We will learn from each other.
- We will have fun!



Many Africas?

Who says?
Selon qui?
¿ Quien dice?
Nani anasema?



Characteristics of “Many Africas”

- ?????
- ?????
- ?????



Characteristics of “Many Africas”

- People are not homogeneous. many tribes
- Many languages. many traditions. many beliefs. many cultures
- Many learning cultures
- Many skill levels and a variety of health care cultures/practices
- Resource levels vary
- Voices through story telling



One Ethics?

- Growth of research worldwide
- Increasing participation of resource constrained country sites and scientists
- Curriculum to train local investigators on research ethics and strengthen the ethic committee process



Case Study, Part 1

Design a training curriculum that is:

- Appropriate for majority of participants residing in sub-Saharan Africa; include visual graphics as it needs to **look** good!
- Designed to engage the learner—how will you “force” participation between the learner and the subject matter?

Define the “look”



Looks Good

- How will the finished training curriculum feel? When you hold it in your hand, what does it feel like? Define your product(s).
- How does the learner interact with the content?
- Visuals? Colors?
- Software?



Lessons Learned

Access

- Hard copy
- CD-ROM
- Web site

Design

- Visual messages i.e. lotus theme
- Colorful (and plenty of white space too!)
- Kinesthetic, visual

Languages

- English
- Spanish
- French
- Chinese



Case Study, Part 2

- Outline what is included so that the participants will feel good about the training or learning material; how and why will it feel good to participants?

Define the "feel" (you want the participants to feel good and you want the trainers to feel good)



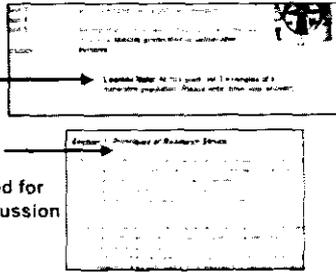
Feels Good

- How is the training (or curriculum) designed so that it feels good to participants? What specifically will appeal to participants?
- Why is it important to think about "making it easy for the trainer"? Identify what you will do to make it feel good for the trainer.



Lessons Learned

- Learner Notes
- Case Studies
- Self-graded Test
- Case studies used for small group discussion



Case Study, Part 3

- Your intervention needs to be participatory (**trains good**).
- It must be designed so that the trainer does not need to spend a lot of time preparing . . .
- Easy to use for the trainer: easy to adapt to different audiences (**trainer-friendly**).

Define the "trainer-friendly" aspects of your intervention



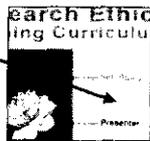
Trains Good

- How are the instructions or technical content designed or presented so that it is "glanceable" for the trainer?
- How are "trainer notes" presented to assist the trainer in delivering the information?
- What materials are made available for participants?
- Where are references and additional resources located for the trainer to study for background information?



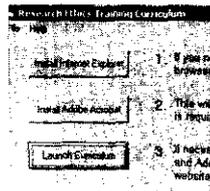
Lessons Learned

- Designed for specific audience
- Tight project management (communication between SME and instructional designers)
- PowerPoint as platform
- User-friendly, low tech, easy
- Self-study or group formats
- Participative training experience
- Training-of-Trainers Guide



Lessons Learned

- No plug-ins needed
- No server side applications
- No frames
- Netscape 4.0 and IE 4.0
- 640 x 480 resolution
- 508 accessibility standards
- Make the technology easy-to-use



Lessons Learned

- Specify technical requirements in advance
- Determine production software
- Plan for language translation
- Plan for final Web location
- Watch for non-standard fonts
- Make it easy (and fun!) to use



An International Perspective

- **CIOMS:** "the ethical implications of research involving human subjects are identical in principle wherever the work is undertaken"
- **S.K. Sharif, Kenya:** "one of the major problems in the Third World is the weak ethics and scientific committees that review scientific studies"
- **S.R. Benatar, South Africa:** "the need to build capacity in research ethics as part of the research endeavor"



Case Study, Part 4

Congratulations! Your training intervention idea has gotten more funding—so now you can go global!

How will you incorporate "thinking global" into your design considerations? What will you change or modify?

Describe additional tasks or activities, that you will consider or perform.



Global Considerations

- Dissemination expenses
- Visual look (think globally)
- Language considerations (and translation costs)
- Field-testing sites (and contacts)
- Timeline considerations
- Two products: one for Africa, the other for global?



Some Suggested Reference and Resource Materials

- *Training Magazine*: www.trainingmag.com
- *The Training Journal*: www.trainingjournal.co.uk/
- *Games Trainers Play*, Newstrom & Scannell, McGraw Hill, Inc. 1980.
- *The Winning Trainer*. Third Edition. Julius Eittington, Gulf Publishing Company, 1996.
- *Facilitation Skills: The ASTD Trainer's Sourcebook*, Dennis C. Kinlaw, McGraw Hill, 1996.



For More Information



Web site

Maureen Kuyoh, Mkuyoh@FHI.or.ke
Jane Schueller, Jschueller@fhi.org
Robert Rice, Rrice@fhi.org



**“Client Profiles”:
Modeling Client-orientation while
Tailoring Training to Local Needs**

Feddis Mumba

Area Manager

AMKENI Project

Sheetal Plaza, Moi Avenue

P.O. Box 99697

Mombasa, Kenya

Phone: 254-11-226-226 254-11-227-248

Fax: 254-11-222-874

E-mail: fmumba@amkeni.org



ENGENDERHEALTH

Improving Women's Health Worldwide

Presentation Outline

- Introduction
- Brainstorming of sexual and reproductive health (SRH) problems
- Small-group work to develop client profiles
- Plenary sharing of profiles
- Demonstration of using client profiles for counseling skills-building
- Discussion

Problem statement

In designing a curriculum for integrated sexual and reproductive health (SRH) counseling, EngenderHealth faced the following challenges:

- Considering all the areas of SRH opens the curriculum to a wide range of possible health issues and concerns.
- The counseling needs of individual clients can vary widely within each area of SRH.
- These concerns, and the services available, and the approaches of service providers vary widely from culture to culture throughout the world.
- Developing case studies and role plays to cover the broad and varying scope of clients' needs would be a monumental task, and, at best, would likely give rise to criticism that the case studies were inadequate, or would become outdated with time, or were insensitive to the cultural nuances of these issues in different countries in different parts of the world.

A different approach was proven successful in field-tests – that of having the participants develop *client profiles* to reflect the realities of the communities and clients that they serve. These profiles became the basis of case studies and role-plays throughout the training. This approach supports client-centered services by focusing on the client as an individual, while tailoring the training to local needs, both of clients and providers.

Learning Objectives: By the end of this session participants will be able to:

- Describe the advantages of using *client profiles* in trainings that cover broad content areas and/or address needs in differing cultural settings.
- Identify the benefits of involving participants in the development of client profiles.
- Understand and apply the process for developing client profiles for training, using brainstormed problems and basic guidelines from the EngenderHealth curriculum.

Lesson Learned #1:

Having the participants develop the client profiles, based on problems that they identify, gives them a feeling of “ownership” for the learning process.

The client profiles, which function like case studies, are referred to repeatedly throughout the training and are used to practice counseling skills in role plays. These profiles, which are based on needs identified by program planners and participants, give the training a local focus and offer the participants a sense of “ownership”- that these are the challenges faced by *their* clients, in *their* service sites, and in *their* communities. The profiles also give each problem a face, a name, and often a family scenario within which the problem must be addressed.

Lesson Learned #2:

Using client profiles supports client-oriented services by giving a human face, relationships, a family, and a community context to SRH problems.

Clients have a wide range of needs and issues that they must deal with to get help for their SRH problems. Each person has a unique combination of background, socioeconomic status, needs, concerns, and information. Also, there are few cases in which a client’s situation affects only himself or herself; someone else is almost always involved in the problem or is affected by whatever decision, if any, the client makes. These unique individual and family situations are demonstrated with great clarity through the development of the client profiles, and the on-going exploration of each client’s situation throughout the training. By coming back again and again to the same profiles, to practice different phases of the counseling process, SRH problems acquire a name and a face that becomes very familiar and very human to the participants.

Lesson Learned #3:

The trainer needs to assess SRH needs and concerns prior to the training.

Although the participants are the ones who develop the profiles, at the beginning of the training they may not be aware of the range of SRH needs and concerns of people in the communities they serve. Thus, during the planning phase, the trainers should involve local program planners and administrators, to identify the needs and concerns to be addressed within the course. Although the process begins with brainstorming to generate a list of real SRH problems that people face, the trainers should be prepared to guide the brainstorming to ensure that the participants cover the needs that were discussed during planning. After the brainstorming, the trainers select which problems will be developed into client profiles, reflecting the needs identified during the planning phase.

Lesson Learned #4:

The trainer may need to “guide” the brainstorming of local SRH problems.

Although specific SRH needs identified in the brainstorming will vary depending on the community and on the participants, in general the client profiles should cover the following categories:

- Men
- Women
- Unmarried youth

- Family planning needs
- HIV and STI needs
- Maternity care needs
- Postabortion care needs

During the brainstorming of local SRH problems, the trainer should probe to make sure that all the key SRH areas are included. Although these are called “client” profiles, participants may need to address population groups that, for whatever reasons, do not routinely access services and thus are never seen as “clients”. For example, if a program focuses on family planning and the participants brainstorm only about the family planning problems of the typical married female clients, trainers should ask: “What about family planning problems faced by men? By unmarried women? By adolescents? By postabortion clients? By people who are HIV-positive? By postpartum women? What about other problems faced by married women who come to your clinics?”

Lesson Learned #5:

Trainers can help to broaden client profiles by adding “new developments” to each situation, later on in the training.

The client profiles determine the focus of the discussion throughout the rest of the training, so it is important to have an appropriate range of issues and client groups represented. However, rather than try to cover all possible SRH needs and concerns in the original client profiles, later in the training trainers can introduce important issues that were not addressed in the original profiles, by adding “new developments” to each client profile. Trainers can use this technique to introduce issues such as power imbalances within relationships, women’s lack of control over when to have sex, denial of services or information to unmarried and adolescent women, men’s lack of access to services, the risk during unprotected sex of HIV and STIs, as well as unintended pregnancy, involuntary HIV-testing, stigmatization of people who are HIV-positive, and pressure for sterilization in postabortion services, among others.

For example, one profile might be a male STI client who is reluctant to tell his wife about his infection and is more worried about her finding out, than about the health implications for her or his other partners. The “new development” might be that he learns his wife is pregnant. Now, the profile requires him to address the need to communicate with his wife about antenatal care and STI treatment issues for her *and their unborn child*, in addition to the standard STI issues.

Lesson Learned #6:

Printed guidelines help participants to stay focused on the task of developing client profiles. To maintain consistency between profiles and to outline the range of issues to be addressed, guidelines are provided for developing these profiles. Not all points must be covered for all the client profiles in the initial session (see *Lesson Learned #5* for ways to address issues that get overlooked), but participants should be encouraged to address each point in some way.

Client Profile Guidelines

Part I. Demographic and social characteristics:

- Name
- Age
- Marital status
- Parity
- Income
- Educational level
- Social background

Client Profile Guidelines

Part II. Questions to Answer about Your Client

- What is the client's current SRH needs? Why did this happen? Who else is affected by this situation?
- What decisions will he or she have to make concerning this SRH problem? Who else will be involved in the decision making?
- Is your client comfortable with seeking services for this situation? Where would he or she go?
- What information will the client need to make those decisions, and where can he or she get that information?
- How does the client feel about this situation? What concerns or worries does he or she have?

The Best Practices Compendium: A Tool for Public Health Trainers

Susan Palmore

Director
Strategic Dissemination
Advance Africa
4301 N. Fairfax Drive, #400
Arlington, VA 22203
Phone: 703-310-3500
Fax: 703-524-7898
E-mail: spalmore@advanceafrica.org

Lauren Pindzola

Technical Officer
Advance Africa
4301 N. Fairfax Drive, #400
Arlington, VA 22203
Phone: 703-310-3500
Fax: 703-524-7898
E-mail: lpindzola@advanceafrica.org

Frequently Asked Questions about the Compendium

Why create a Best Practices Compendium?

The compendium was created to meet the needs expressed in four objectives:

- **To facilitate the dissemination of best practices** in the field of Family Planning/Reproductive Health (FP/RH).
- **To assist program managers** in identifying and selecting successful programs/ practices they might be able to adapt for their own program needs.
- **To promote rigorous standards** and evidence-based public health programs and practices
- **To recognize and publicize** successful public health programs and practices

Are there specific definitions for commonly used Compendium words and terms?

Yes. The following are key definitions as determined by the Advance Africa Best Practices Unit for categorization in the Compendium:

Practice: a specific action or set of actions consistently used by an individual or organization in response to a problem or unresolved issue. The term “public health intervention” may be used interchangeably.

Program: a series of actions taken by an organization or individual that employ several strategies or practices. A program can include one or many public health interventions.

Best practice: a specific action or set of actions exhibiting quantitative and qualitative evidence of success together with the ability to be replicated and the potential to be adapted and transferred. Best practices represent the “Gold Standard” of activities and tools that can be implemented to support program objectives.

Promising practice: a specific action or set of actions exhibiting inconclusive evidence of success or evidence of partial success. It may or may not be possible to replicate a promising practice in more than one setting.

What is included in the Best Practices Compendium?

The Compendium includes FP/RH best practices and promising practices, as well as program models from around the world.



What is not included in the Best Practices Compendium?

The Compendium does not include summary documents of lessons learned, situational analyses, or medical practices.

Participating in the Best Practices Compendium

How are the practices that are included in the Compendium chosen?

In order to promote the unbiased assessment of all FP/RH programs and practices included in the Best Practices Compendium, Advance Africa worked with a Best Practices Advisory Group (BPAG) to create standardized criteria to objectively assess each practice. A clear distinction has been made between untested interventions and those backed by evidence and experience. Advance Africa's criteria for best practices also include evidence of successful replication and potential for transferability. A Best Practices Review Board has been established to critically assess programs and the practices submitted to the Best Practices Compendium.

How was the Review Board formed?

Best Practices Review Board members were nominated by the BPAG based on their expertise in specific technical areas within FP/RH.

What is the Review Board's process of evaluation?

Each Compendium entry is evaluated by a minimum of two Review Board members with expertise in the appropriate technical area. All Compendium entries are classified with an appropriate primary technical area.

Can I submit a practice I think qualifies as a best practice?

Yes, we encourage all individuals and organizations to submit their own best practices to enrich the diversity of information available in the compendium.

What programs/ practices can be entered into the compendium?

Your submission of a practice must be part of a public health program. Submissions must be able to provide evidence of success and/or impact. Evidence of or potential for replicability/ transferability to other settings will also be used as criteria for a best practice. Remember that summary documents of lessons learned, situational analyses, or medical practices will not be included in the Compendium.

How can I submit a practice?

Submit online. The online submission process is quick and easy. From the Compendium homepage go to "Submit Your Practice". First you will be asked to fill out a short preliminary submission form. If your program /practice meets the Compendium's criteria, you will have the opportunity to complete the submission process.

-OR-



Download form. You can also download the online submission form as a Microsoft Word document and submit the form in one of the following ways:

E-mail the document, as an attachment, to:

bestpractices@advanceafrica.org;

Fax the document to:

Attn: Best Practices, Advance Africa.
1-703 -524-7898; *or*

Mail this document to:

Best Practices, Advance Africa
4301 N. Fairfax Drive, Suite 400
Arlington, VA 22203, USA

How will I know if my submission has been accepted for inclusion in the Compendium?

Upon submission, each practice will be promptly reviewed by the Best Practices Unit. You will be contacted by e-mail or by phone when your submission has been received. You may be asked to provide additional information before your program/ practice can be included in the Compendium. All accepted programs/ practices will be reviewed by the Best Practices Review Board to determine whether the program/ practice is a best practice or a promising practice. You will be notified by e-mail of this posting, and of the Review Board's decision regarding your entry. Following notification, programs/ practices will be posted in the Best Practices Compendium.

Can I edit my program/ practice on line?

Yes. Prior to submitting your program/ practice to the Best Practices Unit, you may logon to the Compendium at any time to edit or complete your submission form. You are given the option to either submit or save your submission at each step of the submission process. Once the "Submit" button has been pressed, however, you will be unable to re-edit your submitted program/ practice.

If you have additional relevant information that occurs following your submission, you may contact the Best Practices Unit at:
bestpractices@advanceafrica.org.

How can I become a registered member of the Best Practices Compendium community?

Register to be a member of the Best Practices Compendium community by entering your email and selecting a password. From the Best Practices Compendium homepage select the button to "REGISTER".

Why should I become a registered member?

As a registered member you will be a part of the Best Practices Compendium community. All members are able to:

- *Submit a practice* - As a registered user, your login (see Login explanation above) allows you to save your submission form and return at a later date to edit your saved work.



- *Post a comment* – You can voice your opinions about any program/ practice included in the Compendium. After review by the Best Practices Unit, your comments may be posted online for other members to read and offer their response.

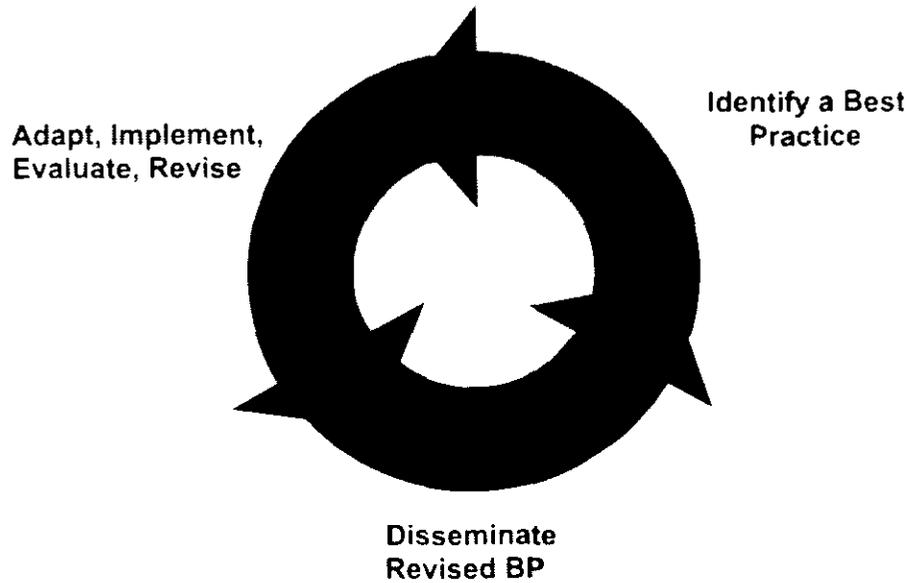
Through your submission or comment you will be able to share resources on a global scale, and encourage replication of your most successful programs/ practices. New programs/ practices will also be considered for a profile in the “Best Practice of the Month” newsletter.

Who can I contact with questions?

Any questions concerning best practices should be directed to the Best Practices Unit at bestpractices@advanceafrica.org. If you have technical questions related to the website, please contact the webmaster at advance@advanceafrica.org.

