PARTICIPANT’S GUIDE

Advanced Training of Trainers

1 Introduction
2 Analyzing the Need for Training
3 Planning for Training
4 Implementing Training
5 Evaluating Training
6 Training Follow-Up
7 Working with a Training Consultant
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Individual modules in the comprehensive curriculum were used to train service providers throughout Pathfinder International’s many field-based programs. Feedback from these trainings has been incorporated into the training curriculum to improve its content, training methodologies, and ease of use. The curriculum has been widely distributed at no cost and is available on Pathfinder International’s website, http://www.Pathfind.org.

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Participant Handout 1.1: Course Expectations

Take notes on your partner’s expectations using this worksheet.

1. What do you hope to accomplish during this course?

2. Do you anticipate any difficulties during the course?

3. What will you miss at home?

4. What will you miss at work?

5. How do you think this training will help you at work?
Participant Handout 1.2: Advanced Training of Trainers Training Needs Assessment

Please answer and complete all items. This questionnaire will help us plan the Advanced Training of Trainers course to meet your needs. This is not a test.

1. Biographical Information:

Name: __________________________________  Age: _________
Position: __________________________________

2. Work Experience: Where do you currently work? What is your position and how long have you worked there?

3. Training Experience:

Have you attended a training of trainers course? Yes No
Where?
When?

4. Experience Conducting Training:

Please describe the training experience you have had. Include information about each training. What kind of training have you provided, where, when, and for what kinds of participants. For example: Trained 15 physicians in IUD insertion in (place) in 1999.

5. Please rate your present level of knowledge or competence by circling the appropriate number using the following rating scale:

   1  None at all
   2  Inadequate
   3  Adequate
   4  Good
   5  Excellent

1. Adult Learning:
   1.1 Knowledge of adult learning
       1  2  3  4  5
1.2 Knowledge of your learning style

1 2 3 4 5

1.3 The experiential learning cycle

1 2 3 4 5

1.4 Knowledge of the clinical problem solving process

1 2 3 4 5

1.5 Knowledge of formulating training goals and behavioral objectives (specific learning objectives)

1 2 3 4 5

1.6 Understanding of the role of TOT (trainer of trainers)

1 2 3 4 5

1.7 Knowledge of group process/dynamics

1 2 3 4 5

2.0 Using Communication Techniques:

2.1 Using both verbal and non-verbal communication to express feelings

1 2 3 4 5

2.2 Providing praise and encouragement in training

1 2 3 4 5

2.3 Understanding how to provide feedback

1 2 3 4 5

2.4 Knowledge of how and when to use open and closed questions

1 2 3 4 5

3.0 Using Training Methods:

3.1 Discussion

1 2 3 4 5
3.2 Question and Answer
1 2 3 4 5

3.3 Demonstration/return demonstration
1 2 3 4 5

3.4 Case studies
1 2 3 4 5

3.5 Mind Mapping
1 2 3 4 5

3.6 Practicum (practical field experience)
1 2 3 4 5

3.7 Group discussion
1 2 3 4 5

3.8 Role play
1 2 3 4 5

3.9 Lecture
1 2 3 4 5

3.10 Small Group work
1 2 3 4 5

4.0 The Training Process:
4.1 Conducting competency-based training
1 2 3 4 5

4.2 Developing a clinical checklist
1 2 3 4 5
4.3 Developing a clinical training site
1 2 3 4 5

4.4 Creating a training needs assessment
1 2 3 4 5

4.5 Developing training goal(s) and behavioral objectives
1 2 3 4 5

5.0 Planning for Training:
5.1 Developing a training plan/design
1 2 3 4 5

5.2 Developing clinical training protocols
1 2 3 4 5

5.3 Developing training curricula
1 2 3 4 5

5.4 Developing pre- and post-tests
1 2 3 4 5

5.5 Developing scoring sheets for pre- and post-tests
1 2 3 4 5

5.6 Developing competency based check lists
1 2 3 4 5

6.0 Implementing Training:
6.1 Developing 5 different types of role plays
1 2 3 4 5

6.2 Demonstrating a variety of brainstorming techniques
1 2 3 4 5
6.3 Developing clinical case studies
1 2 3 4 5

6.4 Using mind mapping
1 2 3 4 5

6.5 Using advanced lecture techniques
1 2 3 4 5

6.6 Using advanced discussion techniques
1 2 3 4 5

7.0 Training Follow-Up:
7.1 Conducting training follow-up
1 2 3 4 5

7.2 Developing tools for training follow-up
1 2 3 4 5

8.0 Evaluating Training:
8.1 Designing and conducting a participant reaction evaluation
1 2 3 4 5

8.2 Designing a learning evaluation
1 2 3 4 5

8.3 Describing behavior evaluation
1 2 3 4 5

8.4 Describing impact evaluation
1 2 3 4 5
Participant Handout 1.3: Advanced Training of Trainers Pretest

Multiple Choice Questions
Instructions: Circle all of the correct answers in each question.

1. Pilot testing a new training curriculum allows you to determine:
   a) If the training materials are effective
   b) If the time allocated is sufficient
   c) If trainees will adopt the new material and techniques after the training
   d) Whether trainee assessment tools are appropriate

2. Competency-based training is a method to help participants:
   a) Enhance problem solving skills
   b) Enhance job satisfaction
   c) Develop attitude
   d) Develop clinical skills up to a specific standard

3. Clinical checklists are used:
   a) To assess skill level prior to training
   b) In demonstration and return demonstration during training
   c) In trainees’ self assessment
   d) During evaluation

4. The factors that are important in helping staff to do their jobs correctly are:
   a) Clear job expectations
   b) Adequate working environment (equipment and supplies)
   c) Motivation and incentives to do the job correctly
   d) Punitive feedback about incorrect performance
   e) The knowledge and skills to do the job correctly

5. The training methodology that requires trainees to use decision-making skills is:
   a) Group discussion
   b) Role play
   c) Brainstorming
   d) Case study

6. Defining training objectives should be based on
   a) Materials available
   b) Trainers’ level
   c) Needs of trainees
   d) Trainers’ expectations

7. There are certain considerations when using examples in training:
   a) Examples should be provided as often as possible.
   b) Complex examples enhance participants’ creative thinking.
   c) A connection should be made between the example and the teaching points.
d) Specific cases should be pointed out with the client’s name to help participants internalize the points.

8. Clinical training sites should be selected based on the following criteria:
   a) Fancy, modern equipment is available.
   b) Staff are trained to give support to the trainees.
   c) It is very close to the participants’ dormitory.
   d) The use of protocols reflect the knowledge and skills covered in the training.

9. The following are objectives of training follow-up except:
   a) Providing feedback on the shortage of trainees.
   b) Improving the quality of services.
   c) Providing trainees with further knowledge.
   d) Ensuring that the trainees are applying the things they learned.

10. During training follow-up the trainer can determine whether the trainee is providing the service he or she was trained for by:
    a) Reviewing the log books to assess the type and mix of clients the trainee is seeing.
    b) Interviewing clients to see if they are satisfied with the service provided by the trainee.
    c) Evaluating the facility infrastructure.
    d) Developing a checklist with the skills learned during the training program and writing in the number of times the trainee has practiced each skill following the training course.

11. There are 4 levels in the most widely-used model to evaluate training. The third level measures:
    a) Reaction: Did the participants like the training?
    b) Behavior: Are the participants performing differently?
    c) Learning: What knowledge or skills did the participants retain?
    e) Results: What is the impact of training?

12. The disadvantages of objective tests (multiple choice, matching, true/false, fill-in) are:
    a) They are difficult to write.
    b) They are time consuming to write.
    c) Grading is time consuming.
    d) They are subjective and open to interpretation.

13. A level 1 training evaluation can be used to measure all of the following EXCEPT:
    a) Learning
    b) Change in attitude or beliefs
    c) Customer or trainee satisfaction
    d) The trainer’s knowledge
**True or False Questions**
Instructions: Circle the letter T for a true (correct) statement or F if the statement is false.

14. T   F  A training needs assessment identifies the gaps between the present performance and desired performance.
15. T   F  For consistency, a training needs assessment should assess only one type of data.
16. T   F  In classic brainstorming technique, it is useful to clarify the idea before listening to the next idea.
17. T   F  A case study with too much information will make it easier for the participant’s to analyze.
18. T   F  Case studies are very good for evaluating participants’ understanding of popular misconception.
19. T   F  During the feedback of role play, the focus should be on the content.
20. T   F  During training follow up, the trainer should check the facility to make sure the trainees are performing their skills correctly.

