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Applying the *Learning for Performance* Approach

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Introduction

As the *World Health Report 2006* emphasized, there is increasing consensus that education and training programs for health workers should focus on "know-how" instead of "know-all." Too often, training curricula are laden with content unrelated to job responsibilities and do not provide adequate opportunities for practice, thus diluting job-related learning. Delivering bloated curricula takes too much time when health systems have a severe shortage of "the right health workers with the right skills in the right place doing the right thing" (WHO, 2006). Further, countries with shortages cannot afford for their existing health workers to be away from service sites for long periods for training, especially for training that does not yield results.

The *Learning for Performance* (LFP) approach is a systematic instructional design process and set of practical tools designed to yield more efficient training that focuses on what is essential for health workers to do their jobs, while addressing the factors that ensure application of new skills on the job (read *Learning for Performance: a guide and toolkit for health worker training and education programs, 2007*). LFP can be an important tool for scaling up training and education, because it emphasizes:

- *Relevance* (to the specific job responsibilities and work environment of employees)
- *Efficiency* (by removing unnecessary content and retaining only essential content, thus shortening the time required for training)
- Preparing learners for *job performance* (by using experiential, competency-based training methods and addressing the performance factors that determine whether new knowledge and skills can be applied) (Murphy, 2008).

Developed by IntraHealth International with USAID support, *Learning for Performance* has been applied in a variety of countries and situations—public sector, private sector, pre-service education, in-service training—and with a range of health worker cadres from physicians and nurses/midwives to community-based health workers. The Capacity Project participated in the development of LFP-informed learning interventions in Rwanda and Mali. Both countries have embraced LFP as a component of broader efforts to address performance gaps and human resources for health (HRH) challenges.

Learning for Performance Process and Applications

LFP places learning interventions in the context of performance improvement—a method of analyzing performance problems and determining and addressing the factors that lead to these problems. When a performance gap is identified, a solution or set of interventions is matched to the root cause of the gap. When the gap is that workers lack essential skills or knowledge, including a performance improvement perspective in learning interventions helps ensure that health workers will be supported to perform their new skills to standard. The LFP process also encompasses the instructional design steps of analysis, design, development, implementation and evaluation (see Figure 1) and strengthens the relevance and efficiency of the learning by systematically linking the curriculum content and learning methods to the job tasks, the specific learners and their work context. The intent is better transfer of learning for improved performance on the job.

LFP users can go through each of the 12 steps in sequence or, depending on the situation, use a subset of the steps, applying LFP to learning interventions of any scale and type. Experience shows that the first few steps usually occur in tandem, and that special attention needs to be paid to LFP steps 10–12 (preparing for implementation, implementing and monitoring, assessing the effectiveness and revising), as these are sometimes overlooked. Throughout LFP learning interventions of any scale, the support and involvement of stakeholders (e.g., ministries, nursing schools, health education professionals) is critical. To facilitate this engagement, the LFP approach is highly participatory from the beginning of the development of a learning intervention through its implementation.

The LFP approach offers many benefits within the context of HRH programming because it:

- Ties learning to specific identified job responsibilities and competencies, which is especially beneficial in task shifting
- Eliminates unnecessary topics from training, which reduces "curriculum bloat"
- Identifies the most appropriate ways to develop health workers (approaches, methods, assessments, etc.)

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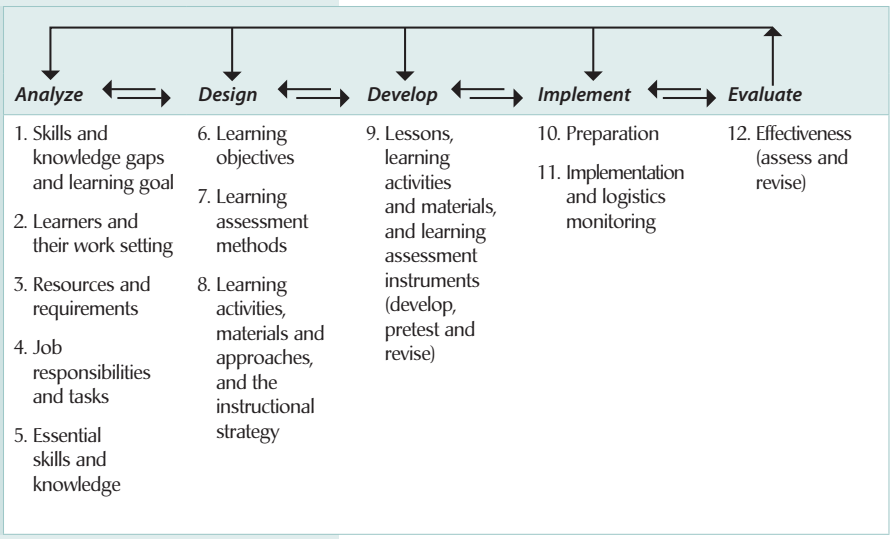
- Incorporates skills practice and application of skills and knowledge that are directly linked to the worker's job situation
- Addresses the performance factors that determine whether new skills and knowledge will be applied on the job (transfer of learning).