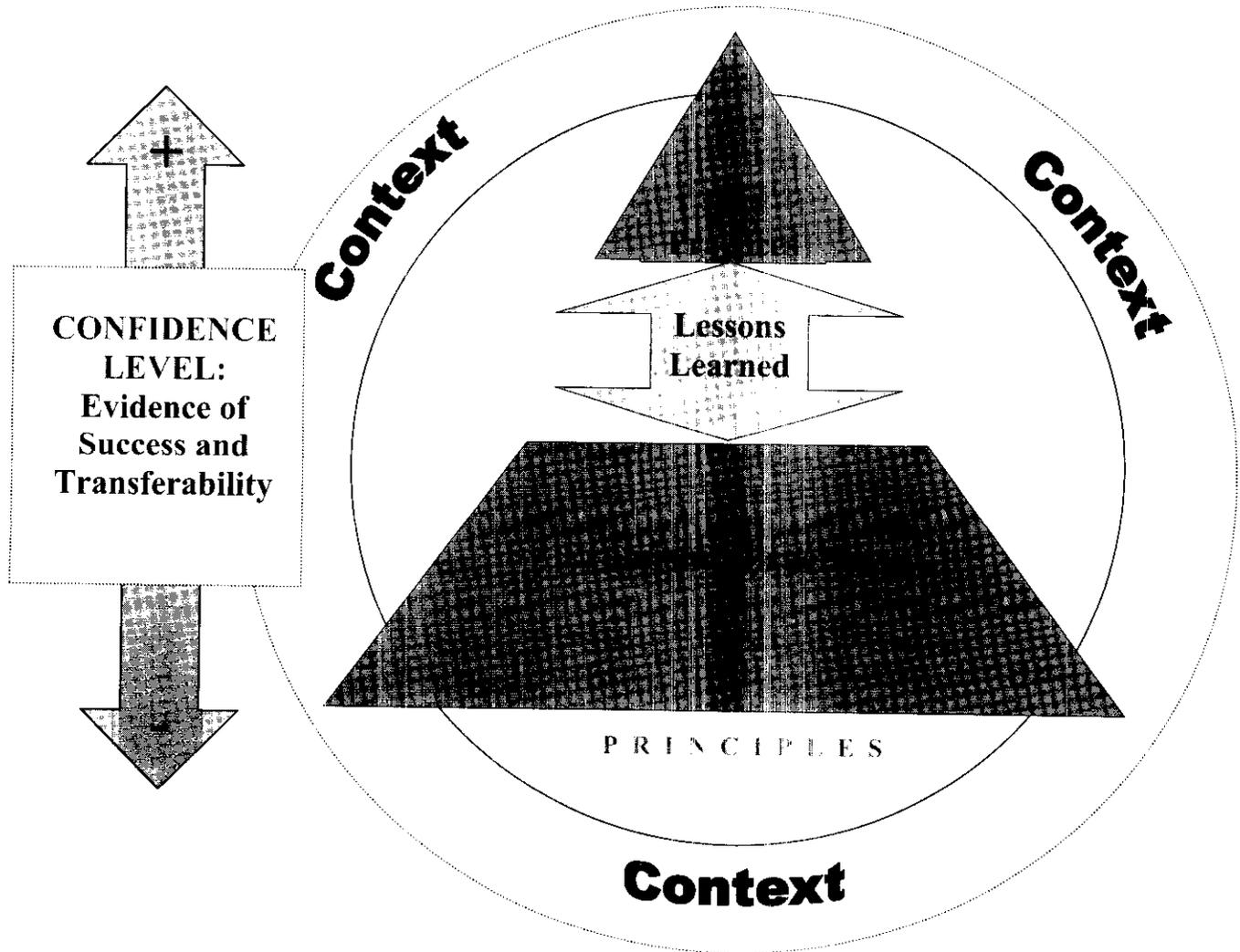


BP Compendium: Start of a process for program improvement



Adapted from: *The Manager's Pocket Guide to Knowledge Management* by Kathleen E.ley, Carolyn L. Martin, Kivowitz

Pyramid of Best Practices in Public Health Interventions



Best Practices Submission Form

Part I

Contact Information: Please include the key contact person and organizational information.

1. Key Contact Name:
 - a. Last family name: _____
 - b. First given name: _____
 2. Organization Name: _____
 - a. Website Address (if available): _____
 3. Organization Address:
 - a. Street Address 1: _____
 - b. Street Address 2: _____
 - c. City: _____
 - d. State Province: _____
 - e. Country: _____
 4. Telephone Number: _____ (ext.) _____
 5. Fax Number: _____
 6. E-mail Address: _____
-

Part II

Please complete all open-ended questions and check the appropriate responses to the Yes/No questions.

1. Program or Practice Title: *

2. Abstract: (provide a brief synopsis summary of the program or practice)

3. Objectives: *

- (1) _____
 - (2) _____
 - (3) _____
-

Program- a series of actions taken by an organization or individual that employ several strategies or practices. Practice- a specific action or set of actions consistently used by an individual or organization in response to a problem or unresolved issue.

Objective -Statement(s) of purpose or intent of the program/practice



4. Key Activities:*

- (1) _____
- (2) _____
- (3) _____

5. Evidence:

a. Has the program/practice been evaluated?

- Yes
- No

b. Is the program/practice evaluation available?

- Yes
- No

c. Briefly describe the evidence of success demonstrating that this is a best/promising practice.*

For example: Quantitative evidence that CPR increased from 5% to 10% or Qualitative evidence that client satisfaction with prenatal service increased.

- (1) _____
- (2) _____
- (3) _____

6. Replication and Transferability:

a. Has this program/practice been replicated?

- Yes
- No

b. If so, where? _____

7. Documentation of Evidence of Program/Practice Success:

Title: _____

URL: _____

Reference: _____

Submit this document to: Best Practices

Advance Africa
4301 N. Fairfax Drive, Suite 400
Arlington, VA 22203, USA
Telephone: (703) 310-3500
Facsimile: (703) 524-7898
E-mail: bestpractices@advanceafrica.org

* Key Activities - Main activities implemented to accomplish program/practice objectives. Indicate persons involved and their roles in the program/practice.

* Best practice- a specific action or set of actions exhibiting quantitative and qualitative evidence of success together with the ability to be replicated and the potential to be adapted and transferred. Promising practice- a specific action or set of actions exhibiting inconclusive evidence of success or evidence of partial success. It may or may not be possible to replicate a promising practice in more than one setting.





**The Best Practices
Compendium:
A Tool for Public Health
Trainers**





Objectives

At the end, participant will be able to:

- Use the Compendium as a training tool
- Explain the best practices process
- Prepare to contribute a best practice in training
- Join the Best Practices Community



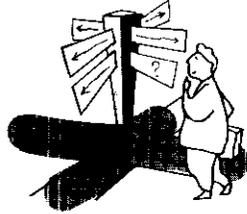


**“Best Practices” for
Meeting Participants**

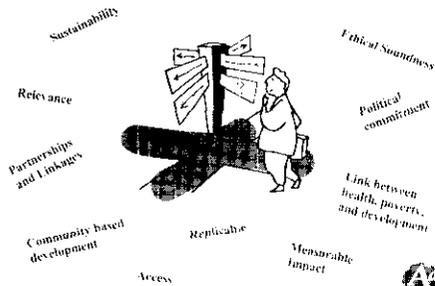
- Active participation
- No cell phones
- No smoking
- Having fun! 😊



What is a "Best Practice"?



What is a "Best Practice"?



What is a Best Practice? Best Practice Compendium Criteria

A program intervention that demonstrates:

- Measurable impact
- Transferability to multiple settings



Why are Best Practices Important?



- To recognize and disseminate successful program interventions.
- To assist program managers in identifying and selecting successful practices/programs to adapt for their own program needs.
- To promote rigorous standards and evidence-based public health practices and programs.



Introducing the Best Practices Compendium

- A searchable database of FP/RH interventions and tools
- A collaborative effort by multiple agencies (BPAG)
- Peer reviewed practices
- Uses public health, not medical criteria



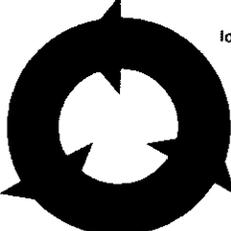
Who is the audience?

- Program Managers
- Public Health program trainers
- Donors
- Cooperating Agencies (CAs)
- Local NGOs
- USAID Mission staff



BP Compendium: Start of a process for program improvement

Adapt,
Implement,
Evaluate,
Revise



Identify a Best
Practice

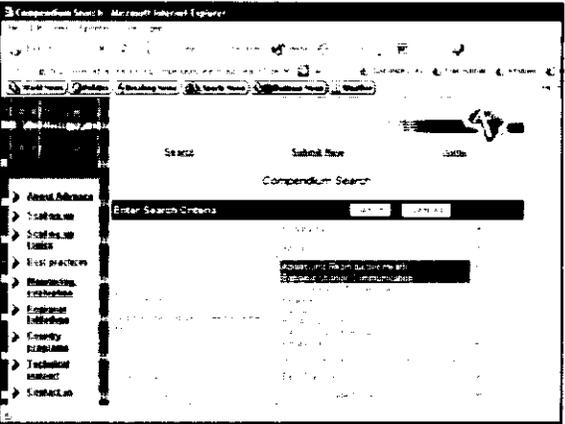
Disseminate
Revised BP



Searching the BP Compendium for best practices

- Online Database Compendium
Address for the searchable database:
www.advanceafrica.org/bestpractices
- CD-ROM
Available from Advance Africa
bestpractices@advanceafrica.org





Additional BP Resources



- **Implementing Best Practices**
(www.who.int/reproductive-health/hrp/highlights/en.html)
- **Maximizing Access and Quality** (www.macweb.org)
- **UNFPA** glossary definitions of BP and LL
(<http://www.unfpa.org/00e/toolkit.htm>)
- **UNDP** criteria on selecting Gender Good Practices
(<http://www.undp.org/gender/practices/guidelines.html>)
- **World Bank** Gender Criteria in Identifying BP
(<http://www.worldbank.org/gender/know/guidenan.htm>)
- **UNAIDS- BP Compendium**
(<http://www.unaids.org/bestpractice/>)
- **UNESCO- MOST** Clearing House of BP
(www.unesco.org/most/bphome.html)



For more information

www.advanceafrica.org/bestpractices

- Susan Palmore, spalmore@advanceafrica.org
- Deryck Omuodo, domuodo@advanceafrica.or.ke
- Lauren Pindzola, lpindzola@advanceafrica.org
- Susan Veras, sveras@advanceafrica.org





Training to Create Adolescent-friendly Reproductive Health Services in Uganda

Stembile Matatu-Mugore

Reproductive Health Clinical Specialist

Intrah Consultant

94 Observatory Dr.

Woodhill

P.O. Box 66068

Pretoria 0076

South Africa

Phone: 27-12-998-3851

E-mail: mugore@mweb.co.za



Training to Create Adolescent Friendly Reproductive Health Services in Uganda

Stembile Matatu-Mugore
Reproductive Health Clinical Specialist, Intran consultant

Rose Mulind
Monitoring and Evaluation Program Assistant, Intran



PRIME II



Situation in Uganda

- ~ 50% of HIV+ are youth
- Early childbearing and unsafe abortion
- Only 7.5% of 15-19 year olds use contraception
- 67% girls' first sexual encounter by age 18
- Adolescents are not using RH services



1998

What do adolescents say?

- RH services lacking
- Misinformation about FP methods, STIs and HIV/AIDS
- Poor confidentiality at health centers
- High costs of RH services
- Health staff unfriendly to adolescents



from baseline



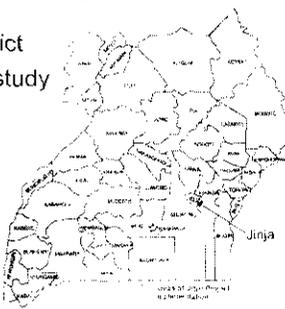
Project Partners

- DISH I and II
- PRIME I and II
- Ministry of Health
- Project funded by USAID
- Jinja District for the pilot
- 10 additional districts for the expansion



ARH Pilot Project

- Jinja District
- Baseline study
- 4 health centres





Pilot Project Objectives

- Improve provider:
 - skills in ARH
 - attitudes toward adolescents
- Attract adolescents to health centers
- Change adolescents' health-seeking behavior
- Provide RH services to adolescents
- Establish M&E system
- Assess findings for replication



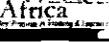
Interventions Used in Pilot

- For providers
 - Training and supervision
 - Supplies, contraceptives & STD kits
- For youth
 - Recreational activities/games
 - ARH information education
 - ARH videos and group discussions
 - Role plays and question/answer
 - Group education sessions
 - ARH services
 - Extended clinic hours in the afternoon
 - FP, STD, PAC AND delivery, counseling
- For the community
 - Sensitisation to ARH needs



Essential Elements of Training and Supervision

- Input from adolescents, community leaders, health workers and parents
- Social scientist specializing in adolescents
- Interactive methods emphasizing attitude and behavior change
- Adolescent reproductive and sexual health, counseling, communication, and referral
- Intensive on-job follow-up/support



Training Design

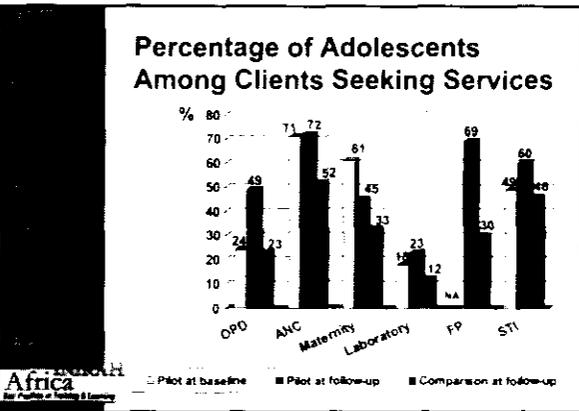
- Week one
 - Highly participatory group training: values clarification, role plays, discussions
 - Emphasized providers' attitudes toward adolescents
- Week two
 - Guided clinical experience with adolescents
- Follow-up/support
 - Feedback on ARH skills
 - Facilitation of video discussions
 - Data used to answer clients' questions and develop youth activities

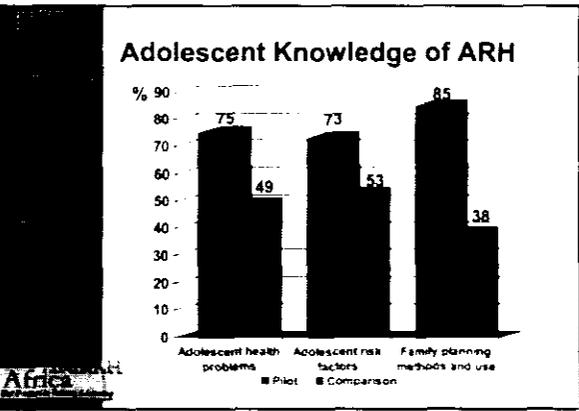
Reasons Adolescents Visited ARH Sites

- Counseling
- Postabortion care
- Screening for pregnancy
- Medical check-ups
- STD treatment
- In-door games



Africa
The Institute for Public Health & Family Planning







Participant Perspectives

"Now I have the self-respect to just say 'no' to boys, and I know I can use condoms if I want to have sex."
Sarah, teenager in Jinja District

"The project helped girls like Sarah to develop more self-esteem. In addition, unplanned pregnancies have declined in the local schools."
Florence, Sarah's mother



Training Alone is Not Sufficient

Constraints	Possible Solutions
<ul style="list-style-type: none"> Lack of drugs and contraceptives Lack of space 	<ul style="list-style-type: none"> Cost sharing Share space Expand service time
<ul style="list-style-type: none"> Affordability/cost Non-supportive adults 	<ul style="list-style-type: none"> Subsidies Sensitise community on ARH
<ul style="list-style-type: none"> Poverty 	<ul style="list-style-type: none"> ARH and income-generation linkages



Pilot Project Challenges

- Maintaining:
 - provider behaviour after the project life and outside ARH sites
 - adolescent attendance of RH services after the project end
- Ensuring continued community:
 - awareness of ARH needs
 - support for ARH service provision



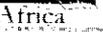
Expansion Project

- 10 districts
- 36 health centres
- Pilot health centres used for providing hands-on training experience
- Trainers from pilot became master trainers and provided on-site technical assistance




Application of Lessons Learned

- Strengthened curriculum in counseling
 - Boy girl relationships
 - Parent adolescent relationships
 - Peer pressure
 - Substance abuse
- Trained peer educators
- Added BCC component
 - Straight Talk
 - Teen Bash
 - Radio messages

Application of Lessons Learned
continued

- More recreation to include gender sensitive games and outdoor activities
- More responsive to provider problems with transfer of learning
- More intense district involvement in site selection






Expansion Project Challenges

- Maintaining volunteer peer educators – is training enough?
- Attracting girl adolescents – gender sensitive approaches?
- Keeping costs and effort manageable – alternatives to labour-intensive follow-up/support and on-site training?



Lessons Learned

- Develop joint BCC/training/service delivery strategy
- Include all stakeholders, including adolescents, in baseline, training priorities, project design and service delivery
- Pilot new approach before scaling up
- Use adolescent specialist for training and on-site TA



Lessons Learned

continued

- Training must emphasize provider attitudes and adolescent client needs
- On-the-job support essential for transfer of training and supporting adolescent services
- Providers need continuous learning to handle adolescents' questions and needs as they become more sophisticated. . .

Training Site Development - What are the Ingredients for Success?

Anita Gibson

Country Representative, Nepal
JHPIEGO Corporation
P.O. Box 8975, EPC 479
Kathmandu, Nepal
Phone: 977-1-524-313
977-1-526-609
Fax: 977-1-544-415
E-mail: agibson@jhpiego.org.np

Kamlesh Giri

Reproductive Health Advisor
JHPIEGO Corporation
1615 Thames Street, Suite 300
Baltimore, MD 21231-3492
Phone: 410-537-1989
Fax: 410-537-1476
E-mail: kgiri@jhpiego.org





Training Site Development: What are the Ingredients for Success?

Anita Gibson
Kamlesh Giri
JHPIEGO-Nepal

Training Best Practices Conference, Lusaka, Zambia



Learning Objectives

By the end of this session, participants will be able to:

- Describe factors contributing to an "enabling environment" for training
- Identify the significant management issues in establishing and maintaining a training site
- Describe the planning required to design training for participants with concurrent service delivery responsibilities particularly for emergency procedures



Overview of Presentation

- Expectations of a training site
- Review of the context in which training site development takes place
- Particular focus on the provider perspective
- Question/Answer (20 mins)
- Summary (10 mins)

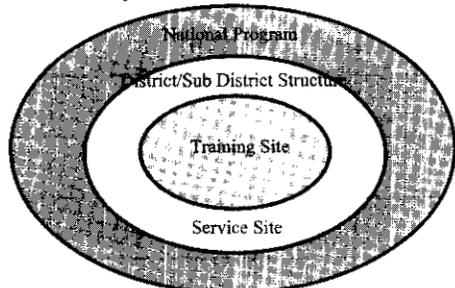


Expectations of a Training Site

- ❖ Participant Perspective?
- ❖ Clinic Supervisor sending a staff member to the site?
- ❖ Trainer Perspective?
- ❖ Supervisor at the training site?

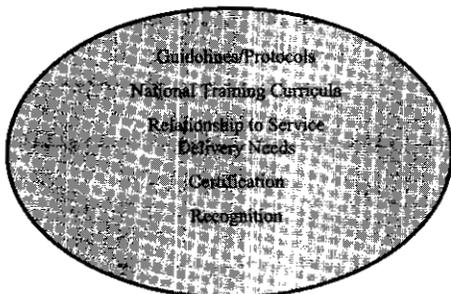


Think about your universe...





National program considerations



"Mid-level" considerations

- Priorities
- Funding required
- Management needs
- Public/Private Needs
- Technical Support Required

Training site considerations

Training Site

- ⊕ Focal persons? Trainers?
- ⊕ Model Services Exist?
- ⊕ Cost for training?
- ⊕ Who manages the logistics (scheduling, materials, etc.) Budget? How?
- ⊕ Benefit to the site?
- ⊕ Benefits to me? (provider perspective)

Providers...who are they?