**Ordering Questions**
21-27. Place the following steps of a training needs assessment in correct order:
   - Develop Assessment tools
   - Compile (organize) data
   - Identify desired performance
   - Collect the data
   - Identify possible (performance improvement) solutions
   - Analyze the data
   - Conduct a cause analysis (determine root causes)

**Short Answer Questions**
Instructions: Write in the correct answers for each question

28. List 4 of the 5 basic components of a training curriculum:
   a) 
   b) 
   c) 
   d) 

29. Give 3 reasons for doing training follow-up:
   a) 
   b) 
   c)
30. What is the hardest part of training to evaluate and why?

**Matching Question and Answers**

Instructions: Write the letter from column B. that corresponds to the appropriate statement in column A.

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<td>31. Demonstrating an IUD procedure</td>
<td>a. Knowledge objective</td>
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<td>32. Listing 3 advantages of the IUD method</td>
<td>b. Skill objective</td>
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<td>33. Following the sterilization procedure during IUD insertion</td>
<td>c. Attitude objective</td>
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Participant Handout 1.4: Suggestions for Effective Participation

**DO**
- Ask a question when you have one.
- Feel free to share an illustration.
- Request an example if a point is not clear.
- Search for ways in which you can apply a general principle or idea to your work.
- Try to evaluate how you are already performing a skill based on new techniques you are learning.
- Think of ways you can pass on ideas to your subordinates and coworkers.
- Be skeptical—don’t automatically accept everything you hear.
- Feel free to ask for clarification.
- Respect the ideas of other participants.

**DON’T**
- Try to develop an extreme problem just to prove the trainer doesn’t have all the answers. (The trainer doesn’t.)
- Close your mind by saying, “This is all fine in theory, but...”
- Assume that all topics covered will be equally relevant to your needs.
- Take extensive notes. The handouts will satisfy most of your needs.
- Try to show how much you know by monopolizing class time.
- Engage in side talk.
- Interrupt others.
Definition of a Training Needs Assessment
A Training Needs Assessment (TNA) identifies gaps between how health workers are currently performing (the actual performance), and how you would like them to perform (the desired performance). The root causes of identified gaps can be linked directly to the absence of one of the five key performance factors:
1. Clear job expectations;
2. Clear and immediate performance feedback;
3. Adequate physical environment, including proper tools, supplies, and workspace;
4. Motivation and incentives to perform as expected; and
5. Skills and knowledge required for the job.

A training course can address only the fifth key performance factor. A clear TNA can assist trainers and health care administrators decide if a training intervention is appropriate to address an identified gap.

Why do a Training Needs Assessment?
It is becoming widely recognized that the outputs of informal and formal training activities can be improved by assessing the needs and the level of skills and knowledge of potential participants before implementing the training. By knowing the overall objectives of an organization and the job descriptions and daily tasks of each staff member, it becomes possible to tailor training activities to the needs of an organization or institute as well as to the personal needs of the staff members. Furthermore, it becomes easier for the organization or external funding agencies to identify who should, and who should not participate in specific courses or workshops. The immediate gains are motivated participants and a higher satisfaction of their immediate needs. The long-term gains are longer-lasting effects of training, when needs have been addressed at the right time in the right way.

Reasons for Conducting a TNA
More specifically, a TNA is done to:
• Determine whether training is really needed,
• Determine causes of poor performance,
• Determine content and scope of a training,
• Determine desired training outcome,
• Provide a baseline for measurement, and
• Gain management support.

Expected outputs from a TNA
The outputs of a good TNA should include the following:
• A description of the objectives and activities undertaken by providers within the facility;
• A brief description of the facility environment in which the providers are presently operating;
• The job descriptions and tasks of all professional staff involved in the area in which the needs assessment is being conducted;
• A profile and analysis of the performance of each member of the staff involved in the area in which the needs assessment is being conducted;
• Recommendations for informal and formal training to be undertaken; and
• Recommendations on immediate follow-up activities to be organized, for example consultant support, workshops, and training courses.
A. Defining Needs Assessment
A needs assessment is the process that identifies both the desired performance of potential trainees and their current performance. The difference between the two, the gap between the actual and the desired level of performance, becomes the training need and provides the basis for the training design. Sometimes this is called a performance assessment rather than a training needs assessment. Correctly identifying the cause of the problem is the key to developing and implementing the appropriate corrective measures.

B. Why is a Training Needs Assessment Necessary?
Overall, the reason for conducting a needs assessment is to avoid using training as a “quick fix” to a problem. If a needs assessment is done correctly it will ensure that the training addresses the real problems and effectively focuses the appropriate resources, time, and effort towards the correct solution. There are many good reasons to conduct a needs assessment:

1. To determine whether training is needed. Training is not always the solution to poor performance. If a service provider is providing reproductive health services of poor quality, the reasons may be many. There may be poor management of the clinic, poor supervision, an inadequate facility, or a lack of supplies and equipment. If the needs assessment is done correctly it will determine whether training is necessary, the performance issues that the training should address, and the non-training needs.

2. To determine the causes of poor performance. As mentioned in the previous paragraph, poor performance can be the result of many factors, including poor incentives, lack of motivation, the clinic environment, inadequate skills and knowledge, poor communication, unclear expectations, or inadequate supervision. In some cases the service provider may not be suited to the job or the clinic manager may not clearly state his or her expectations or standards of performance. If the service provider has the knowledge, skills, and ability to provide good quality services, but is not doing so then the training is better directed toward the clinic manager than the service provider. Again, as mentioned in the previous paragraph, the skills and knowledge needed may be for a new activity.

3. To determine the content and the scope of training. The needs assessment will help to determine what kind of training is needed. The problem is not always poor performance. In some cases the facility or health sector may be adding a new service or may be introducing a new health initiative or a new contraceptive. Should the training be conducted away from the workplace or should it be on-the-job training, distance learning, or self-instruction? Does the training need to include a clinical practicum or be theoretical only? The needs assessment will help identify how long the training should be and what kind of trainees should be included. The needs assessment will help identify the information that should be included and the skills needed.

4. To determine the desired outcomes of training. The needs assessment will help identify the knowledge, attitudes, and skills that need to be addressed during training. The needs assessment will help you focus on what information is “must know” as opposed to “nice to know.” Once knowledge, attitude, and skills have been identified, these can be used later in curriculum
development to formulate training objectives.

5. **To provide a basis of measurement.** The needs assessment provides a baseline to use later in the project when monitoring or evaluating progress.

6. **To gain donor support.** A needs assessment can be used to demonstrate to donors exactly what is needed for the training program to succeed. It gives the donor the opportunity for input and shows the donor that you are developing the training program in response to specific needs.

C. **How to Conduct a Needs Assessment**

The needs assessment can be as detailed or involved as you need it to be. There are many factors to be taken into consideration including time, money, the number of people involved, the areas to be covered, and the resources available.

1. **Identify the problem or need.** In most cases the need will have been identified in a project or program description. Examine the goals and objectives of the project. If possible, identify the desired performance of the potential trainees (health care providers, community-based distribution agents, clinic managers, etc.).

2. **Determine the design of the needs analysis.** There are many options available to you. You will probably want to employ several tools and techniques. These might include interviews with providers, clinic managers, government officials, NGO staff and/or clients, or surveys, questionnaires, observation of provider skills or examination of relevant documents such as logbooks, client records, or job descriptions. The choice of options will probably depend on time, cost, available resources, number of people involved, potential disruption to clinic services, client confidentiality, and the expertise of the assessors available.

3. **Collect data.** There are 6 types of data-collection methods: open-ended questionnaires, closed-ended questionnaires, pre-designed instruments, individual or group interviews, observation, and analysis of information. There are advantages and disadvantages to each method. (See Table 1 on the following page.)

4. **Analyze the data.** Qualitative data (i.e., interviews, open-ended questions, and observation), should be sorted into categories and common themes should be identified. This process is called content analysis. Try to categorize and quantify the data as much as possible with minimal interpretation.

A statistical analysis should be conducted for quantitative data (i.e., survey instruments and closed-ended questions). Keep it as simple as possible. Depending on the results you seek, you may choose to determine the mean (the average, calculated by adding all the values and dividing by the number in the group), the mode (the number that occurs most frequently), or the median (the middle number in a numerical list). You should calculate the responses to various questions in order to determine where the real training needs lie.