The structured process of LFP can be used to develop professional skills, behaviors and attitudes beyond clinical or technical content that may be lacking in the traditional education for health professionals. Examples of such skills are: management skills for nurses, supportive supervision, lifelong learning skills, sensitivity to gender issues, treating all clients or patients with respect and empathy (e.g., destigmatization and elimination of discrimination toward persons living with HIV and women seeking postabortion care).

Figure 1: The Instructional Design Process and Learning for Performance Steps



Applying *Learning for Performance* in Rwanda

LFP and Pre-Service Curriculum Development

In collaboration with the Ministry of Health and its partners, the Capacity Project applied LFP to support the curriculum design and implementation of new three-year, competency-based Registered A1 Nursing and Midwifery programs. The A1 midwifery program is the first pre-service program of its kind in the country, and A1 midwives are a priority health cadre to help reduce the high maternal and child mortality rates and prevent mother-to-child transmission of HIV, according to the Ministry of Health HRH Strategic Plan, 2009–2012. In January 2007, five priority nursing and midwifery schools welcomed the first students in these programs, which are vital to the government's plans to phase out lower-level A2 programs and transition to a workforce of A1 or higher-level professionals. Using the LFP approach, the Capacity Project led the development of the family planning (FP), HIV/AIDS and gender components of the new A1 curricula to strengthen the two cadres' ability to provide high-quality FP and HIV/AIDS services upon graduation.

Participants expressed satisfaction with the innovative and competency-based nature of the LFP approach, although some also noted that involving all stakeholders in a participatory curriculum development process can be time-consuming. Participants voiced particular appreciation for the methodology's focus on needs encountered in the field and progressive acquisition of knowledge and skills from theory and demonstrations to guided practice with clients during their clinical practicum. Most faculty members at the five nursing schools indicated that the competency-based approach improved teamwork and collaboration with each other and with the clinical preceptors. Faculty also felt they were adequately prepared to integrate the FP, HIV/AIDS and gender components into their teaching and expressed particular confidence about the FP component.

Some instructors described challenges in implementing the new content and competency-based approach, requiring:

- Sufficient experience with the HIV/AIDS and gender content
- Adequate time to cover the HIV/AIDS material
- Comfort with participatory teaching methods
- Time for course preparation.

Some respondents also discussed the broader challenge of faculty and staff attrition, noting that training provided through the LFP process is wasted in a context of rapid turnover. One faculty member noted the presence of four different school directors over the past three years and remarked, "We can't expect the school to perform without continuity in leadership."

LFP and Structured On-the-Job Training

The Project also used LFP in Rwanda to identify on-the-job training (OJT) as an appropriate approach for accelerating FP training. The Rwandan government established the goal of increasing modern contraceptive prevalence to 20% by 2010 and 80% by 2020. Toward that end, the Project conducted a situational analysis of FP services in 2006, revealing a number of shortcomings in FP service provision, including limited FP training (reported by only 10% of providers). In 2007, the Project trained 193 service providers in 11 districts, employing a two-week clinical workshop approach that ensured at least two service providers per health facility could provide a complete package of quality FP services.

To further expand client access to FP services, the Capacity Project and teams in the 11 districts embarked on a structured OJT approach in 2008, increasing the number of trained and supported health providers at each facility without interrupting health services. Using LFP tools and processes, the Project worked with the Ministry of Health

to adapt the national two-week FP workshop curriculum to an eight-week OJT approach. Application of LFP streamlined the content and increased opportunities for skills practice. The OJT schedule allowed participants to complete individualized exercises and practice sessions on their own time. Group activities were conducted in the clinic during the afternoons when there were few clients. After successfully completing mid-course knowledge and skills assessments, OJT participants proceeded to guided clinical practice with actual clients during the busy morning clinic sessions. An average OJT trainer-trainee ratio of 1:6 allowed for increased discussion, coaching and feedback with the trainer. In order to receive certification, participants demonstrated knowledge mastery and skills competency in simulated, then actual client interactions. A total of 65 health centers in eight districts participated in the LFP-designed OJT initiative.

Respondents generally acknowledged that the skills development focus of the LFP methodology and the OJT approach was an important contribution to facility performance in the area of FP service delivery. Participants also remarked that the LFP-developed structured OJT approach was able to train to competency more than twice as many FP providers (457) over the same duration of time (about eight months) at half the cost per participant than the two-week workshop approach (193 FP providers). Furthermore, the OJT avoided disrupting regular clinic services. OJT participants served twice as many clients during training as the workshop participants, particularly clients requesting long-acting methods such as Jadelle implants. Respondents valued the participatory process used to develop the structured OJT materials but again mentioned the time demands placed on them to engage in the participatory process. Plans are underway to use LFP to convert the Rwanda Basic Emergency Obstetrical and Neonatal Care training for health center staff to an OJT approach.