Performance Improvement

- ❖ Seeks to understand the myriad elements that influence provider and organizational performance and considers the range of possible interventions to enhance service delivery
- ❖ **Understanding providers better is key to this approach**

Shelton, J.D. *The Provider Perspective: Human Resources International Perspectives*, Vol. 23, Number 3, Sept. 2001



Thinking About the Provider

- ❖ Personal Characteristics
- ❖ Competence/Abilities
- ❖ Needs
- ❖ Control/Comfort
- ❖ Rewards
- ❖ Medical Culture
- ❖ Empowerment
- ❖ Systemic Issues
- ❖ Links to Client/Community



Adapted from MAQ Exchange Curriculum, Washington, Maximizing Access and Quality Initiative, 2001



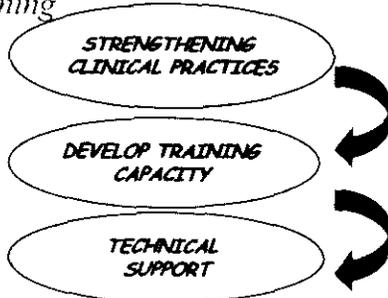
Thinking About the Provider

- ❖ Personal Characteristics
- ❖ **Competence/Abilities**
- ❖ Needs
- ❖ Control/Convenience/Comfort
- ❖ Rewards
- ❖ Medical Culture
- ❖ Proactivity/Empowerment
- ❖ Systemic Issues
- ❖ Links to Client/Community



MAQ Exchange Curriculum, Washington, Maximizing Access and Quality Initiative, 2001

No Model Services...No Clinical Training



Training Site Responsibilities

- ❖ Performance improvement: desired performance must be established at the service site to be used for training
- ❖ Transfer of Learning – role of training site including ongoing technical support

Management of Training - PHBC

- ❖ Priority: to minimize disruption to service provision
- ❖ Clinical Staff trained in the afternoons in small batches – consecutive courses
- ❖ Needed to plan in conjunction with preparation of the duty roster





Applied for MAG Exchange Clinical Case for the most Access and Quality - 2001

Medical Culture

- ⊗ Provider Knows Best
- ⊗ Hierarchical
- ⊗ Insulation
- ⊗ Ritual
- ⊗ Curative
- ⊗ Technical versus Human





Applied for MAG Exchange Clinical Case for the most Access and Quality - 2001

Thinking About the Provider



- ⊗ Personal Characteristics
- ⊗ Competence/Abilities
- ⊗ Needs
- ⊗ Control/Comfort
- ⊗ Rewards
- ⊗ **Medical Culture**
- ⊗ Proactivity
- ⊗ Systemic Issues
- ⊗ Links to Client/Community



Management of Training

- ⊗ PAC-OJT: how to incorporate training into regular duties?
- ⊗ Designated space
- ⊗ Plan ahead
- ⊗ Structured Materials
- ⊗ Clear functional roles and responsibilities of participants, OJT Trainers, Supervisors
- ⊗ Demonstrated support from hospital management, Department of Health Services





Patan Hospital Birthing Center

- ❖ Review/DEBATE of evidence-based practices
- ❖ Involvement of doctors not directly participating in training/service provision





PAC-OJT

- ❖ Stressed cadre-neutral approach, functional roles and responsibilities which meant sometimes nurses supervised physician trainers



Thinking About the Provider

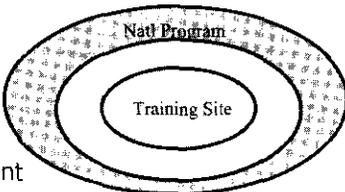
- ❖ Personal Characteristics
- ❖ Competence/Abilities
- ❖ Needs
- ❖ Control/Comfort
- ❖ **Rewards**
- ❖ Medical Culture
- ❖ Empowerment
- ❖ Systemic Issues
- ❖ Links to Client/Community





Rewards

- ❖ Monetary
- ❖ Status/Ego
- ❖ Appreciation
- ❖ Interest/Fun
- ❖ Accomplishment
- ❖ Risk Averseness



MAQ Exchange Curriculum, Washington, "Maximizing Access and Quality Initiative" 2001

Patan and Maternity Hospitals

- ❖ On-the Job Training, recognition by National Health Training Center, Family Health Division
- ❖ Costing Exercise to involve management/ Sr admin staff and to dispel rumors that services were resulting in financial deficits



Thinking About the Provider

- ❖ **What do we know about providers themselves?**
 - ❖ Providers are different, but have patterns
 - ❖ It's a rare provider who's looking for more work.

MAQ Exchange Curriculum, Washington, "Maximizing Access and Quality Initiative" 2001



In Sum...

- ⇨ Think about your universe
- ⇨ No model services, no clinical training
- ⇨ Eyes on the Prize: Performance Improvement, Transfer of Learning
- ⇨ What do we know about providers themselves?
 - ⇨ Providers are different, but have patterns
 - ⇨ It's a rare provider who's looking for more work.
- ⇨ Management, management, management



Providers serving Communities



Distance Learning: Lessons from the Field

Nancy Kiplinger

Instructional Design Specialist

Intrah PRIME

UNC School of Medicine

1700 Airport Road, Suite 300 CB #8100

Chapel Hill, NC 27599-8100

Phone: 919-962-6789

Fax: 919-962-7178

E-mail: nkiplinger@intrah.org

PRIME Training Insights

Getting started with distance learning

The experts agree: Distance learning is as effective as other well designed training methods. Apply sound design principles and practices as with any training program, paying particular attention to these points when designing and implementing distance learning:

Planning and Communication

- Develop a long-range timeline and framework for your project, including a plan for identifying and overcoming barriers, such as the physical and time separation between learner and instructor unique to distance learning.
- Match content with the appropriate technology. For example, the availability of computers should only promote use of this technology if it is suited to the content and desired learning outcomes.
- Make a commitment of support to administrators, teachers, facilitators and students. Emphasize clear communication between institutional leadership and all levels. Anticipate logistical issues that may arise, and develop a plan for dealing with them.

Learner Support

- Carefully design and maintain a learner support system to minimize the separation effect between teacher and learner. Design a comfortable interface to connect learners to the program, especially if learners are using an unfamiliar technology.
- Give students an active role in learning. Share control with them in setting learning objectives. Link them with instructors, facilitators, and mentors and, where possible, with other learners in the program. Provide for occasional face-to-face interaction, when possible.

Instructors and Facilitators

- Provide for effective selection and training of distance instructors.
- Make use of enthusiastic facilitators, well trained in the content, technology being used and facilitation at a distance.

Monitoring and Evaluation

- Focus evaluation on the extent to which program goals have been met, as well as on improving processes and outcomes. Thorough and on-going evaluation will permit interim adjustments to improve overall outcomes.

Find more on distance learning in PRIME's publication called **Making It Happen: Using Distance Learning to Improve Reproductive Health Provider Performance**. For more information, contact Nancy Kiplinger: nkiplinger@intrah.org, or visit PRIME's website at www.prime2.org.

July 1999

PRIME Training Insights

Learner support for distance learning

In the October 1998 PRIME Training Insights, we stated that distance learning is as effective as other well-designed training methods. We emphasized applying sound instructional design principles and practices as with any training program, and paying particular attention to planning, communication, learner support, instructors/facilitators, and monitoring and evaluation. This issue of PRIME Training Insights focuses on learner support.

Learner support is critical to the success of distance learning interventions. It is a carefully designed and maintained system created specifically to minimize the separation between instructor and learner and to connect learners to the learning experience. Learner support is the responsibility of all distance learning program staff. Learner support helps give students an active role in learning. It links them with instructors, facilitators, and mentors and, where possible, with other learners in the program.

A planned system of support ensures that learners receive coaching to facilitate learning and are not isolated. Learner support can be designed into the materials and can be provided by facilitators and/or other learners through face-to-face interventions, telephone, fax, e-mail, regular mail, etc.

Some of the best support will be personal and will come from tutors, advisors/counselors, managers, and mentors. Others who may be good sources of support are colleagues, family, friends, and learning center staff. Support may especially be needed if work, family, or financial concerns distract the attention of the learner. The following are some other needs that distance learners have and some ways you might meet those needs when designing and implementing distance learning.

Learners need...	You can provide...
help organizing their time and developing study skills	an activity plan that learners complete to indicate what tasks or activities they will work on and when they will work on them; estimated time for each unit of study
control over their learning experiences	choices of objectives, examples, practice exercises, length of exposure to the material, order and sequence (but don't overwhelm them with choices!)
feedback about their cognitive achievement and skill development	self assessments (pre- and post-tests), role plays with the facilitator or other learners, case studies
"hands-on" activities to allow them to practice new skills	guided practice, supervised clinical experiences, projects or skill practice with other learners
prompt feedback so they know immediately how they are doing	examples and samples of correct responses to assessments and case studies; quick responses to learners' questions and requests for help
reassurance, help and support from others	encouragement, opportunities for communication and information about their progress or changes in the program
incentives and motivation	plaques, signs, certificates of completion; other "giveaways" such as learners might receive at group training events

Find more information on distance learning in PRIME's publication called, **Making It Happen: Using Distance Learning to Improve Reproductive Health Provider Performance**. For more information, contact Nancy Kiplinger: nkiplinger@intrah.org or visit PRIME's website at www.prime2.org.

Distance learning needs and resources

Areas to assess	Examples of data needed
Learning needs	<ul style="list-style-type: none"> • What are the jobs and tasks to be performed? • What knowledge and skills are needed? • Are there national standards / core competencies to guide state / ministry? • Are there organizational or professional standards / core competencies that extend the national standards / core competencies to guide state / ministry?
Learner characteristics	<ul style="list-style-type: none"> • What is their current level of knowledge, skills and performance? • What is their reading and writing level and in what language(s)? • What is the educational background and work experience of potential learners? -- how long have they worked in the position and what specific services have they been offering to which type of clients? -- do they have confidence in their abilities? -- can they demonstrate their abilities in knowledge and / or skills evaluations? • Are they currently part of the workforce? • Where are the potential learners / trainees? -- how dispersed are they from each other? -- from training facilities or learning centers? -- from facilitators or coaches? • What is their access to transportation? -- to telephone communication? -- to electricity? -- to radio? -- to TV? -- to computer / Internet? • What is their level of familiarity and comfort with different types of media?
Resources	<ul style="list-style-type: none"> • Is there a teaching staff knowledgeable in content? Will they be able to devote time to being content experts? • Are there regional / local colleagues with experience in DL, instructional design, clinical training, mentoring, information management? • What technologies are available? • Are there production, distribution or technology specialists? • Does course content exist for classroom use? -- can it be re-purposed for a distance-based approach? • What learning resources / books, media are available? • Where are the clinical training sites? • What amount of clinical experience is available? • Do the clinical sites meet national service standards? • What administrative / support structures exist?
Official and unofficial support	<ul style="list-style-type: none"> • Is the work environment of potential learners / trainees supportive / good working conditions, responsive supervision, feel needed / important? -- who provides information to them regarding expectations and their job performance? -- where do they go for problems / questions? -- are there adequate equipment and supplies to support their jobs / tasks? • Is there organizational commitment and support for a DL program? • Is there financial commitment for development? for implementation? • What competition exists from other sources of learning?

	<ul style="list-style-type: none"> • Is DL an acceptable method of learning? • Will the learning be recognized as equivalent to traditional learning where a credential is required? • What incentives will learners need and respond to? Certification or other credential mentioned above? Professional or organizational recognition? Intrinsic motivation?
--	---

A Responsive Training and Learning Approach to Improving Client-Provider Interaction and FP/RH Service Quality and Access in Ghana

PRIME supported a one-year initiative in Ghana to demonstrate a self-directed learning (SDL) approach to improving *quality of and access to* family planning and reproductive health services for adolescents by improving midwives' client-provider interaction (CPI) skills. The expected results of this project are

- improvements in midwives' CPI knowledge and skills
- evidence of improved service quality and access for adolescents
- documentation of the potential of the SDL approach for in-service training of midwives in CPI

Background and Assessment

The SDL project, launched in 1999, was a joint effort among the Ghana Registered Midwives Association (GRMA), PRIME, and the FOCUS on Young Adults Project. It grew from needs identified in a 1997 FP/RH assessment of GRMA member midwives conducted by the three partner agencies. The assessment highlighted the need for

- an FP/RH update
- improved counseling and CPI skills
- increasing adolescents' access to services
- the introduction and application of the national service policies, standards and protocols

Process and Learning Components

The project was launched in January 1999 with a meeting of stakeholders, after which GRMA and PRIME developed and pre-tested the six modules for the course. The orientation for learners and facilitators took place in March. The five-month SDL course was conducted with 60 GRMA member midwives in three regions of Ghana. The SDL course consists of several interrelated learning components.

1. Printed learning modules	The six printed modules include reading, interactive activities and suggestions for application of new skills on the job, along with self-assessments to help participants monitor their own learning. Midwives completed the modules at their homes or workplaces over the course of a month.
2. Paired learning	Each learner had a partner with whom she met monthly to practice new skills and discuss the content and learning process.
3. Facilitators	In each region, there were two facilitators who made monthly visits to learner pairs to review and clarify new information, offer assistance in problem solving, and model desired counseling skills and behavior. A GRMA/PRIME team assisted the facilitators with their first peer review visit.
4. Peer review	Each month, participants gathered during the regular GRMA monthly business meetings to process new information and practice new skills. These gatherings offered opportunities for peers to share ideas, shape each other's behavior and provide additional social support for learning.

Findings

GRMA and its private sector midwives were genuinely enthusiastic about and committed to their participation in the program. The midwives were particularly excited about attracting adolescent clients and more confidently teaching them about condom use and other critical L.P. RH messages. GRMA sees great potential for the self-directed learning approach to enable its member midwives to learn new skills and develop additional expertise without having to leave their places of work for extended periods of time. GRMA and PRIME II extended the program in 2011 to 52 midwives and added a module on HIV/AIDS counseling and testing.

May 2012



**Distance Learning:
Lessons from the Field**

Nancy Kiplinger
Instructional Design Specialist
Intrah/PRIME II

William Sampson
Team Leader
PRIME II:Ghana



PRIME II
Africa

Session Objectives

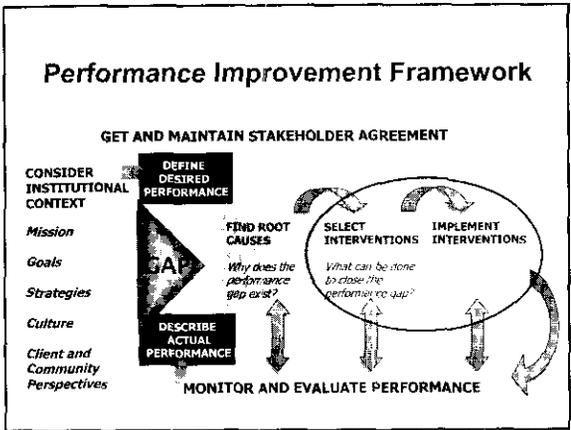
- List the challenges DL can overcome
- Describe an effective process for developing DL that works
- Describe major elements of successful DL programs
- List areas needing special attention during evaluation and describe how evaluation can improve future programs

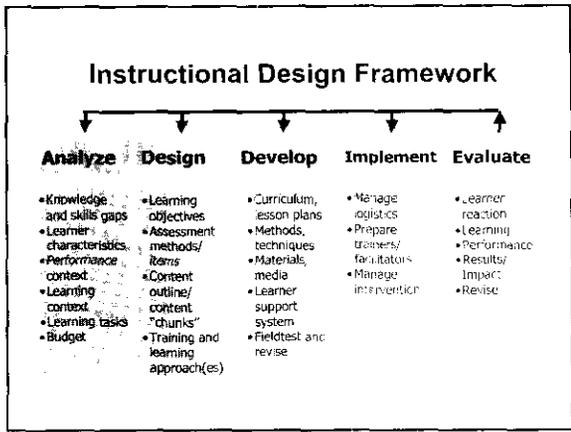
PRIME II
Africa

Discussion Questions

- When is DL appropriate?
- How is DL different from traditional group-based instruction?
- Is DL appropriate for all learners?
- What makes DL succeed?
- Can skills be acquired via DL? What types of skills?
- What challenges might I encounter in developing and implementing DL?
- How will I know DL worked?

PRIME II
Africa





Learning is...

... the ability to apply knowledge and skills on the job.

PRIME II
Africa
New Practices in Training & Learning



Distance Learning is a learning approach...

- where learners and trainers are not together in a classroom for most of the training time and
- that presents content in a pre-produced instructional package



Features of Distance Learning

- Learners
 - take responsibility for their own learning; learning is active and involves self assessment
 - learn alone or in small groups with less frequent help from instructor (but with strong support system)
 - learn from a variety of approaches
 - learn at their own pace in their own time
- Instructors
 - can focus more on individual learners
 - can pace their participation



Distance Learning is appropriate when:

- there is a need to reduce time away from the job
- more flexibility for learner and/or instructor is desired
- some participants live in distant or rural areas with poor transportation systems
- it is important to reduce the costs of delivering training to large numbers of people

Distance Learning Works!

Sound application of learning theory and instructional design principles *and*

- blended learning approaches
- a variety of media
- special attention to learner support

PRIME II
Africa
Best Practices in Training & Learning

GRMA DL Project

- The situation
- Challenges in implementation
- The solution
- Evaluation objectives
- Achievements
- Lessons learned/confirmed



PRIME II
Africa
Best Practices in Training & Learning

Ghana Project: Situation

- Needs assessment results:
 - FP/RH update
 - Improved counseling and CPI
 - Increasing adolescents' access
 - Introduction of national service policies
- Private midwives' need to stay at work sites
- Only 18 months for implementation

PRIME II
Africa
Best Practices in Training & Learning

Implementation Challenges

- Transportation
- Communication
- Time management
- Other?



PRIME II
Africa
The Institute of Health & Society

Design

- Pilot program for 60 midwives in 3 regions
- 5-month course combining multiple learning approaches for knowledge and skills acquisition—
 - print modules (practical exercises and self-assessments)
 - paired learning
 - facilitator visits (6, or 2 per region)
 - monthly group “peer review” meetings
- Content: CPI/counseling and ARH

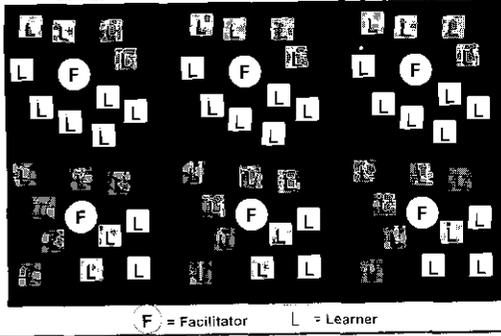
PRIME II
Africa
The Institute of Health & Society

Learner Support System

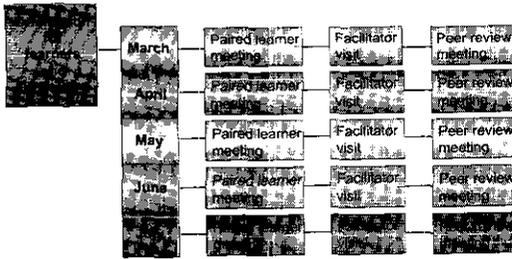
- learning materials specially designed to guide learners through the learning intervention
- opportunities for feedback and problem solving from facilitators and learning peers
- administrative support such as work time for study and practice, and tools and equipment

PRIME II
Africa
The Institute of Health & Society

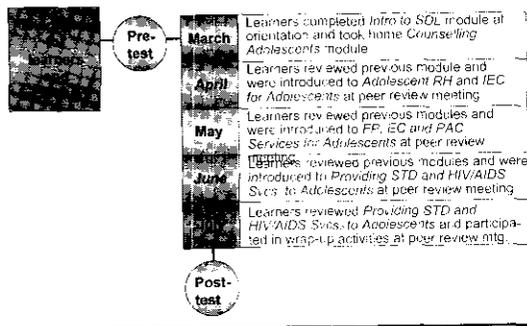
Paired Peer Learning with Facilitator Support



Learner Support



Activities



Evaluation Objective

Assess implementation and achievements:

- How can we improve the implementation of distance learning interventions?
- Can distance learning help providers develop and expand services for adolescents?
- Can distance learning improve CPI?



Achievements in Brief

- 97% completed 5-month program
- Improved knowledge and CPI counseling skills
- Improved interactions with adolescents
- Many altered physical environment/services to improve privacy
- More visibility in communities
- Increased professional collaboration/interest in learning



CPI/Counseling Findings

Significantly more learners...

- ensured private and comfortable counseling environment, confidentiality
- used flipcharts, models or samples in explaining medical information to clients
- discussed sexuality with adolescent clients
- explained contraceptive usefulness to young clients
- discussed STDs/HIV/AIDS



**Lessons Learned/
Confirmed**

- Distance learning can be effective for improving the performance of RH/FP service providers
- An effective learner support system is crucial!
- Facilitators must be adequately prepared and compensated
- Materials should be practical, thorough and engaging; directions must be clear
- Curriculum development skills need to be transferred to host-country partners

PRIME II
Africa
Our Partners in Learning & Leadership

Session Objectives

- List the challenges DL can overcome
- Describe an effective process for developing DL that works
- Describe major elements of successful DL programs
- List areas needing special attention during evaluation and describe how evaluation can improve future programs

PRIME II
Africa
Our Partners in Learning & Leadership

Summary



PRIME II
Africa
Our Partners in Learning & Leadership

Questions?

Ensuring the Effectiveness of Training by Using a Performance Improvement Approach

Wallace Hannum

Director
Performance Systems
Intrah, UNC
School of Medicine
Campus Box 8100
Chapel Hill, NC 27599-8100
Phone: 919-843-4132
Fax: 919-962-7178
E-mail: whannum@intrah.org

Pauline Muhuhu

Director
East and Southern Africa Region
Intrah PRIME Office
P.O. Box 4958
00100 Nairobi, Kenya
Phone: 254-2-211829
E-mail: pmuhuhu@intrah.org
intrahpm@africaonline.co.ke

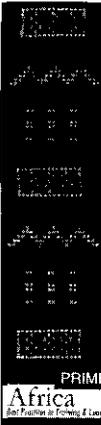




Thinking in terms of performance

- Think of a specific time period when your performance was not as good as usual.
- What was going on that got in the way of your (usual) good performance?

PRIME II
Africa
Best Practices in Training & Learning



Premises

- We all need an enabling work environment to perform at our best.
- We know the things that make up that environment.

When there are performance problems, a simple set of steps will help us find what's missing.

PRIME II
Africa
Best Practices in Training & Learning



What is performance improvement?