5. **Provide feedback.** After the data has been analyzed, identify which area(s) need to be addressed in the training and design an action plan. Your conclusions and recommendations should be
communicated to your organization, the program officer, and the country support team. If the training is to be conducted in a clinic or hospital setting, key personnel in the clinic or hospital should also be aware of your conclusions and recommendations.

This feedback should be presented both orally and in a written report. Remember to keep a copy of this report along with data collected from your needs assessment so that it can be used for comparison during a midterm assessment of the training. The written report should include:

- An executive summary;
- A description of the process, which should include a problem statement, brief description of the needs assessment process, and a rationale for the needs assessment;
- A summary of findings;
- Preliminary conclusions—show how findings support your (or others’) perceptions;
- Recommendations—state your recommended solutions to the problem—what should be included in the training, who should be involved, when and where should it take place; and
- Potential barriers—take a proactive approach by addressing barriers up-front and suggesting ways to overcome them.

### Table 1. The six types of data-collection methods

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<th>Advantage</th>
<th>Disadvantage</th>
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<td>Open-ended questions</td>
<td>Respondent can introduce new topics</td>
<td>Communication is one way</td>
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<td></td>
<td>Easy to develop</td>
<td>Respondents may not want to put comments in writing</td>
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<tr>
<td></td>
<td>Inexpensive</td>
<td>Prone to ambiguity and opinions</td>
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<tr>
<td></td>
<td></td>
<td>Requires respondents to be highly literate</td>
</tr>
<tr>
<td>Closed-ended questions</td>
<td>Easy to answer</td>
<td>Provides limited information</td>
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<tr>
<td></td>
<td>Inexpensive to administer</td>
<td>Requires more skill and work to prepare</td>
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<td></td>
<td>Anonymous and ensures confidentiality</td>
<td>Subject to misinterpretation</td>
</tr>
<tr>
<td></td>
<td>Less time consuming</td>
<td>Difficult and time consuming to construct</td>
</tr>
<tr>
<td>Instruments</td>
<td>Validated through research</td>
<td>Administration and coordination needed</td>
</tr>
<tr>
<td></td>
<td>Quick and easy to administer</td>
<td>Difficult to choose most appropriate instrument</td>
</tr>
<tr>
<td></td>
<td>Can be administered in groups</td>
<td>Difficult and time consuming to construct</td>
</tr>
<tr>
<td></td>
<td>Scored quickly</td>
<td>Need to research different types of instruments</td>
</tr>
<tr>
<td>Individual or group interviews</td>
<td>Can read nonverbal messages</td>
<td>Time consuming</td>
</tr>
<tr>
<td></td>
<td>Easier to talk</td>
<td>Some respondents may feel threatened</td>
</tr>
<tr>
<td></td>
<td>Literacy is not required</td>
<td>Interviewer bias can affect results</td>
</tr>
<tr>
<td></td>
<td>Build commitment for training</td>
<td>Difficult to organize and analyze data</td>
</tr>
<tr>
<td></td>
<td>Clarifies expectations</td>
<td>Respondents may be influenced by their peers</td>
</tr>
<tr>
<td></td>
<td>New topics can be introduced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More detailed information</td>
<td></td>
</tr>
<tr>
<td>Observation</td>
<td>Better understanding of variables</td>
<td>Time consuming</td>
</tr>
<tr>
<td></td>
<td>Provides real-life data and examples that can be incorporated in training materials</td>
<td>Expensive</td>
</tr>
<tr>
<td></td>
<td>Real situations, highly relevant</td>
<td>Requires knowledge of the job</td>
</tr>
<tr>
<td></td>
<td>Relatively low cost</td>
<td>Respondents may be anxious, nervous</td>
</tr>
<tr>
<td></td>
<td>Literacy not required</td>
<td>Difficult to record data</td>
</tr>
</tbody>
</table>

16 ADVANCED TRAINING OF TRAINERS
| Analysis ofExisting Information | Factual, highly valid information | May be outdated  
May not cover all areas needed, not specific | Inexpensive  
Not time consuming  
Easy access to many sources in one place  
Unobtrusive  
Provides specific examples | May be hard to find or access  
Risks misinterpretation  
May be biased  
May be limitations to the accuracy of the existing information |

Participant Handout 2.3 Combined Oral Contraceptives

The Combined Oral Contraceptive (COC) is a reversible contraceptive method, containing 2 kinds of hormones, estrogen and progestin.

1. Indications
Women who need an effective contraceptive method and who are not subject to any contraindications in the use of COCs.

2. Contraindications
- Known or suspected pregnancy
- Breast-feeding a child under 6-months of age
- Within 21 days after delivery, even for mothers who are not breastfeeding
- Aged over 35 and smoking (10 or more cigarettes/day)
- Hypertension, cardiac diseases, liver diseases, diabetes, and coagulation disorders
- Presence or history of breast cancer
- Migraine
- Unexplained abnormal vaginal bleeding
- Treatment of tuberculosis or mycosis

3. Procedures

3.1. Examine and evaluate the client's condition before prescribing the method
- Ask thoroughly about history to identify any contraindication (use a checklist)
- Perform appropriate examination to rule out pregnancy or unexplained abnormal bleeding.

3.2 Timing of use
- Begin use the 1st to the 5th day of the cycle, 1st day is the best.
- If a client does not breastfeed, COCs can be taken from 4 weeks after delivery (If the client does breastfeed, COCs can not be taken by the mother until the child is 6 months of age.
- After an induced abortion or miscarriage use of COC should start within 5 days.

3.3 Modes of use
- Take the first pill on any day of the first 5 days of the menstrual cycle. It is best to start on the first day. Take one pill daily at the same time and follow the arrows shown on the packet.
- If using the 28-pill packet, after finishing one packet use the first pill of the next packet on the next day, despite ongoing bleeding.
- If using the 21-pill packet, after finishing one packet, stop for 7 days before using the next packet, despite ongoing bleeding.

3.4 Management of missed pills, nausea, or delayed period
- If one pill is missed take it immediately at the time of remembering and take another at the regular time.
- If two pills are missed, take two pills immediately then another two tablets on the next day then continue the others at the regular time. Use an additional contraceptive method for 7 days if having sexual intercourse.
- If three pills are missed, give up the used packet, start with a new packet. Use an additional
contraceptive method for 7 days if having sexual intercourse.
• If the client has vomiting or diarrhea within 4 hours after taking pill, take the remaining pills as usual and use an additional method for 7 days after the symptoms stop.
• If the cycle is delayed, the client should be examined for possible pregnancy.

4. Counseling
• Listen and explore the client’s needs for COC.
• Show the client the packet of COCs and tell her how to use it
• Tell her about the advantages and disadvantages of the method. It should be noted that COCs cannot protect against STIs.
• Tell her about possible side effects.
• Follow-up while COCs are being used:
  o The client can revisit for examination and counseling at any time.
  o During the first 3 months of taking the drug, she should return for general examination, blood pressure, and weight measurement.

The client should return for re-examination annually as scheduled.
1. The criteria of a healthy newborn baby
   • Gestational age is from the end of the 37th week to the end of 41st week.
   • Birth weight is greater than 2,500g.
   • The baby cries loudly, his/her skin is pink, s/he breathes evenly, and the respiratory rate is from 40-60 times a minute.
   • Apgar score is 8 or more at 1 minute and 9 or 10 at 5 minutes.
   • The newborn sucks well, does not vomit, and has passed meconium.
   • Has no obvious congenital defect.

2. Care of the baby at birth
   • Clear the baby’s airway.
   • Dry the baby’s body and keep him/her warm.
   • Cord care
     • Assess the baby’s condition, sex, check for any deformity, weigh and measure the baby’s length.
     • Clean eyes with sterile water or saline and put drops in eyes (silver nitrate) to prevent infection due to gonococcus.
     • Inject vitamin K1 1mg intramuscularly, single dose.
     • Return baby to mother for initiation of breast-feeding, the sooner the better.

3. Care on the following days
   3.1 Observe the baby daily
     • Skin color: right after birth, the skin is red then becomes pink. After several days, it may change to pink-yellowish (physiological jaundice).
     • Respiratory rate: normally it is from 40-60 respirations per minute. Greater than 60 or less than 40 is abnormal and needs review.
     • Heartbeat: normally from 120 to 140 beats per minute.
     • Temperature: Take body temperature daily.
     • Breast feeding.