Applying *Learning for Performance* in Mali

The lack of access to high-quality services at every level of the health care system is one of the most critical issues Mali faces. One factor contributing to poor-quality services, highlighted by various assessments, concerns the failure of pre-service education curricula to prepare health workers for real-life conditions. As Mali's policy-makers increasingly emphasize local training of health workers, the need has arisen for curricula that enable health workers to learn and work effectively in their specific local and regional environments.

The *Ecole des Infirmiers de Gao* (EIG), a nursing school, seeks to develop sustainable human resources for health, training approximately 180 students per year to serve three remote and resource-poor regions in Mali's northern zone. In collaboration with national and regional decision-makers, the Capacity Project tested the LFP approach at the EIG in late 2006. Beginning with a needs assessment, the Project and EIG used LFP to develop and evaluate new training modules in reproductive health/FP and child health. Stakeholders identified these topics as important in light of the regions' high maternal and child mortality rates.

EIG teachers, clinical preceptors and managers played a key role in designing and revising the modules and trainers' guides. During the implementation phase, 18 EIG teachers and preceptors received orientation and training on use of the new modules. In fall 2008, the trained EIG instructors incorporated the new modules into intensive two-week class sessions for midwifery and obstetrical students beginning their third year of study.

Applicability and Satisfaction

The LFP process appears to not only be appropriate for the Malian context but is perceived by the EIG's executive director, Dr. Hamada Maiga, as an "ideal approach." According to other stakeholders, the LFP approach fostered a positive "participatory process" that garnered a high level of commitment from the school's leadership, instructors and preceptors and allowed the three groups to productively work together. Participants noted that their active level of involvement in the curriculum development process was novel compared to previous efforts and became a strong source of motivation for using a participatory, performance-based approach in their teaching.

At the level of classroom instruction, the EIG's director of studies, Dr. Mohamed Salia Maiga, remarked that use of the LFP approach had brought about "a revolution in the very concept of instruction." Most participating instructors admitted that lecturing was their most frequently used instructional method prior to the intervention. With the benefit of training on how to implement the new modules, instructors reported incorporating a much broader range of instructional methods linked to the assigned learning objectives, including brainstorming, case studies, group work, role plays, illustrated presentations, practical video or model demonstrations and clinical practica. Students, in turn, reported a high level of satisfaction with instructors' expanded teaching repertoire.

Lessons Learned

- LFP has proved to be an effective way of designing focused participatory training curricula for pre-service education, standard in-service training, and on-the-job training.
- The highly participatory nature of LFP contributes to the approach's success. Applying the LFP fosters teamwork and improves collaboration and communication among managers, teachers, trainers, preceptors and supervisors, which in turn improves student/trainee learning and performance. As shown in Rwanda, the benefits of involving

"HIV, family planning, maternal and child health and gender content is integrated into the courses. Students learn the knowledge and theory in the classroom, go into the community to become aware of client needs and illnesses, and then go to clinical practica in the health centers and hospitals to learn how to practice their skills."

—Sister Winifrida Ugirimbabazi, academic-in-charge and teacher, Rwamagana Nursing and Midwifery School

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- Improve strategic planning and decision making
- Strengthen reports and presentations
- Support HRH advocacy
- Enhance professional development
- Save time.

stakeholders must take into consideration the time that participatory activities require.

- As demonstrated in Rwanda, the LFP process should operate on a timeline that allows adequate time not only for curriculum and materials development but also for instructor/trainer preparation to use the materials.
- The student performance results of applying LFP in pre-service education may be easier to measure if course content is developed and implemented in modular form (as in Mali); however, integration of content throughout the courses in a pre-service curriculum may be more relevant to the needs of a particular pre-service education program (as in Rwanda).

Conclusions

The Capacity Project's experiences in Rwanda and Mali confirm that the *Learning for Performance* approach represents a useful instructional design tool for countries in search of HRH solutions. In Rwanda, plans are underway to scale up use of the nursing and midwifery pre-service education curriculum components and on-the-job training materials developed with LFP guidance. In Mali, the EIG leadership has now expanded use of the new reproductive health/family planning and child health modules beyond the third year of training, incorporating the modules into the first-year curriculum. As users gain greater experience and familiarity with the LFP process, the use of LFP is likely to become increasingly widespread. Because LFP focuses learning on what is most essential for specific job duties, the process can play an important role in addressing HRH issues such as task shifting/reallocation, developing new health worker cadres, accelerating the training and deployment of cadres in which there are serious shortages and aligning training with national health goals.

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Additional Resources

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