- A step-by-step methodology for finding out what is needed to ensure good performance, and delivering it.
- Training alone will not solve many performance problems.

PRIME II
Africa
Best Practices in Training & Learning

Factors Influencing Performance

1. Job Expectations
2. Feedback
3. Environment & Tools
4. Motivation/Incentives
5. Knowledge & Skills
(Organizational Support)

PRIME 3
Africa
The People & Learning Institute

Factors Influencing Performance

1. Job Expectations

Guidelines, policies, procedures, protocols – Do performers know what is expected of them?

PRIME 3
Africa
The People & Learning Institute

Factors Influencing Performance

2. Performance Feedback

PRIME 3
Africa
The People & Learning Institute

Factors Influencing Performance

3. Environment & Tools

The physical environment (facilities, supplies, materials, tools) performers work in - is it adequate?

PRIME II
Africa
The Pathway to Growth & Learning

Factors Influencing Performance

4. Motivation/Incentives

Are there ways to encourage performers to work better?

Are there hidden *dis*-incentives that accomplish the opposite?

PRIME II
Africa
The Pathway to Growth & Learning

Factors Influencing Performance

5. Knowledge & Skills

Do performers know how to do the job required?

PRIME II
Africa
The Pathway to Growth & Learning

Factors Influencing Performance
(Organizational Support)

Does the performer have a supervisor (or someone else) to make sure the factors are in place?

PRIME
Africa

PI is Really about...

- Asking questions
 - What does the situation/environment look like?
 - Who is critical in determining the outcome?
 - What should the performance look like?
 - What does it look like now?
 - What's the difference?
- Analyzing causes
 - Why is it happening?
- Selecting/implementing interventions
 - How can it be fixed?
- Monitoring and evaluating
 - Are we successful?

PRIME
Africa

From Training to Performance Improvement

- "We get requests for training, not PI"
- "We don't want any 'research' done - Just give us a good training course"
- "We already know what's wrong - just give us training"

PRIME
Africa

Examples

Goal:

improve the performance of service providers at service delivery points.

- In Kenya, the Kenya Medical Training College and its constituents part of Zonal Training Centers provided by improvement of service delivery, 2000-2002
- In South Africa, supervisors' training to improve the quality of health care in rural facilities.
- In Tanzania, used to identify performance gaps of Zonal Training Centers
 - to prepare them assume new role to improve reproductive health services.
- In Zambia, used to incorporate health care clients' perspectives of quality
 - into the pre-service training and service standards.

Training In PIA for PST KMTCC

- The Kenya Medical Training College
 - constituents' role
 - importance in Kenya.
- Introduction of PIA within the AMKENI project
- Results from KMTCC
 - use
 - future potential.

Example: Kenya PNA Results

Problem

- Students receive theoretical instruction and minimal clinical practice.

- 25% students score 70% or below in all practical assessments by end of training.



Kenya PNA Results Root Causes

- Clinical practice is a core competence, yet
 - students are inadequately supervised
 - inadequately followed up in clinical areas
- Supervisors at clinical site are too busy
- Lack of clinical instructors
- Lack of interest on part of students
- Large student/tutor ratio



Kenya PNA Results Root Causes (continued)

Supervisors at clinical site are too busy to pay attention to students.

- Competing tasks
- No guidelines/clinical learning objectives from the schools
- Service system under separate management system from training system



PIA Application In KMTC

- Influence on policies related to
 - staffing norms
 - Student-teacher ratio
 - designation of skills development
 - student recruitment
- Clarification of institutional roles and responsibilities regarding
 - supervision of clinical learning in
 - training institutions
 - service sites
 - need different management systems?
- Staff development and continuing education for tutorial staff.



PIA In-Service Training In South Africa

- With EQUITY project support, supervisors learned how to use PIA as a tool
 - to improve clinic performance in recruiting
 - management of TB cases.
- PIA was introduced as on the -job in-service training of supervisors
 - Applications
 - Training interventions
- Clinic supervisor and manager teams developed simple job aids to address specific problems and work environment



PIA In-Service Training In South Africa (continued)

- Results are very encouraging over a period of 9 months of PIA implementation
 - ranging from a 100% performance gaps to 17-66% improvements in 2 facilities.
- Pride and ownership of results is a big motivation factor today
 - supervisors, clinic managers and service providers
 - team ready to move on to other service areas.
- Progressive PI application to other technical and geographical areas is the pipeline. (scale-up)



Zambia Consumer Driven Quality Links to PIA and Training

Introduction

- Need for community involvement in quality of health care.
- GNC efforts to solicit clients' perspectives of quality
- Building a platform of performance standards for service providers
- Influencing policy environment

Summary

- The three cases illustrate
 - Performance Improvement Approach plays an important role in shaping, directing and re-directing
 - pre-service education and
 - in-service training for improved quality of care
 - Performance problems may not always result from lack of training.
 - For training to be effective, other factors must be taken into consideration.

PRIME II
Africa
Our Passion is Training & Learning

Future Considerations

- Performance Improvement efforts should be based on
 - assessments of factors affecting performance
 - application of learning prior to prescribing more training
- Building a rapid PIA approach to ensure efficiency.
- Provide training within overall PI framework
 - design of training
 - training implementation

PRIME II
Africa
Our Passion is Training & Learning

References

1. Inrah/PRIME, Performance Improvement Approach Framework.
2. Kenya Medical Training College, Performance Improvement Approach for Kenya Medical Training College Principals, January 2002.
3. General Nursing Council of Zambia, Client Driven Quality Needs Assessment, 2002.
4. General Nursing Council of Zambia, Family Planning and Reproductive Health Practice Standards (draft), January 2003.
5. J. Wachira et al. Strengthening Clinic Based Care in Eastern Cape, 1997-2002 (unpublished)

PRIME II
Africa
Our Passion is Training & Learning

Evaluation of Impact of Cascade Training Approach on Family Planning Services and Infection Prevention Practices

Cathy Toroitich-Ruto

Senior Programme Coordinator
Institute for Family Health
Family Health International
Africa Regional Office
The Chancery, 2nd Floor, Valley Road
P.O. Box 38835 00623
Nairobi, Kenya
Phone: 254-2-2713913
Fax: 254-2-2726130
E-mail: cruto@fhi.or.ke



Evaluation of Impact of Cascade Training Approach on Family Planning Services and Infection Prevention Practices

Presented by

Cathy Toroitich-Ruto, PhD
Family Health International
Nairobi, Kenya



Presented by Family Health

Training Innovations

- **Competency-based training:** designed to ensure that key skills or "competencies" are transferred
- **On-the-job training:** provided on site to present or reinforce skills within specific contexts
- **Group-based training:** focuses on specific cadres of workers to ensure coordination and complementarity



Presented by Family Health

Training Innovations

- **Whole-site training:** involves workers at specific site so their interdependent skills are fully understood and used
- **Problem-based learning:** uses case studies or other approaches emphasizing the use of skills to address specific problems
- **Cascade training:** Let's find out more about it!



Presented by Family Health

Cascade Training Approach

- Multilevel/multi-tier method for building the competence of health program personnel in selected skills
 - Inexperienced trainers
 - A step-down group-based training
 - Starts with few expert trainers and builds capacity for more trainers and large numbers of service providers

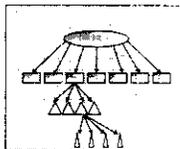


Cascade Approach: Characteristics

- Appropriate for large programs and multi-level service providers programs
- Used where rapid capacity building and transfer of knowledge, skills and attitudes is required
- Requires systematic, extensive planning and monitoring
- Requires management commitment



An Evaluation of Cascade FP Training In Kenya



Collaborative Effort

- FHI
- JHPIEGO
- Population Council



Funded by USAID



Center for Family Health

Kenya's FP/RH Overview

78% of service providers (SP) had basic training

26% of SP had recent in-service course

RH intentions of clients were obtained in only 47% of cases observed or reported

Source: SPA 1999



Center for Family Health

Research Objective

To assess knowledge, attitudes and practices of service providers after Training-of-Trainers courses (TOTs)



Center for Family Health

TOT

- Orientation Package (OP)
 - Training Manual (TM)
- Support Supervision (SS)
 - 1-day visit by supervisor
- Decentralised training system
 - Decentralised training centers (DTC)
 - Developed several years
 - Regional model emulated by other countries

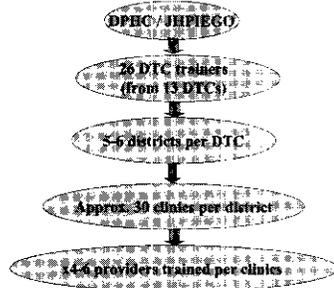


Decentralised Training System

- Trainers are skilled in:
- Training methodology
 - Counseling training
 - Infection prevention training
 - Contraceptive technology updates
 - On the job training
 - Clinical skills

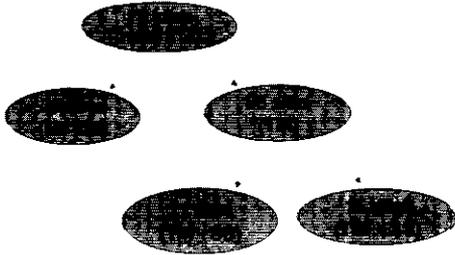


Kenya's Cascade Training Rollout



Research Design

Before training (Baseline)



© 2007 by Family Health

Research Questions

Do knowledge and behavior of trained providers change after dissemination training?

Do knowledge and behavior of co-workers of trained providers change after dissemination training?



© 2007 by Family Health

Research Questions (cont.)

Do knowledge and behavior change more in "Orientation Package" clinics?

Among "Orientation Package" clinics, do knowledge and behavior change more in "Support Supervision" clinics?



© 2007 by Family Health

Data Collection

Clients/providers were interviewed in 72 sites:

- Baseline data collection
 - September 1999
- Follow-up data collection
 - July 2000



Scores

Knowledge / Attitude Score

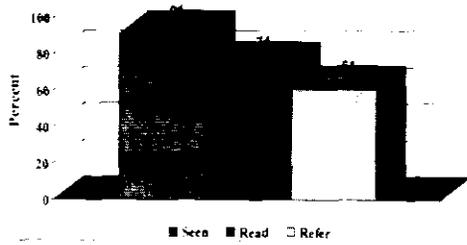
Good Practices Score



What Are the Key Findings?

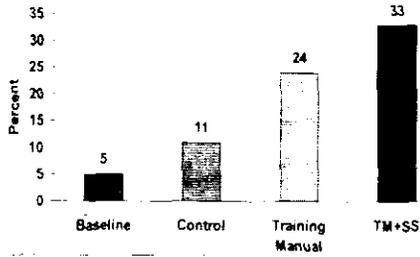


SP Exposure to Updated Guidelines



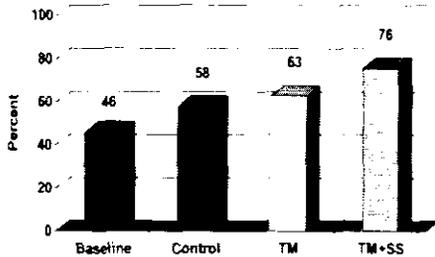
University for Family Health

Providers Who Knew the 3 Conditions of LAM



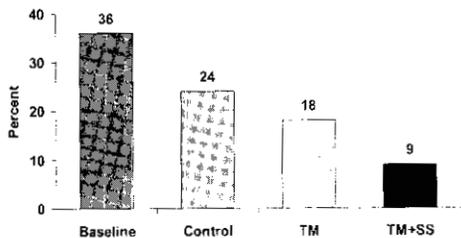
University for Family Health

Providers Who Knew IUDs Are Effective for 10 Years

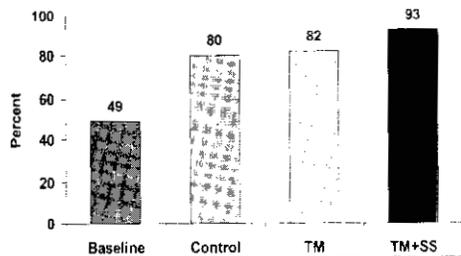


University for Family Health

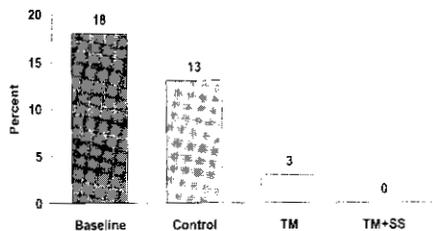
Providers Who Think Vaseline Is a Good Condom Lubricant



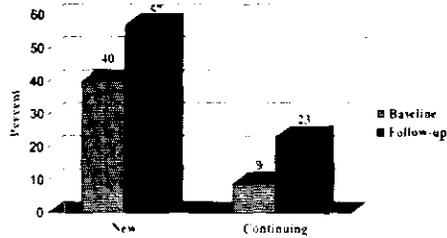
Providers Who Had Heard of Emergency Contraception



How Many New Clients Were Denied Services Due to Menstruation?



Clients Advised to Use Condoms in Addition to Regular Method



Policy Implications

More intensive training provides greater impact in terms of provider's KAP

Information passed through from one service provider to another, can be effective in some circumstances

Conclusions

- KAP improved
- Improvement sustained
- "Cascade" worked
- More reinforcement → better outcomes
- One of the first conclusive evidence that guidelines work

An Assessment of the Impact of Infection Prevention (IP) Training in Tanzania



Evaluation Background

1994/95: Needs assessment reveals lack of proper IP procedures

1995: IP regional training in 6 countries

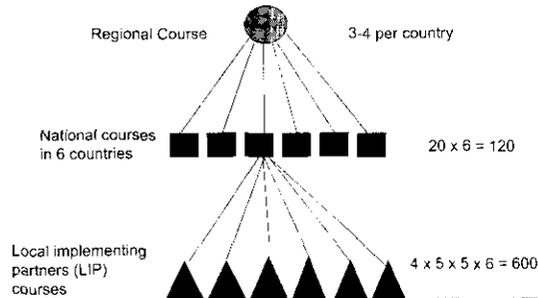
1996: Second, similar, training in quality of care (QOC)

1997: National level QOC/IP training

1999: This follow-up evaluation of the QOC/IP training in Tanzania projects



Cascade Training Approach



Infection Prevention in Tanzania

- 4 trained providers at regional level trained 38 providers at national level, who trained 80 at service delivery points
- Evaluation at 14 clinics run by 5 PI projects
- Organization of Tanzania Trade Unions
- Tanzania Occupational Health Services
- University of Dar-es-Salaam
- Seventh-Day Adventist Church Health Services
- Shinka la Uchumi la Wanawake Tanzania



International Federation of Occupational Health

Content of IP Training

- Decontamination
- Cleaning of instruments
- Asepsis and hand washing
- High-level disinfection
- Sterilization by chemical
 - autoclaving/steam, and dry heat methods
- Use of barriers
- Waste disposal
- Handling of specimens



International Federation of Occupational Health

Service Delivery Points Profile

- Type:** 11 clinics, 2 health centers, 1 hospital
- Location:** 64% are urban, others are peri-urban
- Services:** 100% offer FP services
93% offer under 1 yr, under 5, and antenatal care
50% offer postnatal care
93% provide laboratory services
14% have dental clinics
- FP client load:** Ranged from 10 to 35 FP clients/day
Mean of 15 clients/day
71% of clinics had >10 clients/day



International Federation of Occupational Health

Study Methodology

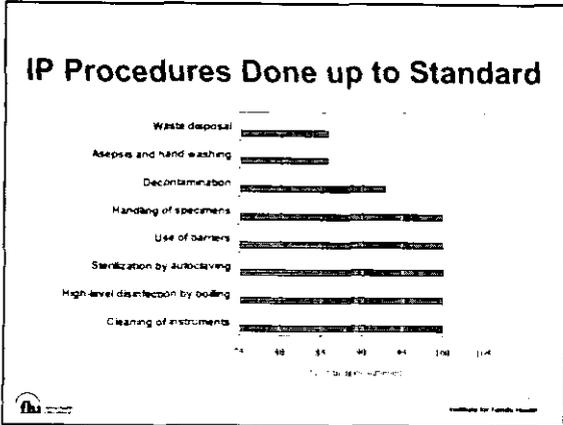
- 3 evaluators
- TA from Principal Investigator Africa Regional Office
- 3 part study instrument
 - Observation
 - Interviews
 - Questionnaires
- Sample size
 - Level I trainees - 28
 - Level II trainees -10

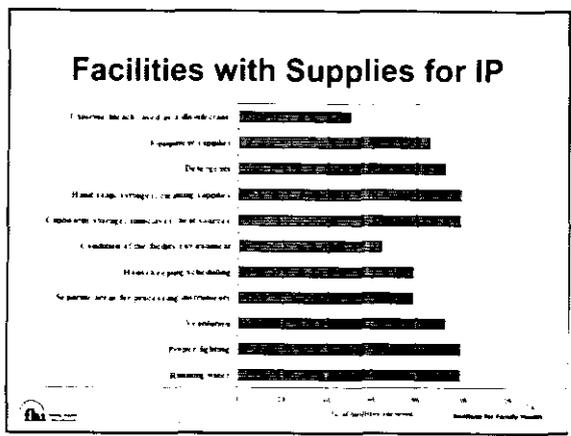


Summary of Findings

Training Accomplishments

- 86% level I trainees received assistance from their management
- 29% level I trainees conducted a formal IP course
- 86% level I trainees provided on-the-job training (OJT) to colleagues at work
- Few level II trainees oriented their community-based distributors in IP procedures





Spillover Effects of IP Training

Some trainees:

- Initiated use of personal towels
- Improved IP procedures in treatment and injection rooms
- Made sure outstanding water and electricity bills were paid
- Saw the repair of sinks, taps, and buckets
- Introduced proper waste disposal systems, improvised incinerators, instituted use of heavy duty gloves
- Established quality improvement committees at organizational and service delivery levels

Source: WHO, 2004. Institute for Family Health

IP plans

Trainees plan to:

- Monitor clinic to ensure IP procedures are followed properly
- Lobby for management support for IP measures
- Improve the existing waste disposal system
- Develop and disseminate clear written guidelines for proper steps in IP



Problems Faced by the Clinics

- The supply of bleach was irregular and inadequate
- General renovation required in some clinics
- A few clinics were in urgent need of surgical instruments
- Some clinics need to improve their waste disposal systems*
- There are still many service providers who have not received IP training (formally or OJT)
- The management of a few of the clinics does not recognize the importance of supporting IP



Conclusions: Is it Working?

- All participants were motivated to use IP measures
- Most clinics had started committees to assist in IP implementation
- Use of bleach for decontamination is now common in 93% of clinics
- Appropriate waste disposal systems have been instituted
- 86% clinics are practicing proper hand washing and use of individual towels



What are the Advantages and Limitations of Cascade Training?



Advantages: Cascade Approach

- Has a rapid multiplier effect
- Transfers knowledge, skills and attitudes rapidly
- Yields many trainers within a reasonable time period
- Is particularly useful in human resource-scarce situations
- Reaches quickly into geographical areas trainers cannot access easily
- Helps standardize regional and national level courses by using same trainers and training materials
- Builds in implementation plans for continuing training at lower levels

Limitations: Cascade Approach

- Requires distribution of large quantities of materials
- Involves intensive planning and monitoring
- Calls for a lot of equipment supplies at service delivery points in a short time
- The immediate build up of capacity creates an urgent need for resources to implement training
- At lower levels, may present a quality control problem, with the danger of watered down transfer of knowledge skills and attitudes

What have we learnt?



fhi Institute for Family Health

Lessons Learned

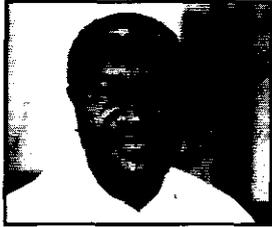
- The service delivery situation on the ground has a direct bearing on the utility of the cascade course content and must be considered in developing materials
- Lack of resources to implement local and national training may slow the cascade to a trickle and prevent the multiplier effect from taking place
- Without management support, the cascade will be stopped in its tracks

fhi Institute for Family Health

How Can You Make the Cascade Approach Work for You?