   3.2 Umbilical cord care
     • Umbilical cord care is a continuous process which should be done after the delivery until the cord stump is detached, leaving a dry scar. Umbilical cord cutting and care should be conducted under aseptic conditions.
     • How to conduct umbilical cord care:
       o If the umbilical stump is normal use glutaraldehyde to clean the stump. The stump will naturally detach after 6-8 days.
       o If the cord stump has a bad smell, is oozing blood, there are small rashes around the umbilical area, and there is late detachment of the stump, use iodine solution to clean it and do not apply antibiotic powder to the stump area.
       o If ulcerative changes appear, clean gently with saline twice a day, keeping it well-aired.
       o If the stump has detached but the inner part of the cord still remains and may be infected with the appearance of granuloma, apply silver nitrate 5% or 10% solutions to the granuloma. If the granuloma is big enough, it should be cauterized (galvanocautery).
       o When the umbilical stump has just detached, keep it dry and clean until it is healed.
• If bleeding occurs before cord detachment, use aseptic thread to constrict the cord. If bleeding occurs after cord detachment, apply silver nitrate 5% solution. If the bleeding cannot be stopped, suture the opening of the umbilicus and remove the suture after 2 days. Vitamin K, 5 mg, intramuscularly is recommended.

• Conduct umbilical care as soon as possible for an unattended delivery or a delivery without aseptic conditions. If possible, give the baby one dose of SAT, 1,500 IU, intramuscularly.

• The village-level provider should refer the client for further care when there are any signs of cord infection such as:
  • A bad smell, discharge of yellow fluid;
  • Red swelling, suppurating umbilicus;
  • Granuloma, oozing blood, wet; or
  • The umbilical area is not clean and the baby has fever.

3.3 Skin care
• Bathe the baby from the second day.

3.4 Keep warm
• The room temperature must be kept warm (from 28-30o C). It should be airy but not windy. Change the nappy regularly. Let the baby lie with its mother.

3.5 Keep clean
• Wash hands with soap and water before handling the baby. The baby’s underwear and clothes must be clean, dry, and warm.

3.6 If the baby cannot be breast-fed
• Utensils such as cups and spoons must be clean and boiled before using.

3.7 Encourage early and complete breastfeeding
• Refer to “Counseling on breastfeeding” section.
Participant Handout 2.5: Intrauterine Contraceptive Device (IUD)

1. Indications
   • Any woman of reproductive age who wants to use long-term and reversible contraception and who is not subject to any contraindications can use an IUD.
   • An IUD can be used as an emergency contraceptive.

2. Contraindications
   • Menstruation: Prolonged, severe bleeding, menstrual pain, menorrhagia due to any cause.
   • Personal characteristics and reproductive history: Pregnancy, between 48 hours and 4 weeks postpartum, puerperal sepsis, immediate post-septic abortion, unexplained vaginal bleeding before evaluation.
   • Reproductive tract infections and disorders: Trophoblast disease, cervical cancer awaiting treatment, endometrial cancer, ovarian cancer, uterine fibroids with distortion of the uterine cavity, any congenital or acquired uterine abnormality distorting the uterine cavity in a manner that is incompatible with IUD insertion, current pelvic inflammatory disease, current purulent cervicitis or chlamydial infection or gonorrhea, increased risk of exposure to gonorrhea or chlamydial infection, AIDS (not on ARV therapy), pelvic tuberculosis

3. IUD insertion and removal procedure

3.1 Examine and evaluate the client’s condition before applying the method.
   • Ask thoroughly about history to identify contraindication (use a checklist).
   • Perform appropriate examination to rule out pregnancy or unexplained bleeding or contraindications.

3.2 When the IUD insertion can be conducted:
   • Principle: An IUD can be inserted at any time during the first 12 days after the start of menstrual bleeding or anytime during the menstrual cycle, provided that the client is not pregnant.
   • Postpartum: Insertion can be performed at the following points of time:
     o Immediately post-placental, or during or immediately after a Cesarean section (special training required), up to 48 hours after delivery (special training required), as early as 40-6 weeks postpartum. Within 6 months after delivery, if menstruation has not returned and the mother is exclusively breastfeeding.
     o In cases where pregnancy is suggestive, a pregnancy test should be carried out.
   • After induced abortion: An IUD can be inserted after an abortion procedure if the uterine cavity is clear of products of conception and not infected.

3.3. Insertion of IUD, TCu-380A type

3.3.1 Preparation:
   • Check the instruments and IUD packet to ensure they are within the expiration date and intact.
   • Ask the client to empty her bladder.
   • Ask the client to lie on the examining table in the gynecological position.
   • Explain the on-going procedure to the client.
   • Perform a bimanual exam to identify the position of the uterus and its volume and check
• Wear sterile gloves.
• Swab the perineum with an antiseptic solution (using the first forceps).
• Cover with the sterile drape.
• Provider’s position: sitting on a chair, between the client’s thighs.
• Assistant’s position: sitting or standing on the left of the provider (wear sterile gloves on the hand that holds the retractor).

3.3.2. Procedure of IUD insertion
• Revealing the cervix:
  o Open the vagina with a vaginal retractor or a speculum.
  o Swab the cervix and the fornices with betadine (using 2nd forceps).
  o Grasp the cervix with a tenaculum and pull down slightly.
• Sounding the uterus:
  o Insert the uterine sound in the correct direction without touching the vaginal wall.
  o Determine the depth of uterus.
• Loading the IUD into the insertion tube:
  o Load the IUD into the insertion tube inside the package, or outside if aseptic conditions can be ensured.
  o Set the depth-gauge of the insertion tube in the correct direction and corresponding to the uterine depth.
• Inserting the IUD into the uterus:
  o Hold the tube in the correct position and direction, hold the tenaculum in other hand and pull the cervix up, gently push through the cervical os until the tube touches the fundus.
  o Hold the rod to withdraw the insertion tube to release the arms.
  o Push the insertion tube slightly until the IUD touches the fundus.
  o Hold the insertion tube to withdraw the rod.
  o Withdraw the rod.
  o Cut the string at 3 cm from the cervical os and fold the end into the fornix.
• Removal of the instruments
  o Remove the tenaculum.
  o Disinfect the cervix and vagina with betadine and stop bleeding (if necessary).
  o Remove the vaginal retractor or speculum.
  o Tell the client that procedure has ended.

3.4 Insertion of Multiload type
3.4.1. Preparation:
• As in TCu-380A
3.4.2. Insertion of IUD
• Revealing the cervix (as in TCu-380A).
• Sounding the uterus (as in TCu-380A).
• Inserting the IUD:
  o Tear the packet off; set the depth-gauge of the insertion tube to the correct direction and corresponding to the uterine depth.
  o Hold the tenaculum in one hand and pull the cervix up, hold the insertion tube in the other hand (with IUD inside), push the IUD gently through the cervical os following the
uterine direction until it touches the fundus.
- Withdraw the insertion tube.
- Cut the string at 3 cm from the cervical os and fold the end into the fornix.
- Removing the instruments (as in TCu-380A)

3.5. Removal of IUD
3.5.1 Indications:
- Medical reasons:
  - Pregnancy (removal can be done if the strings are seen).
  - Excessive bleeding.
  - Severe lower abdominal pain.
  - Uterine infection or pelvic inflammatory disease.
  - Uterine or cervical cancer suspected or defined.
  - IUD expulsion.
  - Menopause (12 months after finishing periods).
  - IUD expired (8-10 years with TCu-380A, 3-5 years with Multiload). After removing the IUD, another one can be inserted at the client’s request.
- Personal reasons:
  - Wishes to become pregnant.
  - Wishes to change to other contraceptive method.
  - Contraception is unnecessary.

3.5.2 How to conduct the removal:
- If the IUD does not have a string, use a designated hook to remove. This should be performed by someone specially trained in this procedure.
- TCu and Multiload have strings so they can be removed by using forceps to grasp both of the strings and pulling it out.
- If the string cannot be found, ultrasound imaging should be conducted to identify if the IUD is in the uterine cavity. A referral should be made to a higher level for IUD removal.