- Need for specific skills/knowledge
- Careful planning
- Management commitment
- Curriculum/materials development
- *Training in training skills*
- Supervision and monitoring
- Evaluation and feedback
- Capacity to meet the demands for resources to implement the new skills

fhi Institute for Family Health



In memory of a dear friend and
colleague, Dr. Ezra Teri



Produced by Teri's Family

THANK YOU



Produced by Teri's Family



Designing Counseling Training that Works

Gail Rae

Manager

Professional Development

Population Leadership Program

529 14th St., NW, Suite 1030

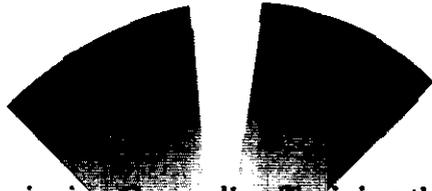
Washington, DC 20045

Phone: 202-661-8021

Fax: 202-661-8029

E-mail: grae@popldr.org





Designing Counseling Training that Works

Gail Rae, Manager - Professional Development
(202) 661-8923 | G.Rae@popids.org
Population Leadership Program
Public Health Institute



Session Plan

- Introduction: What are the challenges to improving how providers treat clients?
- Counseling content crucial to excellent family planning counseling training
- Training methods and exercises
- Sharing your questions and experience



Great counseling trainers pay attention to providers':

- Attitudes about themselves (self-efficacy, self-awareness); their clients (empathy) and the service they provide
- Knowledge about their clients, the helping process, and the services they provide
- Behaviors that are effective with clients
- Context that influences counseling



Key Counseling Skills

- Establishing rapport
- Exchanging information
- Decision making or problem solving
- Next Steps



Helping Providers Become More Effective

- Uncover personal values that help or hurt interaction
- Increase knowledge (sexuality, FP/RH methods, common client concerns, referral resources)
- Increase positive behaviors and target problem behaviors



Training Methods that Help

- Quality standards in curricula design
- Micro-skills training
- Modeling good counseling
- Supervised practice
- Peer review
- Self-assessment
- Positive reinforcement
- Use multiple learning approaches
- Foster strong learner support system

Whole-site Training for Sustained Results: Egypt and Tanzania Experiences

Grace Engesia Wambwa

Program Manager

EngenderHealth Kenya

ABC Place, Waiyaki Way

Nairobi, Kenya

Phone: 254-2-444-922

Fax: 254-2-441-774

E-mail: gwambwa@engenderhealth.org



Whole-site Training for Sustained Results: Egypt and Tanzania Experiences

*Grace Engesia Wambwa,
Program Manager*



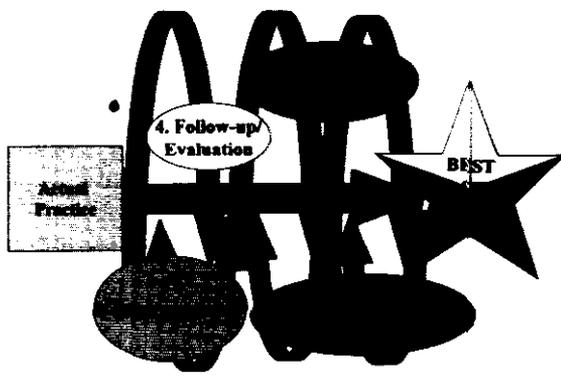
*Training in Africa: Best Practices,
Lessons Learned and Future Directions
Zambia, May 5-7, 2003*

Session Objectives

By the end of the session participants will be able to:

- Describe the elements & the process of the Whole-site Training approach (WST)
- Explain the benefits of the WST approach compared to centralized training
- Develop a plan to apply the WST approach in a specific context

The Quality Improvement (QI) Process



Quality Improvement Principles

- Customer focus
- Staff involvement and ownership
- Focus on processes and systems
- Cost-consciousness and efficiency
- Ongoing quality improvement
- Continuous learning, development and capacity building

4

When Training is the Answer: The Whole-site Training Approach

An approach to training that

- Meets the learning needs of all staff at a service delivery site
- Views a service delivery site as a system and treats staff as members of the team that makes the system work
- Makes training more cost efficient

5

Whole-site Training Approach

Types of Training *Locations of Training*

- | | |
|------------------------|--------------------------------|
| • Service orientations | • On-the-job training |
| • Knowledge updates | • On-site training |
| • Skills training | • Regional or central training |

6

Whole-site Training: The Six Elements

- Linking the supervisory and training systems
- Assessing site training needs and planning to meet them
- Focusing on teams, not only individuals
- Tailoring the level of training to the needs of different employees
- Expanding the locales where training occur
- Building sustainable capacity

Changing the Role of the Supervisor

- Help identify training needs
- Act as catalysts for change
- Serve as trainer or identify appropriate resources
- Help sites access training resources
- Help sites plan training
- Routine follow-up of trainees
- Monitor training and results

Assessing Site Training Needs and Meeting Needs

- Site staff and supervisors identify gaps in Quality of Care (use of COPE[®] or other needs assessment)
- On- and off-site supervisors help identify skills and other learning needs during supervisory visits
- Site staff participate in planning and organizing training, orientations, and updates

Building Sustainable Capacity

- Supervisors routinely facilitate all aspects of training
- Training follow-up becomes routine
- Many staff involved in training
- Sharing of knowledge and expertise encouraged
- Problem solving becomes part of performance improvement mindset
- Lessens the impact of staff turnover

19

Assuring Quality of Training: Applying the WST Approach

- Well-trained supervisors - effective monitoring of training and post-training performance
- Access to specialized training resources, when needed
- Adequate training handbooks and evaluation tools
- Type of training and training location are appropriate to training need
- Establishment of site libraries

21

Inreach



A strategy for informing *clients* and *staff* within a facility about other services available, and referring clients to services in other facilities according to the clients' needs

The purpose is to reduce missed opportunities for providing services to clients and establish linkages and referrals between the facility's departments

12

**Tanzania Experience
1992 - 2002**

National Study in 1993 on the Quality of Reproductive Health Services: Results

Poor quality of services caused by:

- Shortage of trained providers
- Centralized training not meeting sites' training needs
- Lack of teamwork
- Lack of staff ownership of quality of services and of the quality improvement process

Study was conducted by MOH, UMATI, and EngenderHealth

National Study in 1993 on the Quality of Reproductive Health Services: Recommendations

- Train managers and supervisors in facilitative approach to supervision
- Build services based on quality improvement principles
- Link the supervisory and training systems

Implementing the Whole-site Training Approach in Tanzania

- 1994 - The training plan
- 1995 - Training for supervisors and managers in facilitative supervision and QI
- 1995 - Whole-site training approach introduced to service providers and supervisors
- 1995 - On-The-Job Training Guides developed (MVA Technique, Infection prevention, Counseling, PA FP)

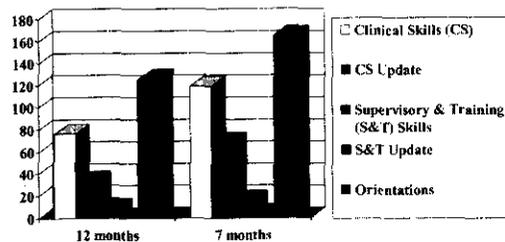
16

National Outcomes: Staff Trained

Period of Time	Centralized	WST: Skills training	WST: Knowledge update	WST: Orientations
1992-1994	271	1	0	0
1995-1997	1,613	117	406	2,222
1998-2000	621	948	407	1,409
2001-2002	47	398	123	548

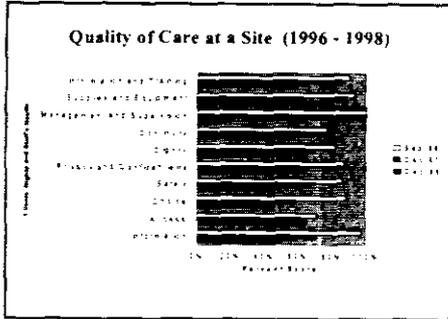
17

Expanding Training Opportunities at Maswa District Hospital



18

Improved Quality of Services at Maswa District Hospital



Applying the Whole-site Training Approach to Pilot PAC Services

- 1997 - PAC Pilot project: Dodoma Regional Hospital, Morogoro Regional Hospital, and Kibaha Hospital
- Improve quality and access to reproductive health services, including FP, by establishing comprehensive PAC services
- Strengthen linkages among other reproductive health services in these hospitals

Applying the Whole-site Training Approach to Pilot PAC Services (2)

- Site staff and supervisors identified gaps in quality of care (COPE[®] and other assessment tools)
- Internal and external supervisors together with staff identified site training needs (monitoring, supervisory visits, use of assessment tools)
- Staff participated in planning and organizing training events

Staff Trained in:

- Infection prevention
- Counseling in FP
- Norplant insertion and removal
- PA IUD insertion
- MVA
- Facilitative Supervision
- COPE (Morogoro & Kibaha Hospitals)
- Cost Analysis Tool
- The Quality Measuring Tool

22

Cascade Training

- Selected staff from Morogoro and Kibaha hospitals attended centralized trainings in Kenya
- Those staff trained the Dodoma staff
- TOT to improve quality of on-site trainings
- On-site training activities: service orientations, knowledge updates, & skills training

23

Pilot PAC Project Outcomes

- Improved management of PAC services as a result of FS and WST courses and orientations for supervisors
- Larger number of staff introduced to the concept of PAC
- Staff rotation was reorganized - the services are available 24 hours a day
- Provision of supplies improved

24

Pilot PAC Project Outcomes (2)

- UMATI staff conduct supervisory visits more frequently providing better support to the staff
- Record keeping had improved
- Inreach activities resulted in common understanding and establishment of a referral system and linkages to other RH services

**Applying the WST Approach:
Lessons Learned**

- Orientation of supervisors to the WST approach and training in facilitative approach to supervision are crucial
- Staff involvement in training needs assessment and planning and implementing solutions creates a teamwork and ownership
- Linking the supervisory and training systems builds in sustainability

**Applying the WST Approach:
Lessons Learned (2)**

- Supervisors support, monitor, and evaluate trainees' performance when those apply knowledge and skills acquired
- Supervisors support knowledge and skills transfer and mentoring and monitor quality of cascade trainings
- Implementing the WST Approach brings changes in organizational structure and culture making the QI process sustainable

Egypt: The Safe Reproductive Health Program Experience

28

Safe Reproductive Health Program

A hospital-based *service model* designed to increase family planning and other reproductive health service options, access, and use. Focused on the particular needs of women with *medical reasons to prevent pregnancy* and on the missed opportunities to serve women in the perinatal period

29

Program Characteristics

- Whole-site Training approach to programming, systems, and training
- Holistic programming approach
- Inreach
- Offering more options at more service points
- Designed to be sustainable

30

Program Elements

- Service standards and training curricula
- Client screening and referral system
- Counseling
- Improved infection prevention
- Postpartum and interval FP and tubal ligation services including PPIUD and PABIUD
- Client record and information system
- Quality improvement tools
- Business plans to achieve sustainable services

Using the Whole-site Training Approach

- Program orientation for all levels of staff from all departments
- Infection prevention training
- Counselor training for staff from multiple service points
- Clinical skills updates for PPIUD insertion and ML service teams
- COPE
- Training in record keeping and information system

Follow up Activities

- Routine on-site monitoring by internal supervisors and project monitors
- Periodic site visits by managing CA
- Transfer of knowledge and skills to new staff

Outcomes

- Common understanding of critical issues
- Program identity "owned" by staff
- Broader range of services offered routinely
- Counseling established
- Infection prevention strengthened and expanded
- Extensive team of providers with service and training capacity established for sustainable program

34

Whole-site Training Approach: Results

- Common understanding of critical issues and roles at different levels
- Strengthened team work and systems
- Improved organizational effectiveness
- Sustained change in organizational culture and practice
- On-going knowledge and skills transfer for sustained capacity and results

35

Lessons Learned

The Whole-site Training Approach

- Fosters a supportive environment for applying new skills and creates institutional ownership
- Strengthens service teams
- Permits practical application and adaptation of learning to real work setting
- Stimulates transfer of learning for wider, on-going application of new skills

36

Lessons Learned (2)

- Orientation for administrative and management staff is as important as training the service team to ensure support for new services or practices
- Training alone rarely changes attitude and practices; it must be backed by leadership, clear performance expectations and sustained support through facilitative supervision

Challenges

- Distractions of job responsibilities
- Ensuring skilled supervisors are available to monitor and follow-up
- Motivating staff to mentor colleagues to transfer knowledge and skills
- Ensuring quality of training as it is decentralized
- Coordinating differing donor-supported training approaches

Additional Benefits of Whole-site Training

- Demystifies training
- Everyone is involved
- Encourages mentoring
- Foundation for sustainability
- Long-term benefits - change in organizational culture



Training Clinical Decision-makers: Nurses and Cervical Cancer Prevention

Sylvia Deganus

Project Manager

Cervical Cancer Prevention Program
(CECAP)

JHPIEGO Corporation

Ghana, Accra

Phone: 233-0-21-500-713

Fax: 233-0-21-510-098

E-mail: sdeganus@yahoo.com

sdeganus@jhpiego.org.sh



Training Clinical Decision-makers:
Nurses and Cervical Cancer Prevention

JHPIEGO

Dr. Sylvia Degarus
Cervical Cancer Prevention Program (CECAP)
JHPIEGO/Ghana

Learning Objectives

- Describe multimedia and co-assessment approaches used to train nurses in clinical decision-making and
- Recognize some of the challenges faced when training nurses in clinical decision making

2

What is Cervical Cancer

- Malignant, uncontrolled growth of cervical tissue
- Caused by? Human Papilloma Virus (HPV) infection
 - Sexually transmitted virus
 - Oncogenic strains trigger abnormal growth
 - Oncogenic strains present in 99% of cervical cancers
 - Long latency, slow progression

3



Cervical Cancer: Magnitude of the Problem

- 400,000 new cases worldwide each year
- At least 200,000 women die of cervical cancer each year, in the prime of their lives
- 80% of new cases and deaths occur in developing countries
- The third most common cancer worldwide
- Disproportionate burden on poor women

4



Cervical Cancer Prevention Program (CECAP)

- Member of Alliance for Cervical Cancer Prevention (ACCP)
- Funding from Bill & Melinda Gates Foundation
- Objectives:
 - Assess new testing and treatment approaches & technologies for cervical cancer prevention in low resource settings
 - Improve delivery of preventive services
 - Encourage community involvement
 - Advocate for increased global awareness of cervical cancer
 - Assist countries to move from research to programs

5



Project Approach in Ghana

- Assess **S**afety, **A**ceptability, **F**easibility and program **E**ffort of Single Visit Approach to cervical cancer prevention
- VIA screening linked to cryotherapy treatment
- Nurse-midwife Service Providers
- ObGyn Clinical Supervisors
- Urban and rural sites
- Cancer Management at tertiary center

6



Project Training Goals

- Trained nurses will achieve:
 - Procedural competence in VIA and Cryotherapy
 - Confidence in making clinical judgments

10



Novel Training Methodologies

- Independent clinical Co-assessment
- Video review of clinical practice
- Digital image review with CD-ROM

11



Co-Assessment

- Compare VIA decision of Provider and Clinical Supervisor
- Performed independently
- Measure agreement
 - Expect 80% agreement
 - If <80% agreement, then retrain

12

Co-Assessment Results

- Number of women tested $N = 123$
- Percent agreement = 97%
- Kappa = 0.93

13

Video Review

- Photos of classroom work here

14

CD-ROM

- DEMONSTRATION OF CD ROM HERE

15

Conclusion

- Nurses can be trained to:
- *Procedural* competence in cervical cancer prevention skills
- Confidence in making clinical judgments

Use of Competency-based Assessment Tools in Clinical Skills Development

Emmanuel “Dipo” Otolorin

Senior HIV/AIDS Advisor
JHPIEGO Corporation
1615 Thames Street, Suite 300
Baltimore, MD 21231-3492
Phone: 410-537-6494
Fax: 410-537-1477
E-mail: eotolorin@jhpiego.net



Use of Competency-based Assessment Tools in Clinical Skills Development

JHPIEGO

Emmanuel Dipo Otoloria
Senior HIV/AIDS Advisor
JHPIEGO Corporation
otoloria@jhpiego.net

Session Objective

By the end of this session, the participant will be able to use competency-based skill development and assessment instruments for measuring progress in learning and evaluating performance.

Enabling Objectives (1)

- List examples of clinical skills required for quality RH services, including HIV prevention
- Define terms associated with competency-based skill development and assessment
- Identify three levels of competency
- Identify two types of assessment systems

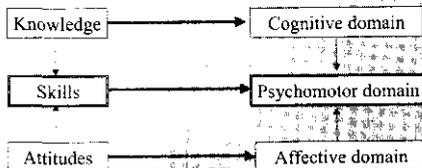
Enabling Objectives (2)

- List steps in designing learning guides and checklists
- Demonstrate use of learning guides and checklists
- List lessons learnt in using competency-based assessment instruments

How were your clinical skills assessed prior to your qualification as a clinician?

- A. Not assessed
- B. You were observed performing procedure(s) and then rated (*no checklist used*)
- C. You were observed performing procedure(s) and then rated (*using a checklist*)
- D. You were observed performing procedure(s) and rated (*using a checklist that you had previously used during your training*)

To Train Someone to Perform a Task, We need to impart...





What Are Some Examples of Reproductive Health Tasks Related to Our Psychomotor domain?

Illustrative Clinical Skills (1)

- Family planning
 - Pelvic examination
 - IUD insertion and removal
 - Mini-laparotomy
 - Norplant insertion
 - FP counseling
- HIV/AIDS
 - Pre-test counseling
 - Rapid HIV testing
 - Post-test counseling
 - Condom care
 - Tapid spraying
 - Bed bathing

Illustrative Clinical Skills (2)

- EOC
 - Normal delivery
 - Vacuum extraction
 - Episiotomy repair
 - Repair of cervical tear
 - Manual removal of placenta
 - Uterine evacuation with MVA kit
 - Immediate newborn care
- Infection prevention
 - Hand washing
 - Decontamination
 - High-level disinfection
 - Sterilization

Why do we need to refocus our approach to skill development?

- Many students exit from pre-service education or inservice training without real skills:
 - Unclear job expectations
 - Limited contact with clients during training
 - Too few clients or patients
 - Too many students
 - Inappropriate training approach
 - Humanistic training (using anatomic models) not institutionalised
 - Trainers in a hurry (distracted by other responsibilities)
 - Tendency to want to "see one, do one, teach one"
 - Trainers worried about medication, diagnosis or private patients avoiding use of the word "competence" too much contact with trainers

10

Definition of Terms

- Competency-based skill **development**
- Competency-based skill **assessment**



- Learning guide
- Checklist

11

Levels of Skill Performance

- Skill Acquisition
- Skill Competence
- Skill Proficiency



12

Skill Acquisition

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



Using Learning Guides for NFAA
Acquisition in Bangladesh, August 2005

13

Skill Competency

- 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.



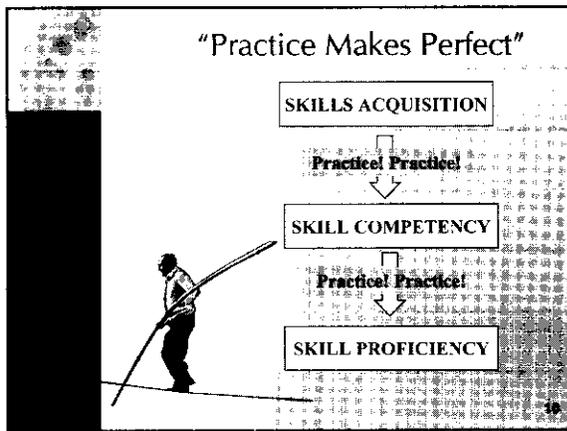
Using Learning Guides for NFAA
Evaluation in Bangladesh, August 2005

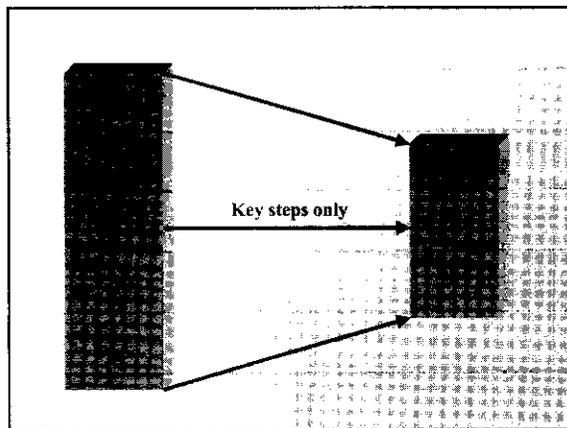
14

Skill Proficiency

- 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)**.







Using Learning Guides

- Participants follow the steps as the trainer role plays counseling a client or demonstrates a clinical procedure using anatomic models
- Participants use the learning guides during classroom practice as trainer observes and coaches
- Participants assess each other using the learning guide

Using Checklists

- Ensures participants have mastered the clinical skills and activities, first with models and then with clients
- Ensures all participants skills are measured according to the same standard
- Forms the basis for follow-up observations and evaluations

Types of Rating Systems

- Numerical (multi-level)
- Yes/No (pass/fail, satisfactory/unsatisfactory)

LEARNING GUIDE FOR CLASSROOM PRESENTATION SKILLS

To be completed by Participants.

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

1 Needs Improvement Step or task not performed correctly or out of sequence, if necessary not completed.

2 Competently Performed Step or task performed correctly in proper sequence, if necessary, but participant does not progress from step to step efficiently.

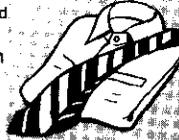
3 Proficiently Performed Step or task efficiently and perfectly performed in proper sequence, if necessary.

Steps to Design an Assessment Instrument

- Reach consensus on end product
- Identify the steps or tasks to reach end product
- Place steps in the correct sequence
- Identify standards or minimum levels of performance (rating scales)
- Provide directions (equipment, supplies, materials, how to use)
- Field test the instrument

Small Group Exercise

- Divide into 4 groups:
- Each group to practice using a learning guide for a selected everyday skill e.g.
 - knotting a necktie, or
 - tying a female African head scarf
- Duration of activity: 20 min



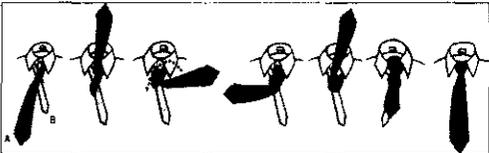
"Globally, 500 million ties knotted everyday"

22

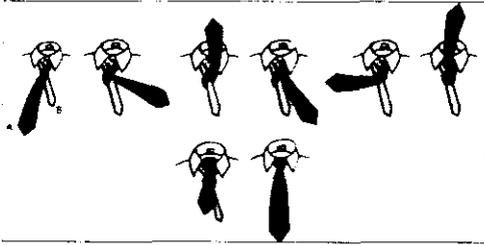
The Four-In-Hand Knot



The Windsor Tie Knot



The Half-Windsor Tie Knot

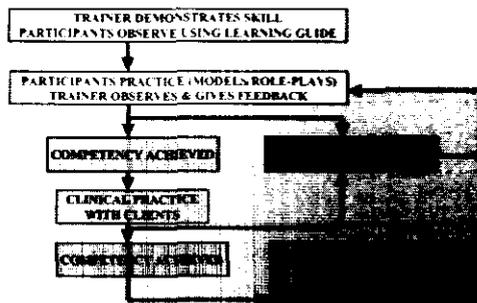


When has a participant satisfactorily performed a task?



- When **ALL** the steps of a procedure have been satisfactorily performed in their correct sequence and in accordance with laid down guidelines

Clinical Skill Development Process



Tracking Learner Performance

Illustrative Tracking Sheet for Multiple Skill Development in Emergency Obstetric Care

Clinical Skill / Participant's #	1	2	3	4	5	6
Labor assessment	<input type="checkbox"/>					
Use of the Partograph in Labor	<input type="checkbox"/>					
Normal delivery	<input type="checkbox"/>					
Episiotomy repair	<input type="checkbox"/>					
Newborn resuscitation	<input type="checkbox"/>					
Adult resuscitation	<input type="checkbox"/>					
Using MVA kit	<input type="checkbox"/>					
Bimanual Comp. of the Uterus	<input type="checkbox"/>					
Manual Removal of Placenta	<input type="checkbox"/>					
Repair of Cervical Tear	<input type="checkbox"/>					
Vacuum extraction	<input type="checkbox"/>					
Breech Birth	<input type="checkbox"/>					
Manage shock	<input type="checkbox"/>					

Competent on clients
 Competent on models

Illustrative Tracking Sheet for Multiple Skill Development in Family Planning

Clinical Skill	Participant's Name or Number					
	1	2	3	4	5	6
Group education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual counseling for FP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IUD insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IUD removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Norplant insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Norplant removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing injectables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decontamination of used instruments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Competent on clients
 Competent on models

Lesson #2

- Learning guides form the basis of classroom or clinical demonstrations by the trainer.



Trainer demonstrating normal delivery in Dhaka, Bangladesh, 2002

34

Lesson #3

- Learning guides and practice checklists are great tools for self- and peer assessment during training. It fosters participants' interaction while reducing stress.



Participants practice Norplant insertion in Uganda using learning guides (2000)

35

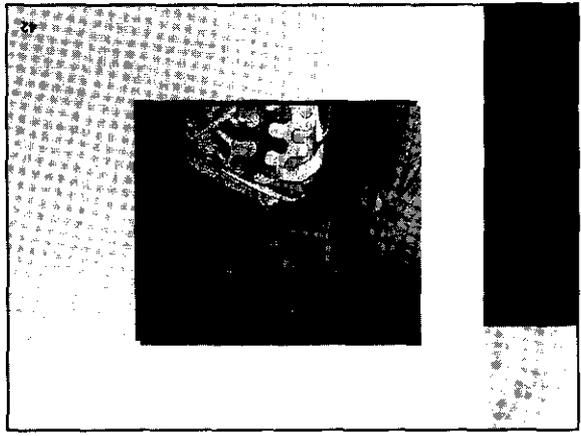
Lesson #4

- Checklists are an acceptable basis for objective evaluation of performance to determine competency or proficiency in a skill learnt.



Evaluating postpartum pelvic examination in Uganda, 2000

36



Summary

- Learning guides enable participants to chart their progress in learning new skills and, by breaking the skill or activity down into its essential elements, helps to pinpoint areas needing improvement
- Competency-based checklists are used to measure a variety of participants' skills and behaviours in realistic job-related situations
- "Lecture time" or "Number of practice cases performed" should no longer be the primary basis for qualification

Challenges (2)

- Provide an adequate number of skilled clinical trainers to conduct the training (competency-based clinical training usually requires a one-on-one relationship)
- Invest in anatomic models and equipment to create realistic scenarios for clinical training

LEARNING GUIDE FOR TYING THE "FOUR-IN-HAND" NECKTIE KNOT

Participant's Name: _____

Course Dates: _____

Instructions

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

1. **Needs improvement:** Step not performed correctly and or out of sequence (if required or is omitted). *PUT 1*
2. **Competently performed:** Step performed correctly in proper sequence (if required) but participant does not progress from step to step efficiently. *PUT 2*
3. **Proficiently performed:** Step efficiently and precisely performed in proper sequence (if required). *PUT 3*

N/O Not observed: Step not performed by participant. *PUT N/O*

TASK/ACTIVITY	PRACTICE SESSIONS		
Getting ready			
1. Assemble needed materials <ul style="list-style-type: none"> • Necktie • Tie-clip (optional) • Mirror (optional) 			
Tying the knot			
2. Insert tie under the shirt collar			
3. Situate the tie so that the fuller end (A) is longer than the thinner end (B) and cross A over B (see Figure 1.1)			
4. Turn A behind and underneath B (Figure 1.2)			
5. Bring a back over in front of B (Figure 1.3)			
6. Pull A up and through the loop made between your shirt collar and the necktie (Figure 1.4)			
7. Hold the front of the knot loosely with your index finger and bring A down through the front loop (Figure 1.5)			
8. Remove forefinger and tighten knot snugly to collar by holding B and sliding the knot upwards (Figure 1.6)			
9. Ensure that the knot is placed centrally over the first button of your shirt collar (use a mirror as needed)			
10. Apply a tie clip to hold the necktie to the shirt (optional)			

Figure 1: The "Four-In-Hand" Knot

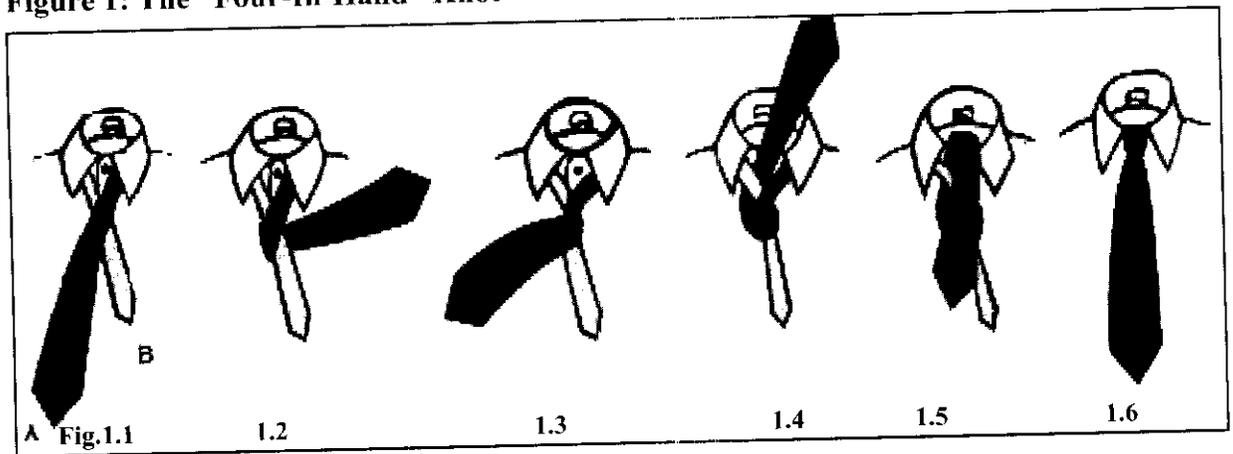


Figure 2: The Windsor Necktie Knot

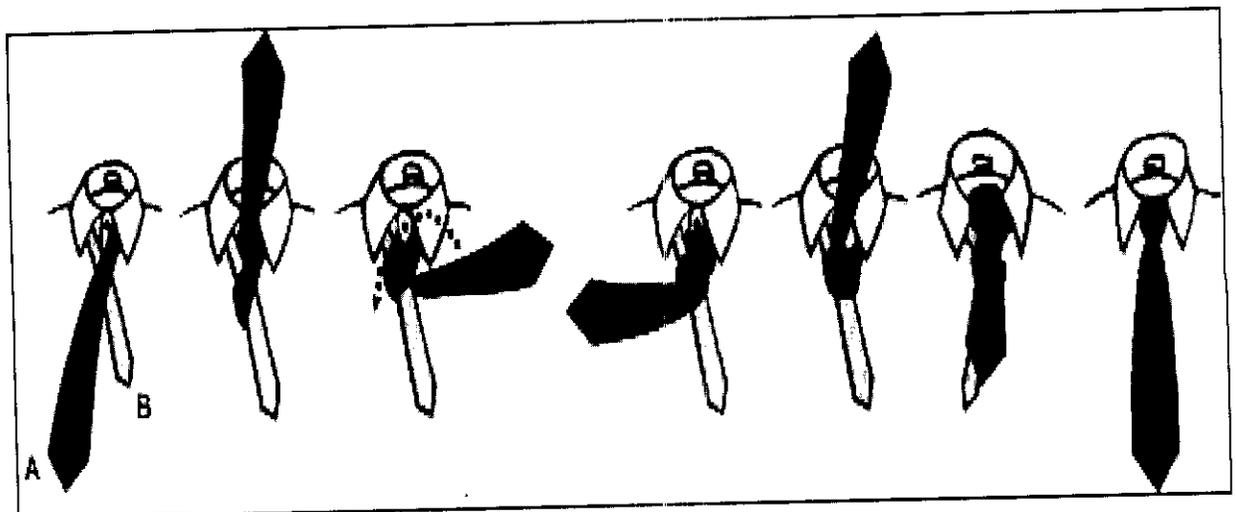
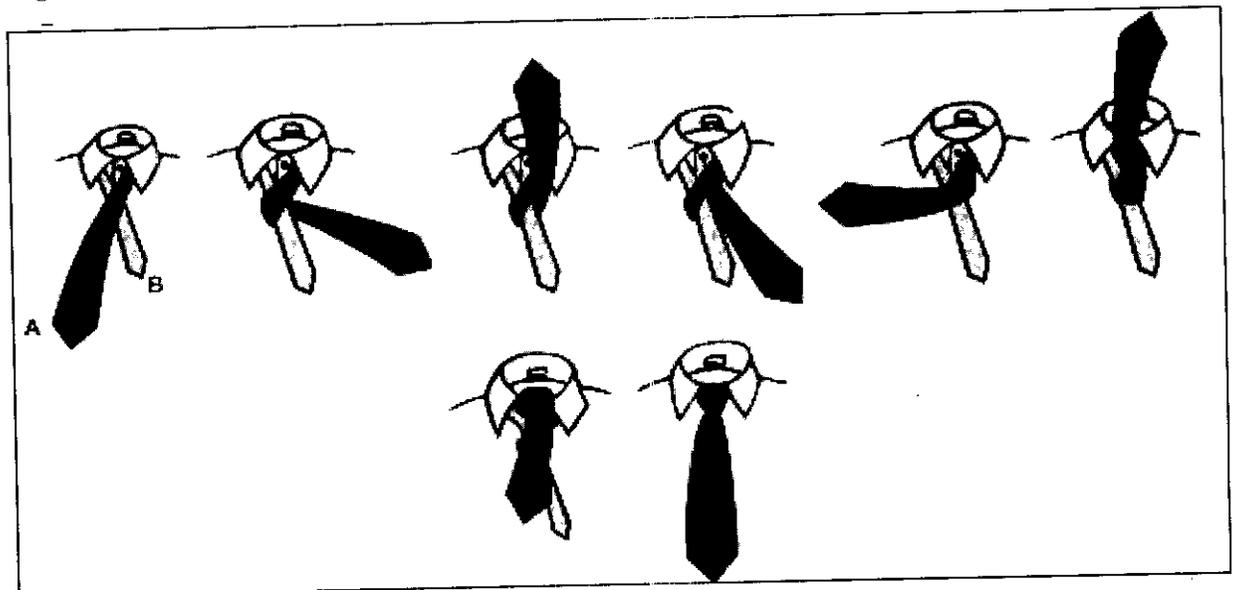


Figure 3: The Half-Windsor Necktie Knot



Trainer Development for Decentralization of Postabortion Care Services: the Guinean Experience

Yolande Hyjazi

Vice-Dean
Research at the Faculty of Medicine,
Conakry
B.P. 158
Conakry
Phone: 224-26-26-089
224-13-40-8405
E-mail: hyolandefr@yahoo.fr

Tsigué Pleah

Reproductive Health Advisor
JHPIEGO Corporation
1615 Thames Street, Suite 300
Baltimore, MD 21231-3492
Phone: +10-537-1903
Fax: +10-537-1476
E-mail: tpleah@jhpiego.net



JHPIEGO

**Trainer Development for Decentralization
of Postabortion Care Services:
the Guinean Experience**

Yolande Hyjazi
Vice Dean, Medical school of Conakry

Tsiqué Pleah
Senior Reproductive Health Advisor, JHPIEGO



Session objectives

- Describe Trainers Development Path way
- Describe the Guinea Experience in Decentralization of Postabortion Care Services
- Describe lessons learned



WHY PAC ?

- Patients presenting with abortion complications tend to be neglected
- Abortion complications contribute to 17% of maternal mortality EDS 1999
- Postabortion care (PAC) represents a key strategy of fighting against maternal mortality



THE PAC STRATEGY

- Components cover curative and preventive aspects of *abortion complications*
- Helps to reduce the risks of mortality linked to abortion
- Increase the rates of contraceptive use.



4

History of the introduction of PAC in Guinea

- 1994: ICPD - Cairo
- 1994: Regional African Conference on Unsafe Abortion (Mauritius)
- 1996: RH *National Symposium* Guinea (Abortion management = RH component)
- 1997: National RH Service Delivery Guidelines developed
- 1998 – 1999: National PAC Service Delivery Guidelines developed; PAC introduced at 2 national teaching hospitals
- 2001: Expansion to 7 sites in Upper Guinea launched



5

Why decentralize PAC Services?

- Maternal mortality rates in rural Guinea range from 528 to 800 maternal deaths per 100,000 live births;
- Abortion is a key contributor to high maternal mortality (17 to 20%);
- High unmet need for family planning services in rural settings (CPR < 2%);
- Only 27,5% of service providers are deployed in rural settings.



6

Why Decentralize PAC training?

- Compliance with the National RH in-service training strategy
- Shortage of national and regional trainers
- Sustainability of the training system
- Training costs reduced (less travel for trainers and participants)
- Decentralized training supports expansion of PAC services
- Conduct training where the underserved clients are

Overview of the Decentralization Process

- Training of service providers to initiate PAC programs in two teaching hospitals
- Develop the two teaching hospitals as a training site
- Service providers competent and qualified to offer PAC services
- Strategy to expand services in rural setting developed
- Need identified for national trainers to support decentralization.

Overview of the Decentralization Process (continued)

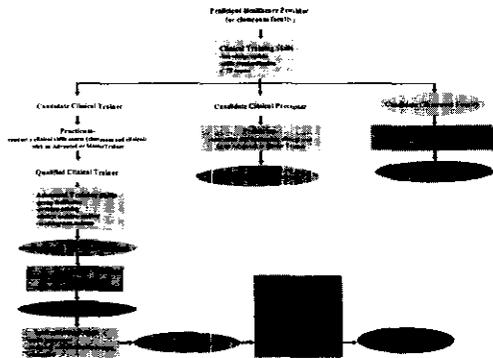
- PAC Training sites identified and developed (Farahan)
- Clinical Training Skills Course conducted in the region to train regional trainers
- Clinical training activities conducted (IP, CTU) at Farahan Regional Hospital

PAC Core Competencies for Trainer Development Process

- Mandatory PAC courses
 - Infection prevention (IP)
 - Contraceptive technology update(CTU)
 - Manual vacuum aspiration(MVA)
- Practicum in all PAC competencies
- Competent and qualified service provider



FACULTY AND TRAINER DEVELOPMENT PATHWAY



National Trainer Development Process

- Identification of service providers in teaching hospitals
- Mandatory PAC courses
- Practicum and follow-up to become competent and qualified service providers



National Trainer Development Process (continued)

Pool of national qualified PAC service providers participated in West Africa Regional clinical training skills course in April 2001, Burkina Faso

(Training in Reproductive Health Project)

- PAC skill standardization
- Knowledge update



13

National Trainer Development Process (continued)

- Candidate trainers completed practicum and qualified during first PAC expansion (IP, CTU, and MVA courses) with an advanced trainer
- Qualified trainers supported second PAC expansion in Upper Guinea (training activities, site needs assessment and monitoring)
- Guinea candidate PAC trainers introduced to the PAC OJT approach during a regional training skills course



14

Why PAC OJT

- Case load constraints
- Flexible, efficient, effective
- Practical



15

Regional Trainer Development Process 1

- Identification of service providers in regional and prefectural hospitals.
- Mandatory PAC courses, practice and follow-up to become competent and qualified service providers (conducted by national trainers).



16

Regional Trainer Development Process (continued)

- Clinical training skills course for competent and qualified regional service providers in their own region at Faranah regional hospital.
- Co-training/qualification with national trainers (IP, CTU, MVA courses).



17

Progress on the trainers Pathway

Six National and Regional qualified PAC trainers participated in West Africa Regional Advanced training skills course (Burkina Faso, February 2003).