4. Counselling
- Provide the client with information about an IUD:
  - Listen and explore the client’s needs for contraception and the reasons she wants to use an IUD.
  - Let the client look at the different types of IUDs available, but mainly give information on the specific IUD that will be used by the client.
  - Use a picture or model to explain the IUD position in the uterus and how it will be inserted.
  - Tell the client the advantages and disadvantages of an IUD. The client should be told that an IUD can not prevent STIs.
  - The client should be informed that infertility is highly possible if the client contracts an STI while using this contraceptive method.
  - Tell the client when the IUD expires and needs to be removed.
- Instruct the client to self follow-up. Tell the client how to take the drugs provided after insertion.
- Tell the client to come back for reexamination after 1 month, return for annual screening visit, or for removal if abnormal signs appear, as examination is needed immediately.
- The client has the right to request IUD removal and to use another method if she does not want
to continue with an IUD.
• Ask questions on the key counseling issues and check for her response.

Ensure privacy and confidentiality of the client.
Participant Handout 2.6: Care of the Mother and Newborn the First Day After Delivery

1. Monitoring and care of the mother and baby for the first two hours
   • Mother should stay in the delivery room.
   • Monitor the mother’s general status, pulse, Blood Pressure (BP), contraction of uterus, bleeding at 15 min, 30 min, 45 min, 60 min, 90 min, and 120 min.
   • Monitor the baby’s respiration (crying), skin (pink, warm), breastfeed at the times mentioned above.

Below is the summary of problems that may occur and their management.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Fast pulse (over 90 beats per minute)</td>
<td>Check BP, contraction of the uterus, bleeding</td>
</tr>
<tr>
<td>Low BP (systolic less than 90 mm Hg)</td>
<td>Treat for obstetric shock</td>
</tr>
<tr>
<td>High BP (systolic over 140 mmHg, diastolic over 90 mmHg or increases by 15 mmHg)</td>
<td>Treat for preeclampsia</td>
</tr>
<tr>
<td>Soft uterus, and fundus is higher than the umbilical level</td>
<td>Manage for uterine atony</td>
</tr>
<tr>
<td>Bleeding amount over 250ml and still continues</td>
<td>Manage for postpartum hemorrhage</td>
</tr>
<tr>
<td>Vaginal and perineal tears</td>
<td>Prepare for suturing</td>
</tr>
<tr>
<td>Hematoma</td>
<td>Refer to higher level</td>
</tr>
<tr>
<td>Baby</td>
<td></td>
</tr>
<tr>
<td>Difficulty breathing, cyanosis</td>
<td>Resuscitate and refer to hospital</td>
</tr>
<tr>
<td>Baby is cold or the room temperature is low</td>
<td>Keep warm, use kangaroo method, and use heating system if available</td>
</tr>
<tr>
<td>Umbilical bleeding</td>
<td>Tie off the cord stump again</td>
</tr>
</tbody>
</table>

2. Monitoring and care of mother and newborn from the 3rd hour to the end of the first day after birth
   After intensive monitoring in the first two hours, if the condition progresses normally continue to monitor from 3 to 6 hours as follows:
   • Lay the baby next to the mother, monitoring the above-mentioned signs every hour.
   • Keep the baby warm.
   • Give the mother absorbent sanitary towels.
   • Help the mother with her meal and sleep.
   • The mother can move gently after 6 hours.
   • Encourage early breastfeeding.
   • Teach the mother how to take care of her baby and check if the umbilical cord is bleeding.
   • Tell the mother and her relatives to call the health workers if the baby does not suck or breathe, is cyanosed, or has umbilical bleeding.
   • Ask them to call the health workers if the mother has excessive bleeding, abdominal pain, headache, dizziness, or any other problems.

3. Monitoring and care of mother and newborn from 7 hours after birth:
   • Monitor the mother’s general condition, fundus of uterus (firm, round), look at the sanitary towel
(check for the amount of blood loss)
• Monitor the baby’s breathing (count the respiratory rate), if its skin is cold (take its temperature), check if the umbilical stump is bleeding, and ask if the baby has breastfed.

The following table lists problems that may occur and their management.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Management</th>
</tr>
</thead>
</table>
| **Mother:** | • Massage the uterus. Press the fundus to express the coagulated blood  
• Give another 10 IU of oxytoxin intramuscularly.  
• Examine and treat according to section on “postpartum hemorrhage.” |
| • The uterus is not well contracted (uterus is soft, above the mother’s umbilical level).  
• There is a large amount of blood on the sanitary towel after 1 hour. | |
| **Baby:** | • Encourage the mother to breastfeed the baby immediately.  
• Keep warm, use kangaroo method and use heating system, if available.  
• Resuscitate and refer to higher level.  
• Tie off the umbilical stump again.  
• Check if the anus is patent. |
| • Has not been breastfed.  
• Is cold or the room is cold.  
• Has difficulty in breathing, dyspnoea, or cyanosis.  
• Has umbilical bleeding.  
• Has not passed meconium. | |
Participant Handout 2.7: Steps to Conducting a Training Needs Assessment

A Training Needs Assessment (TNA) identifies any gaps between the present performance of a provider and the desired performance. A discrepancy between the two is often stated in terms of what is necessary to perform a job or series of tasks. These abilities can be classified into three learning areas:

- Knowledge, which focuses on the knowledge and understanding necessary to perform a job or task;
- Skill, which looks at the skills and practices necessary to perform the job or task; and
- Attitude, which examines the attitudes or beliefs associated with performing a job or task.

**Step 1: Identify the Problem**

In order to identify the problem, the desired performance must be determined and compared to the actual performance. At the beginning of the TNA, the actual and desired performance may only be known in general terms. A problem may be recognized such as the need to reduce the rate of infections in a particular facility or the need to have trained providers to provide reproductive health services.

**Identify Desired Performance**

Define performance in the most specific and measurable terms possible. For the definition to be valid, you must ensure that all key stakeholders have input and/or agree on the performance statements. This process will take time, as individual stakeholders may have opinions that differ, especially when they are forced to be specific. As many of the following sources of data as possible should be used to describe desired performance:

- National clinical standards and guidelines,
- Job descriptions,
- Providers who are skilled in the area,
- Supervisors,
- Program personnel,
- Clinic records and program statistics,
- Current reference manuals, and
- Any existing skill development learning guides and performance checklists.

The purpose of this review is to identify the general knowledge, skills, and attitudes required to do the job. Good definitions of performance have the following qualities:

- They state the accomplishments and/or behavior of the performer;
- They are observable;
- They are measurable;
- They can be agreed upon by independent observers;
- They give a clear, unambiguous, yes-or-no answer to “Do they or don’t they?”; and
- They are under the control of the performer.

For each statement of desired performance you should arrive at a performance indicator that describes a quality, quantity, time, or cost. This step will help the group decide what really matters about the performance in question: Is it how well it is done, how often it happens, on how timely a basis, or all three? Once you have decided on the measurable indicators for the performance in question, help the group set targets for each
indicator. For example, should the performance follow the standard 100% of the time, or is 90% acceptable to start with? Should the providers always arrive by 9:00? Or is it OK to arrive occasionally at 9:15? Remember that the targets you set now may be revised as time goes by. As with “ideal” performance, setting targets that are unrealistic can be a detractor for performance. Revising targets is a good technique when performance levels are initially very low and you need to set interim goals for performers.

Identify Actual Performance

In the previous stage, desired performance was defined in specific and measurable terms. Using those same indicators and measures, assess what knowledge, skills and attitudes providers currently possess (the current, or actual, performance).

Step 2: Decide on methodology

First decide who and what is to be assessed. A series of methods are available and commonly used in a TNA for the gathering and subsequent analysis of information related to the job functions and tasks performed by staff potentially in need of training. To avoid a skewed picture of the actual needs, the same kind of information will often be sampled by slightly different means, for example:

- Analyzing answers to personal questionnaires,
- Interviewing key persons,
- Conducting focused workshops with staff in charge of providers/facilities where training will be conducted,
- Reviewing recent key publications, or
- Observations of working practices and working conditions.

Step 3: Decide on the assessment tools to be used and develop them

Once methods for assessment of actual performance are decided upon, the team, or a subset of the team, will need to design data collection instruments. The forms should simplify data compilation and be easy to use in the field. Data collection instruments often include interview guides, observation checklists, focus group discussion guides, questionnaires, and survey forms. Be sure to prioritize your questions so that you obtain essential information first.