18

Training to Build Capacity for Long-term and Permanent Methods (LTPM) of Family Planning

Dr. Henry Kakande
LTPM Specialist, Intra Health Consultant



Situation in Uganda

- Declining use of LTPM due to lack of access
 - 20 LTPM facilities nationwide
 - no daily access
- Available services – low quality
 - improper client counseling
 - long waits, multiple returns
 - stock outs (including local anaesthesia)
- Lack of LTPM awareness among clients
 - high unmet FP need (high TFR, low CPR)
 - methods not mentioned by providers
 - fears and misconceptions



DHS and DISH 1999

Strategic Goal

- Increase use of LTPM and improve service quality:
 - vasectomy
 - tubal ligation
 - Norplant
- Target audience
 - men and women
 - aged 30-45 years
 - within 10km of LTPM facility
- CYP changes measured at 80 sentinel sites





LTPM Strategy

1. Improve access and quality
 - supervision
 - training
 - provider commitment
 - facilities/equipment/supplies
2. Inform and educate clients
 - raise awareness
 - improve attitudes
 - mobilize community



Strategy for Improving Access and Quality

- Improve services at existing facilities and prepare new facilities
 - train supervisors/providers (especially other cadres for Norplant)
 - regularize static services
- Expand services to other clients via outreach
 - prepare "theatres" and equipment
 - circulate regional teams at outreach centers to perform procedures
 - train local providers to counsel clients and assist with procedures



Strategy for Informing and Educating Clients

- Deliver behavior change messages
 - recruit, train supervise CHWs
 - conduct community health talks and home visits
 - offer counseling and referrals
- BCC materials included:
 - signs at clinics announcing services
 - newsletters, radio programmes and posters for clients
 - information about methods (video, method samples)
 - counseling cue cards for providers

Training Interventions to Improve LTPM Services

- Regional team
 - recruited from skilled doctors and nurses
 - prepared to conduct outreaches, OJT and support supervision
- Focal person
 - selected from each outreach facility
 - trained to coordinate outreach activities, counsel clients, assist with procedures and follow-up
 - trained to offer Norplant services

Africa
For People & People's Health

Training Interventions to Improve LTPM Services
(continued)

- Medical officer
 - learned LTPM procedures on-the-job during outreaches
- Community health worker (CHWs)
 - trained to educate and motivate clients

Africa
For People & People's Health

Regional Team Responsibilities

- Leave regional hospital sites for scheduled outreach sessions
- Participate in outreaches
 - conduct surgical procedures
 - train local medical officers/nurses
 - train/supervise focal persons
 - ensure IP and informed consent
 - give feedback to CHWs
- Deliver equipment, supplies and methods

Africa
For People & People's Health

Focal Person Responsibilities

- Identify and train CHWs along with DISH and district reps
- Coordinate LTPM activities in community and at facility
- Counsel clients to ensure volunteerism
- Arrange logistics for outreach
- Maintain records
- Provide on-going supervision for CHWs

Africa
Our Partners in Training & Learning

Medical Officer Responsibilities

- Participate in scheduled outreaches
- Learn surgical procedures
- Establish static LTPM services
 - adequate demand
 - suitable facilities

Africa
Our Partners in Training & Learning

Community Health Worker Responsibilities

- Attend training to learn skills
- Counsel potential LTPM clients
- Conduct home visits
- Organize health talks
- Refer potential clients to outreach facilities
- Mobilize community members
- Promote outreaches

Africa
Our Partners in Training & Learning

Process for Conducting a Typical Outreach

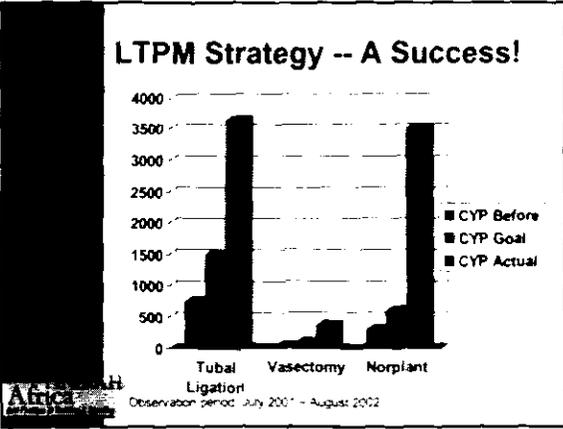
- CHWs conduct home visits and health talks
- CHWs refer interested clients
- Critical mass of clients identified
- Outreach scheduled and organized
- CHWs inform potential clients

Africa
The Promise of Family Planning

Process for Conducting a Typical Outreach *(continued)*

- Facility prepared for outreach
- Clients arrive, are counseled, informed consent granted
- LTPM procedures completed (MOs and nurses receive OJT)
- Clients return for follow-up

Africa
The Promise of Family Planning





Lessons Learned and/or Reinforced

- Training alone is not adequate to improve access and quality of services
- It takes a dedicated team of skilled people to provide successful outreach services
- Outreach events provide excellent opportunities for OJT which in turn builds capacity for the district

Africa
Not Permitted to Training & Education



Lessons Learned and/or Reinforced *(continued)*

- Lower level health facilities can be used to offer LTPM services — increase accessibility
- CHWs are a valuable asset for educating and mobilizing communities
- Regular interaction with and giving feedback to CHWs increases their motivation

Africa
Not Permitted to Training & Education

Move Forward with Teachback: A Unique Methodology for Training Trainers

Michele Evering-Watley

Health Education Specialist
Centers for Disease Control and Prevention (CDC)
National Center for HIV, STD and TB Prevention
Global AIDS Program
1600 Clifton Rd. N.E. MS E-04
Phone: +04 498-2763
Fax: +04 498-2750
Email: mee+w@cdc.gov

Catherine A. McKinney

Training Team Leader
Centers for Disease Control and Prevention (CDC)
National Center for HIV, STD and TB Prevention
Global AIDS Program
1600 Clifton Rd. N.E. MS E-30
Phone: +04 498-2753
Fax: +04 498-2785
Email: ckm6@cdc.gov

Cheryl Tryon

Training Specialist
Centers for Disease Control and Prevention (CDC)
National Center for HIV, STD and TB Prevention
Global AIDS Program
1600 Clifton Rd. N.E. MS E-30
Phone: +04 498-2798
Fax: +04 498-2785
Email: ct11@cdc.gov

Cheryl D. Mayo

Public Health Training Specialist
Centers for Disease Control and Prevention (CDC)
National Center for HIV, STD and TB Prevention
Global AIDS Program
1600 Clifton Road, NE, MS E-30
Atlanta, Georgia 30333
Phone: +04 498-2788
Fax: +04 498-2785
Email: CMayo@cdc.gov

**Combining Postabortion Care (PAC)
Clinical and Structured
On-the-Job Training (OJT) Skills
for Sustained Results:
Malawi Experience**

Joseph Ruminjo

Senior Medical Associate, Maternity and Postabortion Care

EngenderHealth

440 Ninth Avenue

New York, NY 10001

Phone: 212-561-8458

Fax: 212-561-8067

E-mail: jruminjo@engenderhealth.org



**Combining PAC Clinical and
Structured On-the-Job Training
(OJT) Skills for Sustained Results:
Malawi Experience**

Joseph Ruminjo


ENCOUNTER WITH
Training in Africa: Best Practices,
Lessons Learned and Future Directions
Zambia, May 5-7, 2003

Session Objectives

By the end of the session participants will be able to:

- Describe a competency-based approach to learning
- Explain benefits of individualized competency-based, mastery approach and structured OJT methodology, using humanistic methods
- Analyze and develop plan to apply competency-based approach in the specific context of training in clinical and OJT skills

**Implementation process of the Malawi
Postabortion Care (PAC) Program
2001- 2003**

- PAC policy, guidelines and standards
- Needs assessment conducted
- Supplies, equipment, materials secured
– for service and training
- OJT guides adapted
- Central training: PAC clinical, OJT skills
- PAC service delivery and site OJT
- Follow-up, program monitoring, evaluation

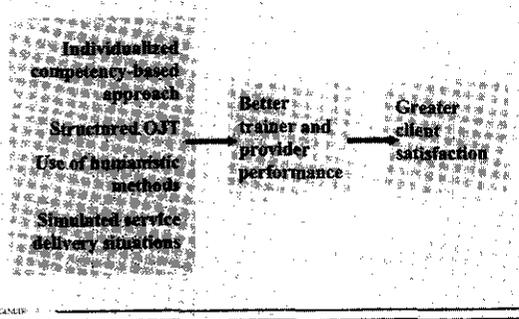
Results of PAC needs assessment in 8 district hospitals, Nov. 2001

- Inadequate knowledge, attitude and skills (KAS) despite central training
 - Low Manual Vacuum Aspiration (MVA) skills
 - Limited structured OJT skills at sites
 - Comprehensive PAC absent or fragmented
 - Weak community/provider partnerships
 - Poor linkage, referral, integration to other RH
- Weak Health Management Information Systems (HMIS)
- Low material resources, sustainability

Recommendations from PAC needs assessment of Nov. 2001

- Train providers in Comprehensive PAC
 - Service provision
 - Training others on the job
- Build services based on Quality Improvement (QI) principles
- Develop and integrate PAC into other HMIS
- Link the supervisory and training systems

Best practice in training



Central training workshops: details

- 2 workshops conducted Jan. - Feb. 2002
- 23 participants
 - 10 Clinical Officer/registered midwife teams
 - From 9 district-level and one central hospital
 - Also 3 service managers/coordinators
 - Representing Malawi MOH, Christian Health Association (CHAM) and Reproductive Health Unit (RHU)

Central Training workshops: logistics

- Organized by MOH
- TA provided by EngenderHealth
- Under the auspices of USAID
- EngenderHealth/JHPIEGO collaborated on
 - Training materials
 - Personnel resources
 - Training methodology and standardization

Central training workshop: objectives

- Be able to offer quality comprehensive PAC
- Perform MVA, use gentle, aseptic technique
- Provide holistic counseling, manage pain
- Recognize and manage complications
 - arising before or during MVA
- Describe important follow-up, RH linkages
- Integrate with QI approaches, improved IP
- Provide OJT for suitable site colleagues

Applying the principles of competency-based training (CBT)

- Learning was by Doing
- Focused on specific KAS for PAC and OJT
- Participatory learning, Coaching, Feedback
- Clinical skill broken to essential steps/tasks
- Each step standardized
- CBT skill development (learning) guides
 - Made learning easier
- Assessment instruments (checklists)
 - Made assessment more objective

Central Training Workshops: content

- Comprehensive PAC
- Hands-on MVA
- Infection prevention
- FP and humanistic Counseling
- COPE (at selected sites)
- Cost Analysis Tool

Mastery learning

- Each participant expected to master KAS
 - Different pace, variety of methods
- Learning was self-directed
- Assessment was continual, participatory
 - Dynamic
 - Less stressful
 - Competency-based

This training approach recognized the principles of adult learning

- Participants ready to learn
 - conducive environment built on self-motivation
- Built on what trainees knew already
- Trainees aware of what they needed to learn
- Variety of training methods used
- Utilized participatory learning
 - Interactive, relevant, practical
- Included mentoring/ observational learning

Better training by use of humanistic techniques

- Used learning aids
 - Videotapes
 - Anatomic models
 - MVA instruments, visuals, in simulated setting
- Facilitated learning, shortened duration
 - Decreased no. cases to achieve competence
- Gained skill competency, early proficiency
 - Before first contact in clinic setting
- Ensured patient comfort and safety

Combined clinical and OJT training approach: benefits

- Met learning needs of providers at the site
- Viewed service delivery as a system
 - Staff as team members who make system work
- Made training more cost-efficient

Some training methods used

- Role plays, case studies
- Micro-teaching practice
- Individual and group exercises
- One-on-one realistic simulated practice
 - Using anatomic pelvic (Zoe) models
 - Demonstration and return demonstration
- Simulated practice with IP, emergency equip
- Guided 'live' clinical activities
 - Performing MVA, improved IP, counseling

Structured OJT: benefits

- Ensured sustainability, personnel resource
- Used CBT for high, measurable standards
- Tailored to numbers and flow of clients
- Considered trainee availability
- Focused on process, system and ownership
- Ensured continuous learning, built capacity
- Resulted in some standardized materials
 - Curricula, learning aids, references

Other workshop activities

- Workshop activities included
 - Knowledge-based classroom didactics
 - attitude and skills-based clinical area practicum
 - Integrating team members as equal partners
 - Help to team members in conducting
 - self and partner-assessment using the checklists

Training follow-up with internal and external supervision

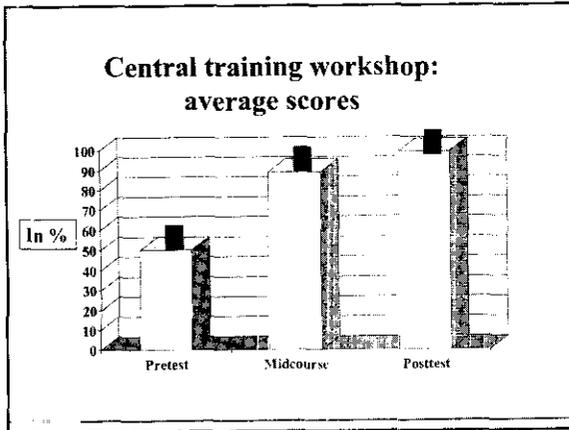
- Act as catalyst for change, identify resources
 - Training handbooks, evaluation tools
 - Site libraries
- Routinely follow-up, monitor training/ results
- Identify skills, OJT and other learning needs
- help staff organize training, orientation, update
- Encourage sharing of knowledge and skills
- less impact of staff turnover, poor deployment

Training evaluation methods

- Pre-course, mid, post-course questionnaire
- learning guides and checklists for each skill
 - Client screening, MVA, anesthesia, counseling
- Open course- questionnaire
- Formative evaluation
 - Questions during didactics and in clinical area
 - Early self-evaluation followed by
 - Constructive feedback by colleague/ trainer

Central training workshop: scores

- Pre test score average was 55; 50%
 - weak in MVA procedure, IP and PAC FP
- midcourse was 90; 89%
 - with six of 23 scoring 100%
- post test average was 99%
 - lowest mark 90%



- ### Next steps: post-training
- Trainee follow-up in 3 months
 - to ensure they develop proficiency
 - not only as PAC providers but trainers on Job
 - developed a monitoring/evaluation tool
 - for comprehensive PAC service delivery
 - in collaboration with JHPFEGO

- ### Applying the training approach to pilot PAC services
- Introduced to 10 pilot sites
 - in south, north, central region
 - Established Comprehensive PAC services
 - Staff rotation re-organized to offer 24 hr cover
 - Improved, strengthened linkages with other RH
 - Included FP, community participation
 - Improved counseling, holistic and for FP
 - Developed and integrated PAC HMIS

Cascade benefits to site from initial training

- Site selected staff for training
- Centralized training in Blantyre and Zomba
- Site colleagues trained in clinical, OJT
- In turn, these colleagues conducted
 - Clinical and OJT skill training for others
- Additional site training activities
 - Service orientations, knowledge updates

Training follow-up activities

- Routine on-site follow-up and monitoring
 - Internal supervisors and project monitors
- Periodic site visits by managing CA
- OJT for other suitable staff at site
- Evaluation

Program achievements: immediate outputs

- We trained 22 participants to competency
 - in clinical and OJT skills
- Trainees trained colleagues on the job
- All participants received MVA kits
- Development, buy-in achieved at sites
- Site-specific action plans created
- CAs collaboration achieved

Program achievements: intermediate outputs

- Improved personnel resource sustainability
 - team of providers have service, training capacity
- Better quality of PAC services at 10 sites
 - PAC clients attended by time of evaluation
 - Improved counseling established
 - IP strengthened and expanded
- Program identity 'owned' by staff

Program achievements: longer term impact

- All PAC clients counseled
 - holistically and for FP
 - Most left with a method
- For clients who required it
 - Referral, or
 - Linkages to other RH services at site
- Improved provider/community partnership
- Initiated MAP, Young adult RH initiatives

Training approach: effects on the training system

- Strengthened team work and systems
- Improved organizational effectiveness
- Changed organizational structure, practice
- Knowledge, skills transferred ongoing basis
 - For sustained capacity and results

Lessons learned

- Administration support is crucial
 - ensure buy-in and orientation to approach
- Staff teamwork, ownership important
 - Involvement in assessment, planning and implementing solutions
- Linking the supervisory and training systems builds in sustainability
- There is need to monitor and support quality of cascade training

Lessons Learned from training approach: *Recommended best practice*

- Fosters supportive environment for applying new skills
 - creates institutional ownership
- Strengthens service teams
- Allows practical application and adaptation to real site
- Stimulates transfer of learning
 - for wider, on-going application of new skills

Challenges

- Some inappropriate trainee selection
- Weak and varied basic knowledge or skills
 - In IP, FP, Counseling, training methodology
 - Difficult to pass on these crucial aspects
 - (within the 2 weeks of training)
- Some poor early institutional buy-in, support

Challenges (continued)

- OJT difficult to standardize
 - didactic, practicum, references.
 - process assessment, references, learning aides
- Difficult to maintain quality of training
 - especially beyond second generation
- Poor motivation by trainers
 - to mentor, transfer knowledge and skills
- Poor motivation of trainees
- Weak supervision, monitoring, follow-up

Recommendations

- Establish CBT, humanistic methods
 - during training for PAC scale up
- continue combining clinical with OJT skills
- ensure support systems at site, QI, HMIS

Recommendations (continued)

- Ensure service/training supplies, equipment
- Motivate, support training on site or nearby
- Establish site libraries
- Develop ways to monitor, maintain skills
 - Despite challenges: few clients, staff turnover

Importance of Training Sites in the Competency-based Training Approach

Paul Sossa

Training Director
Family Health and AIDS Project
JHPIEGO Corporation
BP 3068
Lome, Togo
Phone: 228-221-8104
228-221-1336
Fax: 228-221-6165
E-mail: phs@sfps.or.ci



IMPORTANCE OF TRAINING SITES IN
THE CBT APPROACH

Prepared by :
Paul SOSSA
Eliane DOGORE

MAY 2003



INTRODUCTION

- A CHINESE OLD PROVERB SAYS:
- I FORGET WHAT I HEAR
- I REMEMBER WHAT I SEE
- I UNDERSTAND WHAT I DO



SOME KEY ELEMENTS OF
THE CBT APPROACH

- PRACTICAL
- ALL TRAINEES MUST MASTER THE NEEDED
KNOWLEDGE, ATTITUDES AND SKILLS
- EACH TRAINEE NEEDS A SPECIAL ATTENTION



WHY USE TRAINING SITES?

- TO PROVIDE:
 - ✓ OPPORTUNITIES AND CONDITIONS TO TRAINEES TO LEARN AND PRACTICE NEEDED SKILLS IN REAL SITUATIONS
 - ✓ SKILLED PRECEPTORS AND TRAINERS
 - ✓ APPROPRIATE EQUIPMENT AND TEACHING MATERIALS



SELECTION CRITERIA

- ADEQUATE NUMBER OF CLIENTS
- ADEQUATE INFRASTRUCTURES
- APPROPRIATE EQUIPMENT, TRAINING MATERIALS AND SUPPLIES
- COMPETENT TRAINERS, PRECEPTORS AND PROVIDERS.



SELECTION CRITERIA (CONTINUED)

- HIGH QUALITY SERVICE DELIVERY PRACTICES
- COMMITMENT ON THE PART OF THE CLINIC TO BE A TRAINING SITE.



STRATEGY FOR DEVELOPING
CLINICAL TRAINING SITES

ADVOCACY

- SITE MANAGERS
- SITE SUPERVISORS
- SITE SERVICE PROVIDERS

SITUATION ANALYSIS

- EXISTING INFRASTRUCTURES
- UTILIZATION OF SERVICES BY CLIENTS
- NUMBER OF SERVICE PROVIDERS
- COACHING EXPERTISE AVAILABLE ON THE SITE
- TECHNICAL SKILLS AND PRACTICES OF THE SERVICE PROVIDERS



SITUATION ANALYSIS
(CONTINUED)

- MANAGEMENT OF THE SITE
- AVAILABILITY OF A DEVELOPMENT PLAN OF THE SITE
- EXISTENCE OF TRAINING AND TEACHING MATERIALS
- QUALITY SERVICE DELIVERY
- CLINICAL AND OTHER EQUIPMENT



REQUIRED AREAS OF
COMPETENCIES AND EQUIPMENT

PRECEPTORS/TRAINERS

- CTS (COMPETENCY-BASED TRAINING SKILLS)
- CLINICAL SKILLS
 - PIC+IUD
 - NORPLANT
 - DUAL PROTECTION



PRECEPTORS/TRAINERS
(CONTINUED)

- MINILAP
- INTERPERSONAL COMMUNICATION
- FACILITATIVE SUPERVISION



SERVICE PROVIDERS

- CLINICAL SKILLS IN :
 - PIC+IUD
 - NORPLANT
 - MINILAP
 - DUAL PROTECTION
 - INTERNAL SUPERVISION
 - INTERPERSONAL COMMUNICATION



EQUIPMENT AND MATERIALS

- TRAINING MATERIALS
 - ANATOMIC MODELS (ZOE OR PELVIC MODEL, BREAST, PENIS, UTERUS...)
- TEACHING MATERIALS
 - FLIPCHART
 - TRAINERS GUIDE
 - REFERENCE MANUAL



EQUIPMENT AND MATERIALS (CONTINUED)

- OTHER EQUIPMENT
 - CLINICAL EQUIPMENT
 - TABLES
 - CHAIRS
 - BENCHES
 - IP EQUIPMENT AND SUPPLIES



ILLUSTRATION

- EVALUATION OF TRAINING SITES
BASED ON PRE-SELECTED CRITERIA

CRITERIA	CLIENTS	INFRASTRUCTURE	PROVIDERS	CENTER	MATERIALS	SERVICES	SCORE	SCORE
	RES.	YES	NO	YES	NO	YES	AT	AT
							BEGINNING	ADVANCED
							YES	NO
NAME	YES	YES	YES	YES	NO	YES	YES	NO



**TRAINING SITES
DEVELOPED BY SFPS**

- BURKINA FASO: 9
- CAMEROON: 8
- COTE D'IVOIRE: 6
- TOGO: 9



LESSONS LEARNED

- THE TRAINING SITES PRESENT REAL OPPORTUNITIES TO TRAINEES
- THEY ARE SITES OF EXCELLENCE AND REFERENCE FOR RH SERVICES
- THEY CONTRIBUTE TO THE REINFORCEMENT OF TRAINING CAPACITY IN THE COUNTRY.