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews with: • Management • Supervisors • Workers</td>
<td>Interviews are conducted one-on-one or with a small group (the smaller, the better so that everyone has a chance to contribute fully). Interviews can be used throughout the data gathering process, but they are perhaps most useful during the performance analysis stage, when you are trying to determine what the real performance deficiency is. Although the process is time consuming, it is useful because you can gather specific information and ask follow-up questions to get more detail on items of particular interest.</td>
<td>1. Write down your questions before the interview and give them to the person(s) being interviewed, if possible. 2. Decide beforehand how you want to document the information you gather. 3. Consider videotaping the interview so that you have a record to refer to later. 4. Put the persons being interviewed at ease by telling them the purpose of the interview and how you will use what they tell you. 5. When appropriate, assure them that what they say will be kept confidential.</td>
</tr>
</tbody>
</table>
Panels of Experts
Panels of experts are used to gather the collective observations and opinions of the “best of the breed.” They are particularly useful when there is not one correct solution or procedure (e.g., conducting a goal analysis).

1. Make sure that each participant is truly an expert.
2. Let participants know well in advance what you expect of them and give them time to prepare.
3. Focus the discussion on the topic at hand and keep participants on track.
4. Document your panel just as well as you documented the interviews.

Observations
Direct observation of work performance is an excellent means of gathering data. Observations are usually done in conjunction with another data-gathering method that is used to fill in the gaps and answer questions.

1. Make sure to arrange your observations well in advance and get permission from management.
2. Let workers know why you are observing them.
3. If possible, have an expert with you who can tell you what to look for.
4. Videotaping observation sessions works well if it is permitted.

Method | Description | Tips
---|---|---
Surveys | Surveys are used when you want to gather data from a large number of people and when it is impractical to meet them all face to face. Surveys can be both formal (where the results are subject to statistical reliability and validity) and informal (where results are anecdotal). In the developing-world reproductive health context, there are relatively few commercially designed instruments. Even if there were generic survey instruments available, the unique problems and country differences might limit their usefulness. Clearly, it is expensive to design a survey for one performance improvement effort, so while we include surveys in this table, we are not optimistic about their applicability (except on a small, informal basis). | 1. Decide up-front if you need to base your conclusions on statistically valid and reliable data. If so, consult an expert to help determine your sample group, method of data collection, and how you will compute your results.
2. It is best to use commercially-designed instruments if they are available. They save development time, and they have been tested to ensure they work.
3. If you must design your own survey, make sure you try it out on a sample group from the target population.

Reviews of Performance Data | Almost all organizations maintain records. They may include data about time and attendance, rates of production, and cost of goods sold. A review of some of these records can provide valuable information to substantiate the performance deficiencies under consideration and lead to potential causes. A frequent challenge will be to determine which data are relevant and whether the quality of the data is adequate. | 1. Make sure you understand how the data were collected and what the data mean.
2. Make sure that the data you have are current. Outdated data can be more harmful than no data at all.
3. It is important that you comply with any restrictions your client puts on your use of their data. Unauthorized use of confidential data can be illegal and harmful to the organization.

Step 4: Collect the data
After developing the tools, identify the data collectors and prepare them for activity in the field. At times, the data collectors will come from your immediate team or organization. Other times, you will need to hire data collectors. In any case, once the team is identified, they must be equipped with everything they need to collect baseline data. Readying them may include training, supplying vehicles, or obtaining lodging in the field. When gathering information from people during the assessment, be sure to clearly explain the reason for the interview or data gathering, as well as the goals of the assessment. Be sensitive, factual, and diplomatic in your explanation. When analyzing
the data you have collected, try to ensure that you collect mostly facts rather than opinion or perception. To help clarify which is which, consider tactful ways to gain clarification (for example, “Can you give me some examples of what makes you say that?”). Decide who will supervise the data collectors and set a timeline for data collection.

Compile the data that have arrived from the data collectors in the field. For smaller projects, this compilation may be done by hand on tables and check sheets. For larger efforts, statistical analysis software may be used. In either case, the data should be compiled in a way that communicates the current level of performance to the team and to others outside the immediate team. For example, if the desired level of performance is that 90% of eligible clients will receive treatment, what is the actual performance? 40%? 50%? Keep the audience in mind when choosing presentation formats.

**Step 5: Analyze and present the data**

Keeping in mind the clearly stated performance issue and how it affects the organization, document the data you have gathered by identifying consistencies and inconsistencies within the data. Be careful not to jump to conclusions at this point. Just document your findings and the facts within those findings. Once documented, identify performance gaps by comparing what the target audience is doing to what they need to be doing. Be able to back up the statements with appropriate data presentations (charts, graphs, etc). Be careful not to jump from the problem immediately to the solution. To ensure that your recommendations will work the first time around, you should first complete a cause analysis to uncover the real causes for performance gaps. Using the same measures that were used to describe desired and actual performance, describe the performance gaps which correspond to learning needs.

**Step 6: Conduct a cause analysis**

Before deciding on possible solutions to close the performance gap, you need to first identify the causes for the gap. Is the gap due to a lack of skill or knowledge? Are there motivational or environmental barriers to desired performance? Have job expectations and necessary information been adequately communicated to the job performers? Can desired performance be obtained through training? What obstacles are facing the providers?

If you are unsure of the causes (that is, you do not have the data to support your cause analysis), ask more questions to determine the true causes of the performance gap.

Based on the cause(s) of the performance gap, determine the best solution(s) to close the gap. Keep in mind how the performance issue links to organizational results and needs, to ensure that your proposed solution(s) are acceptable and relevant. Also keep in mind your audience’s sensitivities and predispositions. For example, if the vice president of Human Resources has publicly announced that the solution will entail training, make sure that your recommendations include a training solution that is adequately supported by the data. Most likely, you will identify more than one solution, especially if there are multiple causes for the performance gap.
### Performance Improvement Specification Form

<table>
<thead>
<tr>
<th>Performance</th>
<th>Actual Performance</th>
<th>Performance Gaps</th>
<th>Root Cause(s)</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
**Participant Handout 2.8: TNA Example 1**

**Complicated Delivery (obstructed labor) (Partograph)**

Date of Assessment: Month: _____________    Year:_____________
Assessment Conducted by: _________________________________
Name of Facility:_________________________________________
Location: _______________________________________________

Select the first patient records that meet the selection criteria outlined below:
- Descent is static for three hours or more,
  Or
- Strong contractions with no progress for three hours.
Exclude multiple births (twins, triplet, etc.).
Exclude non-cephalic presentation (breech, shoulder, etc.).
Record the following information from the record:

<table>
<thead>
<tr>
<th>CDO1</th>
<th>Was the descent of the head static (no progress for three hours or more)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tick one box</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CDO2</th>
<th>Were strong contractions recorded for more than three hours without descent of the head?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tick one box</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CDO3</th>
<th>What is the recorded condition of the baby at birth?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circle one</td>
</tr>
</tbody>
</table>

- Stillbirth
- Live birth, not good condition (Apgar score 6 or less or equivalent)
- Live birth, good condition (Apgar score 7-10 or equivalent)
- Not recorded

<table>
<thead>
<tr>
<th>CDO4</th>
<th>What is the recorded mode of delivery?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circle one</td>
</tr>
</tbody>
</table>

- Spontaneous vaginal delivery
- Vacuum extraction
- Forceps delivery
- Caesarean delivery
- Symphysiotomy
- Not recorded

<table>
<thead>
<tr>
<th>CDO5</th>
<th>In case of caesarean operation, how many hours elapsed past the action line (to the right of the line) before the caesarean operation was conducted?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enter number of hours</td>
</tr>
<tr>
<td></td>
<td>If caesarean operation was performed before the action line, enter hours as negative (e.g., “-1”)</td>
</tr>
</tbody>
</table>
Participant Handout 2.9: TNA Example 2

CHECKLIST FOR POSTABORTION CARE – FP COUNSELLING SKILLS

Date of Assessment: Month:_____________    Year:______________

Assessment Conducted by:____________________________________

Name of Facility:____________________________________________

Location:____________________________________________________

NOTE TO ASSESSOR: If no clients are present during the time the assessment team visits this facility, you should ask the service provider to describe to you all elements of the visit that s/he would include in a labor admission. You should mention that the service provider should include counseling/client education as well as the relevant physical examination and procedures. You should not coach the service provider/tutor, nor remind her of items she neglected to mention. Only record items spontaneously mentioned by the service provider. Use this form to record this description but please check the box below that this information was collected by interview rather than by observation.