**LESSONS LEARNED
(CONTINUED)**

- THE DEVELOPMENT OF TRAINING SITE IS A PROCESS WHICH REQUIRES THE DEVELOPMENT OF APPROPRIATE ACTIONS AND STRATEGIES TO MEET THE CRITERIA.
- RELATIONS AND COMMUNICATION BETWEEN SITE SERVICE PROVIDERS, THE PRECEPTORS AND THE SITE MANAGERS ARE IMPROVE.



LESSONS LEARNED (CONTINUED)

- STANDARDIZATION OF SKILLS TO BE TRANSFERRED TO TRAINEES
- THE TRAINING SITE STRATEGY IS ADOPTED AND USED IN WEST AND CENTRAL AFRICA

CONSTRAINTS

- CLINIC STAFF TURN OVER
- INADEQUATE CONFIGURATION OF CLINIC BUILDING
- LACK OF SPACE TO MAKE REQUIRED CHANGES TO THE CLINIC
- LIMITED PROJECT RESOURCES TO MEET ALL THE NEEDS AND DEMANDS



CONCLUSION

- THE TRAINING SITE STRATEGY IS A MUST FOR THE CBT APPROACH
- NEED FOR LOCAL HEALTH AUTHORITIES TO INCLUDE THIS STRATEGY INTO THEIR HEALTH POLICY
- THE DEVELOPMENT OF TRAINING SITES ENABLES THE SUSTAINABILITY OF TRAINING ACTIVITIES





Towards Adolescent-friendly Clinics - the Use of Values Clarification to Facilitate Change in Public Health Clinics

Melanie Pleaner

Director of Training
National Adolescent Friendly Clinic
Initiative
Reproductive Health Research Unit
Department of Obstetrics and Gynaecology
University of the Witwatersrand
Chris Hani Baragwanath Hospital, Soweto
P.O. Bertsham 2013
Johannesburg, South Africa
Phone: 041-581-3124
Fax: 041-581-8435
E-mail: mpleaner@mweb.co.za



Conference: Training in Africa - Best Practices, Lessons Learnt and Future Directions, Zambia, 5-17 May 2003

Paper Title: Towards adolescent-friendly clinics - the use of values clarification to facilitate change in public health clinics

Presented by: Melanie Pleaner - Training Director, National Adolescent Friendly Clinic Initiative, Reproductive Health Research Unit

Contact Details: Melanie Pleaner - NARCI
RHRU
Department of Obstetrics and Gynaecology
University of the Witwatersrand
Chris Mar, Baragwanath Hospital, Soweto
P.O. Boksburg, 2013
Johannesburg, South Africa
Tel: +27 (0) 41 581 3114
Mobile: 082 5730611
Fax: +27 (0) 41 581 9435

Towards adolescent-friendly clinics
the use of values clarification to facilitate
change in public health clinics

Training in Africa
Best Practices, Lessons Learnt and Future Directions
Zambia, May 2003

Presented by **Melanie Pleaner**
Training Director, National Adolescent Friendly Clinic Initiative
Reproductive Health Research Unit, South Africa

Objectives for the Session

By the end of the session it is hoped that participants will have an understanding of:

- why it is important to provide health care providers with the opportunity to explore their own personal values and attitudes in the training and quality improvement process.
- different training approaches, methodologies and tools used in the Values Clarification process
- the usefulness of the values clarification training process in working with adolescent health care providers specifically, and how it can be applied to a range of other sexual and reproductive health issues more generally

Overview of presentation

- Values Clarification – Participative experience
- The context: Why focus on adolescents
 - Global
 - South Africa
- The Context: Programme
 - loveLife
 - NAFCI
- Values Clarification
 - Defining Values Clarification
 - Key Features
 - Objectives
 - Key components
 - Summary of Methodology
 - Introduction to the training manual: *Stand Your Ground -- Facilitating Change Towards Adolescent-friendly Clinics*
- Evaluation
- Lessons Learnt
- Future Directions
- Applying Values Clarification to other SRH issues

**The Global Context:
Why focus on adolescents?**

Adolescence is a time of opportunity and risk

Opportunity
Attitudes, values and behaviors that determine a young person's future begin to crystallize and take shape

And Risk
Increased exposure and experiment

WHO, 1998

**The Global Context:
Why focus on adolescents?**

- 1.2 billion adolescents worldwide
- One in every five people in the world is between 10-19 years
- 85% live in developing countries
- 70% of premature deaths among adults are largely due to behaviours initiated during adolescence
- 1.1 billion smokers in the world, 90% started before the age of 19 years

WHO, 1998

**The Global Context:
Why focus on adolescents?**

- 7000 new HIV infections per day, five every minute
- Girls <18yrs are 2-5 times more likely to die in child birth than women in their 20's
- 4.4 million unsafe abortions each year
- Approximately 300 million young smokers
- 100 000 adolescents commit suicides per year

WHO, 1998

**The South African Context:
Why focus on adolescents?**

Whilst the average contraceptive use amongst sexually active youth is relatively high (about 60%) ...

- significant numbers of youth have never used a condom.
- the injectable the most common form of contraception (51%), followed by the pill (9%) - no protection against STIs and HIV

Source: South African DHS 1998, PAGE 143 Age: 15-19 years

**The South African Context:
Why focus on adolescents?**

Teenage Pregnancy:

- By the age of 19 years, 35 percent of 15-19 years olds have had a child
- One in three births in South Africa are to teenage girls

(SADHS 1998)

The South African Context: Why focus on adolescents?

- 30% of 16- 21 year olds had experienced an STI, but only 50% sought medical treatment (HSDU,1997)
- The majority of young South Africans sexual activity starts in the mid-teens
- High risk behaviour
- High level of sexual coercion

Source: DHS 1998 140-141 Age: 15-19 years

The South African Context: Why focus on adolescents?

[HIV prevalence trends by age group among antenatal clinic attendees in South Africa 1999-2001]

Age Group	Estimated HIV+ 1999	Estimated HIV+ 2000	Estimated HIV+ 2001
<20	16.5	16.1	15.4
20-24	25.6	29.1	28.4
25-29	26.4	30.6	31.4
30-34	21.7	23.3	25.6
35-39	16.2	15.8	19.3
40-44	12.0	15.8	9.1
45-49	7.5	10.2	17.8

HIV levels among youth are still unacceptably high!

HIV spreading at a rate of at least 1700 new infections a day, one of the fastest growing rates in the world

Over half of these are in young people!

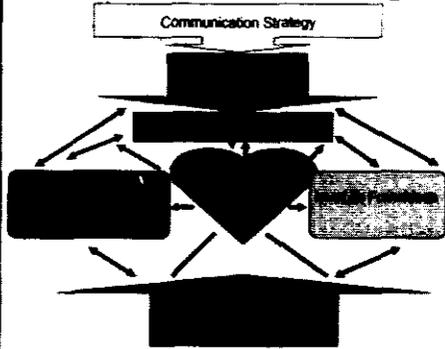
What is ^{love}Life ?

love Life

Is a collaborative programme of non-governmental organisations in partnership with the department of health, the UNICEF, other governmental agencies, and private sector organisations.

The primary GOAL is to effect positive behavior change among young South Africans to reduce teenage pregnancy, sexually transmitted diseases and HIV/AIDS

loveLife Service Strategies



The National Adolescent –Friendly Clinic Initiative **NAFCI**



What is NAFCI?

- NAFCI is a comprehensive service performance and quality improvement accreditation programme
- NAFCI was designed to improve the quality of adolescent health services at primary care level & to strengthen the public sector's ability to respond appropriately to adolescent health needs
- NAFCI is an integral component of



Aims & Objectives of NAFCI

Aim:

- The aim of NAFCI is to improve the quality of adolescent health services at the primary care level

Objectives:

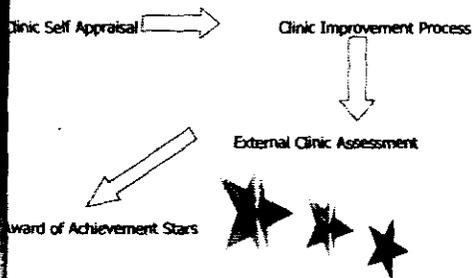
- To make health care services more accessible and acceptable to adolescents
- To establish national standards and criteria for adolescent health care in clinics throughout the country
- To build the capacity of health care providers to improve service performance for the delivery of adolescent-friendly services

NAFCI standards

Ten key elements were identified as important for an adolescent friendly clinic:

1. Management
2. Clients rights
3. Access
4. Environment of care
5. Drugs, supplies, equipment
6. Trained staff
7. Information, education, communication
8. Client assessment
9. Individualised client care
10. Continuity of care

NAFCI Accreditation Process



NAFCI Process



NAFCI tools developed include:

- Self-Appraisal
- External Assessment

NAFCI support materials include:

- "Going for NAFCI Gold: A Clinic Guide to NAFCI Accreditation"
- NAFCI Handbook of Adolescent SRH Care
- NAFCI Resource Directory
- NAFCI Values Clarification Manual

Defining Values Clarification

Melanie Pleaner 2002

Values clarification is a process whereby health care providers are given the opportunity to identify and reflect on their own values, attitudes and beliefs; and assess how these may impact on the service they deliver.

Why Values Clarification?

- Barriers impact negatively on the health seeking behaviour and health status of young people:
 - Young people are refused certain services.
 - Distrust and misunderstanding of health services.
 - Awareness campaigns do not have the institutional backing – less effective.



- Increase in health problems : STIs, HIV/AIDS and teen pregnancy

Why Values Clarification?

- Studies in South Africa (Wood 1997, Richter 1996, HSDU 1997) show main barriers to young people seeking reproductive health services are the perceived attitudes of nurses.
- Major issues identified, judgementalism, fear of nurses, lack of respect and lack of confidentiality.
- Interviews with health providers - contradictions between the need to provide adolescent sexual and reproductive health services on the one hand and personal values relating to morality, religious beliefs, traditional values, gender, reproduction, sexuality on the other hand.
- Impacts negatively on the health seeking behaviour of young people:
 - Young people are refused certain services.
 - Distrust and misunderstanding of health services
 - Awareness campaigns do not have the institutional backing – less effective

Objectives of Value Clarification Workshops

To provide health care providers working with adolescents with the opportunity to :

- explore their own beliefs, values and attitudes in a safe, supportive environment and how these may influence the client-provider interaction
- understand the needs and rights of adolescents, and the necessity for adolescent-friendly services, and understand the different dimensions of an adolescent-friendly service – what is acceptable and acceptable to young people

Key Features of Values Clarification

- It challenges people to separate personal and professional values
- It draws a distinction between personal beliefs and the delivery of an effective public health service
- It uses a rights-based approach: it attempts to balance the rights of individual practitioners to hold certain values with the rights of the client to receive information and an effective, quality service.

Key Features of the Values Clarification Process

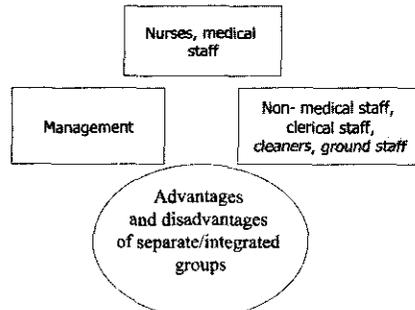
- It is a training tool
- It is a dynamic process
- It is an interactive process
- It encourages critical thinking
- It challenges people to change their mind set in a supportive environment
- It takes place within the context of quality improvement

Objectives of Value Clarification Workshops (cont)

To provide health care providers working with adolescents with the opportunity to :

- identify and find strategies to deal with barriers to young people seeking help for their health from health services
- separate personal values from effective health service delivery

Who to involve in the Value Clarification Process



Summary of key components of Values Clarification Process

- Concerns Assessment
- Belief Statements
- Why focus on adolescents, the case for adolescent-friendly services
- Rights and responsibilities
- Identifying barriers
- Overcoming barriers
- Tuning into youth
- Practical application -- knowledge, attitude and skills
- Examining beliefs, values and attitudes
- Reassessing values
- Personal reflection/evaluation
- Forward planning

**Tools Used in
Values Clarification Training**

- Belief Statements
- Sentence completion
- Role Play
- Small group work
- Personal reflections/personal challenges
- Memory recollections/guided fantasy
- Comfort continuum
- Exploring possible scenarios
- Forward planning action wheel

**Underlying Challenge:
Personal Reflection**

- How do your beliefs/values impact on the quality of care given to clients generally, and adolescents specifically?
- How far do your beliefs/values effect your communication with your clients generally, and adolescents specifically?
- How far do your beliefs /values create barriers between yourself and your client?

Evaluation

- Workshop evaluation
- Pre and post Questionnaire
 - Human rights
 - Sexual and reproductive health rights
 - Beliefs, values and attitudes
 - Knowledge
 - Feelings about being at the workshop and its relevance to them
 - Understanding of adolescent friendly services

Evaluation: Key findings

- Overwhelmingly positive
- An openness and willingness to acknowledge areas where attitudes need to change.
- A new perspective concerning clients rights reported.
- Identify a new understanding of SRH rights not only as they relate to adolescents, but other clients more generally.
- A reported improvement in communicating with their own teenage children.
- An appeal for management, policy-makers and budget holders to attend the workshop

Lessons learnt # 1

- The need to include all categories of staff in some of the training.
- The need to involve management.
- Material and methodology must be appropriate, accessible and flexible.
- Title 'Values Clarification' misleading – Manual 'Grounds for Respect - Facilitating Change Towards Adolescent friendly Clinics'
- Training not an event but a process which needs to be supported and reinforced

Lessons learnt # 2

- The theme separating **personal beliefs** and the **delivery of an effective public health service needs to underpin the training process**
- Advocacy component critical: a compelling, convincing case motivates health care providers to change
- Sequencing important.
- Attitudes relate to recognising and willing to act on change as it relates to physical arrangements, hours of operating; environment; as well as attitude of all staff.
- Must not be seen as a vertical programme.

Future Directions # 1

Evaluation

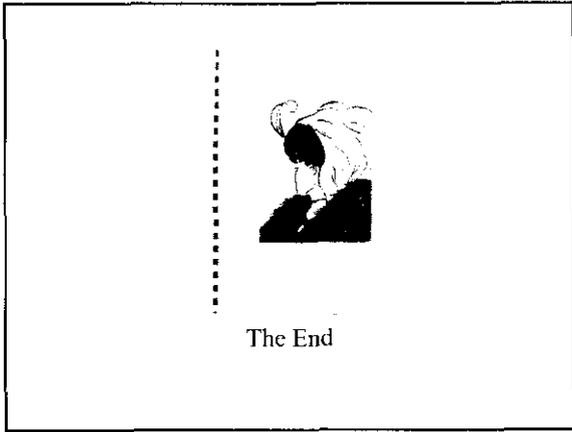
- FGD with youth and health workers pre-workshop
- Pre and post workshop questionnaire
- Evaluation of workshop
- FGD/ interview with clinic staff, management and youth post-workshop

Future Directions # 2

- Development of an expanded package, integrated package
- Training of trainers
- On-going support in terms of change-management
- Involvement of wider group of stakeholders working with youth in the community.

Applying values clarification to other sexual and reproductive health issues

- Termination of Pregnancy
- HIV/AIDS
- Working with sex workers
- Mother to child transmission



Training for Home-based Care - Nurses, Community, Traditional Healers

Felisbela Gaspar

Ministério de Saúde

Av Ed. Mondlane/Salvador Allende

CP 264

Maputo, Moçambique

Fax: 258-1-431103

E-mail: gfelisbela@hotmail.com



REPUBLIC OF MOZAMBIQUE
MINISTRY OF HEALTH
NATIONAL INSTITUTE OF HEALTH

TRAINING TRADITIONAL
HEALERS IN STDs/HIV/AIDS

SPECIAL CHALLENGES

By: Dra. Felisbela Gaspar



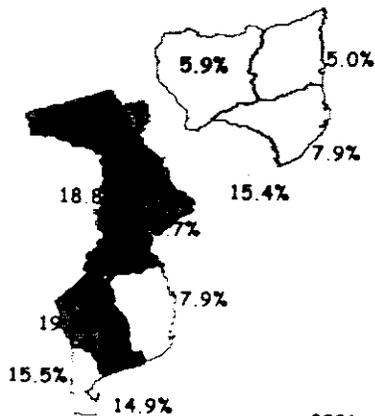
Maputo, March 2003



MOZAMBIQUE

Adults (15-49 years)

Prevalence 13.0%



2001



HIV Prevalence
by age and sex



HIV/AIDS in MOZAMBIQUE



Maternal Orphans
1999-2010



HIV/AIDS in MOZAMBIQUE



Health Care

US-MDs 125: 50,000
Cuba-MDs 182: 50,000

Mozambique
MDs 1: 50,000
Nurses 1: 4,000
Traditional Healers 1: 200

- > 75% of Mozambicans use Traditional Healers
- > 40% have access to formal health care

IMPACT OF HIV ON THE HEALTH CARE SECTOR

- Insufficient hospital beds
- Quality of health services decreased
- Health personnel overloaded
- Health personnel reduced due to HIV
- Fewer resources for other illnesses
- More opportunistic infections such as TB

- > We must be more proactive in the inclusion of Traditional Healers in strategies to combat HIV!

WHAT IS TRADITIONAL MEDICINE?

Traditional Medicine: is the total combination of knowledge and practices, whether understandable or not, used in the diagnosis, prevention or elimination of disease whether of physical, mental or social origin, that can originate exclusively from experience and observation and be transmitted in an oral or written form. (WHO, 1978)



THE IMPORTANCE OF TRADITIONAL MEDICINE

Declaration of Alma Ata in 1978, recognized the role of Traditional Medicine.

Traditional Healers offer:

- A personal approach,
- Culturally appropriate, holistic and accepted by clients

This is especially important in the case of STDs/HIV/AIDS.



CHALLENGES

- Change behaviors and beliefs that impede prevention of DTSSs, HIV and AIDS
- Improve techniques and practices used in the treatment of STDs, and Opportunistic Infections r/t HIV/AIDS
- Collaborate with THs to create a referral system. Mutual respect: modern <-> traditional



TRAINING CONTENT

- ✓ STDs/HIV/AIDS
- ✓ Transmission
- ✓ Prevention
- ✓ Symptom recognition/diagnosis
- ✓ Blood and body fluid precautions
- ✓ Case finding and referral
- ✓ Counseling (culturally appropriate)
- ✓ Home Based Care (new strategy in the pilot phase)



Methodology

Participatory

- Open questions in an accepting atmosphere
- Training through dialogue and exchange of ideas
- Never assume THs are "empty vessels" waiting for your ideas

LIMITING FACTOR

Language and Illiteracy

Solution - translation into
local language

Motivation

- Traditional songs
- Traditional stories
- Traditional Dances
- Performances
- Games
- Praise

Training

- Drama
 - Role play
 - Films and others visuals
 - Open debates
 - Community visits (with Home Based Care teams, VCT sites, Labs, Health Units)
 - Demonstrations of techniques
-
- Allow free movement for those who are not accustomed to the discipline of the classroom

Evaluation

- Symbols
- Illustrations



Aspects to consider

- Evaluate THs understanding of causation before trying to teach other concepts
- Take into account beliefs, myths and taboos about STDs/HIV/AIDS
- Verify common treatment techniques and advice for various symptoms



TRAINING FOR PREVENÇÃO

THs are influential - key decision makers in the community

✓ Find solutions in coordination with THs:

- Community discussions
- Distribution of condoms
- Referral of those suspected to have a DTS, TB or be HIV+ for testing and treatment
- Blood and body fluid precautions



TRAINING FOR PREVENTION

Special considerations

- Blood and body fluid precautions
- Circumcision
- Scarification
- "Vaccination"



COUNSELING

Counseling is very important as:

- Many family problems are resolved using THs
- Delicate subjects can be approached by THs such as such as family planning by those HIV+



TRAINING IN COUNSELING

- ❖ Through role play and dramatization one can verify and discuss advice being given



Key Points

- Capacitate THs to be able to educate the community in prevention of HIV/AIDS
- Collaborate with THs so that they will refer to health unit
- Motivate THs to participate voluntarily to support those ill with AIDS in the community

Lesson Learned

Participatory
training is more
effective with
THs

THANK YOU