Data on this form was collected by interviewing a service provider, not by observing the provider’s work.

Each item should be completed based on the observations of the assessor.

Use the following to score each step in the observation:

1 = Performed, satisfactorily  
2 = Performed, but unsatisfactorily  
3 = Not performed  
4 = Not observed
### Initial Interview

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greet the woman respectfully and with kindness and introduces him- or herself.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>2. Offers the woman a seat.</td>
<td></td>
</tr>
<tr>
<td>3. Assesses whether counseling is appropriate at this time (if not, arranges for her to be counseled at another time).</td>
<td></td>
</tr>
<tr>
<td>4. Assures necessary privacy.</td>
<td></td>
</tr>
<tr>
<td>6. Asks if she was using contraception before she became pregnant. If she was, finds out if she: • Used the method correctly, • Discontinued use, • Had any trouble using the method, or • Has any concerns about the method.</td>
<td></td>
</tr>
<tr>
<td>7. Provides general information about family planning.</td>
<td></td>
</tr>
<tr>
<td>8. Explores any attitudes or religious beliefs that either favor or rule out one or more methods.</td>
<td></td>
</tr>
<tr>
<td>9. Gives the woman information about the contraceptive choices available and the risk and benefits for each. • Shows where and how each is used. • Explains how the method works and its effectiveness. • Explains possible side effects and other health problems. • Explains the common side effects. • Explains if the method protects against STIs/HIV, or explains use of dual method.</td>
<td></td>
</tr>
<tr>
<td>10. Discusses the woman’s needs, concerns, and fears in a thorough and sympathetic manner.</td>
<td></td>
</tr>
<tr>
<td>11. Discusses the woman’s sexual risks in a thorough, nonjudgmental, and sympathetic manner.</td>
<td></td>
</tr>
<tr>
<td>12. Helps the woman choose an appropriate method.</td>
<td></td>
</tr>
</tbody>
</table>

### Skill/Activity Performed Satisfactorily

**Client Screening**

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screens woman carefully to make sure there is no medical condition that would be a problem. (Completes the client screening checklist.)</td>
<td></td>
</tr>
<tr>
<td>2. Explains potential side effects and makes sure that each is fully understood.</td>
<td></td>
</tr>
<tr>
<td>3. Performs further evaluation (physical examination), if indicated.</td>
<td></td>
</tr>
<tr>
<td>4. Discusses what to do if the client experiences any side effects or problems.</td>
<td></td>
</tr>
<tr>
<td>5. Provides follow-up instructions.</td>
<td></td>
</tr>
<tr>
<td>6. Assures woman she can return to the same clinic at any time to receive advice or medical attention.</td>
<td></td>
</tr>
<tr>
<td>7. Asks the woman to repeat instructions.</td>
<td></td>
</tr>
<tr>
<td>8. Records the relevant details for care on the woman’s record/family planning card.</td>
<td></td>
</tr>
<tr>
<td>9. Asks the woman if she has any further questions or concerns and answers them appropriately.</td>
<td></td>
</tr>
<tr>
<td>10. Thanks the woman for coming and tells her when she should come for her next visit.</td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 2.10: TNA Example 3

General Note: Use day 1 to gather data only. Refrain from providing feedback unless absolutely necessary.

Date of Assessment: Month:___________ Year:___________

Assessment Conducted by:______________________________________

Name of Facility:_________________________________ Location:________________________

Instructions to assessor: Please complete this form through discussion with the in-charges and through visiting various areas of the facility. Feel free to make notes on this form about any additional relevant information that is collected during the course of this facility assessment.

You may need to see delivery records, admission/discharge registers, mortality registers, monthly reports, and/or log books for the past 12 months or a 12 month period, i.e., January 1999 through December 1999. Feel free to make notes on this form about any additional relevant information that is collected during the course of this facility assessment and any comments you may have.

<table>
<thead>
<tr>
<th>Infrastructure/Equipment/Supplies/Drugs</th>
<th>Quantity</th>
<th>Adequate for Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter correct number below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1- Available and satisfactory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 - Available but not satisfactory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 - Not applicable for this facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Equipment**                          |          |                     |
| Sphygmomanometer                       |          |                     |
| Stethoscope                            |          |                     |
| Fetal stethoscope                      |          |                     |
| Clinical oral thermometer              |          |                     |
| Measuring tape                         |          |                     |
| Weighing scale (baby)                  |          |                     |

Pathfinder International
<table>
<thead>
<tr>
<th>Equipment</th>
<th>Quantity</th>
<th>Adequate for Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal speculums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protective clothing (shoes, aprons)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery sets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episiotomy sets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacuum Extractor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric Forceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scissors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suture needles and suture material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needle holder, long</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cloth or towel to dry baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blanket to wrap baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction machine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heating lamp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bag and mask for neonatal resuscitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laryngoscope with blades size no. 0/1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bag and mask for adult resuscitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laryngoscope</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine dip sticks (or proteinuria test supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partographs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile/HLD gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable syringes and needles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV kit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord ties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood giving sets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction catheter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cotton</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauze</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-anemia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron and folic acid</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-malarials</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloroquine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sulfadoxine-Pyrimethamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artemisinin-based combination drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>Quantity</td>
<td>Current stock-out</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Anti-infectives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ampicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzathine penicillin or Procaine Benzylpenicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefazolin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cloxacillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythromycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentamicin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kanamycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitrofurantoin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procaine Penicillin G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pencillin G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetracycline 1% or Silver Nitrate 1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethoprim + Sulfamethoxazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-hypertensives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methyldopa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydralazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nifedipine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labetolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-convulsives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium sulfate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valium</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Steroids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dexamethasone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oxytocics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misoprostol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ergometrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxytocin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Synometrine</td>
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<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>Quantity</td>
<td>Current stock-out</td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>IV Fluids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose (5%, 10%, 50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal saline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ringer's lactate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Analgesics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paracetamol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pethidine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sedatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenobarbitone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anaesthetics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lignocaine (1% or 2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aminophylline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prednisone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prednisolone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atropine sulphate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium gluconate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium citrate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digoxin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ephedrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frusemide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promethazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naloxone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium trisilicate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunologicals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus toxoid vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus anti-toxin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-tetanus serum</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Drugs

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Quantity</th>
<th>Current Stock-out</th>
<th>Stock-out in last 6 months</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disinfectants and antisepsics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorhexidine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical spirit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Partograph

<table>
<thead>
<tr>
<th>Times Observed Use</th>
<th>Recorded Use</th>
<th># Correctly Used/Total Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments

Please comment on record keeping:

### General Conditions

<table>
<thead>
<tr>
<th>Adequate</th>
<th>Below Adequate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### General Conditions

- General cleanliness
- Privacy for patient

How many beds are there in this facility for intrapartum care?

Enter number

At this facility how many full-time and part-time occupied posts are there for:

<table>
<thead>
<tr>
<th>Posts</th>
<th>Full-time</th>
<th>Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered midwives and nurse-midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians (both generalist and obstetrician/gynecologist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthetists and nurse-anesthetists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Students

In the following table, indicate the maximum number of each cadre of students who may be receiving training at this facility at any one time. Also, indicate whether or not these students may overlap with other students or interns.

<table>
<thead>
<tr>
<th>Cadre of Student/Interns</th>
<th>Number</th>
<th>Overlap</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing student</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery student</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical student</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatre student</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inservice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other activities

<table>
<thead>
<tr>
<th>Are other activities going on at this facility which may interfere with training activities?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please elaborate:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which of the following complications have occurred and have been managed at this facility within the past six months?

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antepartum hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preeclampsia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained placenta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breech presentation/delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruptured uterus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tally information on the number of cases of various conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>In the past month</th>
<th>In the past 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instrumental deliveries (vacuum extraction or forceps)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal vaginal deliveries (breech, face, shoulder deliveries)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caesarean operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruptured uterus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal deaths (Total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstructed labor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eclampsia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stillbirths (Total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macerated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early neonatal deaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are on-call services available at night and on weekends?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are on-call services available for care of complicated deliveries available at night and on weekends?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are on-call services available for caesarean operation available at night and on weekends?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Once you decide to refer an obstetric emergency case, about how long does it take for her to arrive at the referral facility and receive care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How far is the nearest referral facility, in kilometers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are blood transfusions available?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have a radio or telephone system and an ambulance to transport the woman?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Who generally accompanies the woman (other than the driver)?

<table>
<thead>
<tr>
<th>Which laboratory facilities are available:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematocrit/Hemoglobin</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood group and Rh Factor</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Malaria smears</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>RPR</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Participant Handout 2.11: Writing a Training Needs Assessment Report

Once the data have been analyzed, a report should be written that includes:

- **Overview**: A brief overview of the purpose, objectives and the results of the training needs assessment.

- **Description of the Process**: Describe the entire needs assessment process, including the purpose, the method(s) used to collect information, and the people involved.

- **Summary of Results**: In this section the data should be clearly and concisely presented and should highlight any significant patterns or results.

- **Preliminary Conclusions**: Write about the analysis of the data and focus on key issues that you have observed. Explain what conclusions you have made and why.

- **Recommendations**: Make recommendations regarding the training. Arrange the recommendations so that the most critical issues or training areas can be addressed first. Identify training issues, be clear about how the program should be implemented, who should be involved, and how, when, and where the training should take place.

- **Potential Barriers**: Identify potential barriers and possible solutions.
Participant Handout 2.12: Sample Training Needs Assessment Report

REPORT OF A VISIT TO FACILITIES
14-17 AUGUST, 2001

Summary
An evaluation of provider performance and quality of services related to some components of Safe Motherhood (SM) services (antenatal, intrapartum, and postnatal care) is part of the process for the development and implementation of a SM strategic plan for ____________/districts. Part of this evaluation included an initial visit to polyclinics, maternity hospitals, women’s consultations in _________ clinic and ________ health post in ____________ and __________ to determine:

- Availability, utilization, and quality of SM health services (antenatal services, care during labor and birth, and postpartum services), including the quality of client-provider interaction; and
- Availability and condition of equipment, supplies, and drugs to provide these services.

Methods used to attain the objectives of the initial visit were those suggested by the World Health Organization (WHO), adapted to the national setting and the circumstances of the visit. Methodology consisted of examination of various resources at the health facilities, observation of providers using checklists, and interviews with service providers.

The major findings of this visit are presented in the following categories:

Service provision
- Facilities appear to be over-staffed; all of the facilities had a full contingent of staff with very few patients.
- Operational capacity of the health facilities is very limited in regard to laboratory and ultrasound diagnosis, as well as other diagnostic tools. Some facilities had ultrasounds, albeit very dated, but did not have personnel who were competent to perform basic ultrasonic examinations. All ultrasounds were for abdominal ultrasonic examination and none had vaginal probes.
- All of the facilities had very old equipment, in varying degrees of repair. Availability of drugs and supplies was limited in all facilities.
- Service provision is very hierarchical, with nurses and midwives having a very limited and submissive role.
- Service delivery sites reach the lowest level, the village, but providers at these sites serve mainly as referral agents, and provide very limited services.

Utilization of available services
- Data from the Reproductive Health (RH) Survey - 1997 shows the following coverage rates:
  - Antenatal care—82% of pregnant women had at least 1 visit;
  - Family Planning (FP)—60% of women were using a family planning method (but the majority of women are using coitus interruptus); and
  - Postnatal consultation and postnatal FP counseling—80.2% of postpartum women did not receive adequate postpartum FP counseling or care.
- There appears to be an increasing trend to begin antenatal care late and to give birth in the home. This is apparently due to the economic downturn, and women not having the necessary funds to receive care within the formal health care infrastructure.
- Very few adolescent girls seek care in the maternity hospitals or women’s clinics. There appears
to be some controversy among providers as to why this is. Some physicians and authorities interviewed believe that it is because adolescent girls do not require FP, SM, or STI services. Other physicians, however, believe that adolescent girls do require these services, but do not feel comfortable seeking the services within the formal health care system.

• Male involvement in women’s RH is largely absent. Men bring their wives to the facilities, but must remain outside the consultation, labor, and delivery rooms.

Quality of services

• On observation, counseling during consultations appears to be largely absent.
• Antenatal and postnatal visits are provided by many providers: a nurse, midwife, obstetrician/gynecologist, stomatologist, and terapeft, and the woman is required to go from one office to another to complete her visit.
• Partographs are not used to monitor labor, and there did not appear to be protocols about frequency of monitoring during first, second, or third stages. There is no active immediate post-delivery supervision.
• Some provider practices do not reflect recent WHO standards—i.e., expectant management of third stage, bed rest and hospitalization for threatened abortion, routine enemas and perineal shaving before birth, beginning infertility investigations after 6 months in an active sexual relationship without a pregnancy, hospitalization of an obese pregnant woman with no identified complications, routine repeat cesarean operations, etc.
• Tetanus is no longer a problem in _______. By the time women reach reproductive age, they have already been completely vaccinated and there are no cases of neonatal tetanus.
• Infection practices are not uniform from one facility to another. No facilities had sharps containers or separated their medical waste. All facilities had their waste disposed of in the municipal dump.
• Running water was not available in most of the facilities and, where running water is not available, providers use Veronika buckets and store water in either a bathtub or various plastic water containers.
• Registration of clients does not appear to be uniform from one service delivery site to another. Antenatal and postnatal visit charts were mostly incompletely filled in.

In conclusion, it was evident that the SM program has many needs. For the action plan in the ________ to respond to these needs, the strategic plan must include the following components:

• Provision of equipment, supplies, and drugs;
• Development of policies and standards for the provision of SM services;
• Liberalization of policy to allow both nurses and midwives an expanded role (and a new job description) to increase access to services;
• Updating of personnel;
• Rationalization of personnel; and
• Community mobilization.
I. OBJECTIVES
1. Purpose
Obtain qualitative and quantitative data on SM services to use in developing a plan for implementing some components of a SM program strategy in the _____________ that will be jointly decided by the Ministry of Health (MOH), USAID, and the XXXXXXXX project.

2. Specific objectives:
   • Availability, utilization, and quality of SM health services (antenatal services, care during labor and birth, and postpartum services).
   • Availability and condition of equipment, supplies, and drugs to provide these services.

II. METHODOLOGY
In view of the stated objectives, a combination of four methods was used during the visit:
   • Checklists were used to evaluate service provision, including Infection Prevention (IP) practices. In the absence of clients, providers were interviewed about practices.
   • A questionnaire about infrastructure, services, equipment, supplies, and drugs was used to evaluate adequacy of materials and infrastructure to provide services.
   • Providers and managers were interviewed.

The four members of the team were Dr. ____________, Leading Specialist of the Maternal and Child Department of the MOH, Professor ______________, Head, Obstetrics/Gynecology at the ________ Medical Institute, Dr. ____________, consultant, and Ms. _____________.

The team was assisted by two translators, Ms. ____________ and Mr. ________________, who were invaluable in the process of interviewing and gathering information at the facilities.

III. FINDINGS
3.1 Policies and protocols (clinical standards) for Safe Motherhood (SM)
There do not appear to be comprehensive SM policies or clinical standards that are either developed or disseminated. During the visit, the following information was collected about policies and standards:

- On October 6, 1999, the Board of the MOH adopted and endorsed the policy paper, Mother and Child Health Problems and Further Strategies: 2000-2010.
- UNFPA has translated the JHU/PCS manual on FP which outlines FP protocols. It is not clear that policies about FP are available.
- UNICEF has developed training modules for physicians and midwives on SM, which can serve as the basis for the development of protocols for SM services besides antenatal care.
- The Association for Family Health is apparently preparing protocols on adolescent sexual health.
- The MOH has just prepared training modules on detection of cervical and breast cancer, which can serve as the basis for the development of protocols.

Ministerial decrees were available at the regional health authority level, but other protocols were not available at health facilities and providers did not appear to have access to them. Job aids were limited or absent.

3.2 Staffing

3.2.1 Availability of personnel:

In _________the situation is as follows:

- The average number of physicians per 10,000 population is 17.2 (1998);
- The number of hospital beds per 10,000 population is 55.4 (MOH facilities) (1998); and
- The average occupancy of hospital beds is 35% (1998).

The optimization program is well underway, but there appears to be an excess of personnel in all facilities. Very few clients were seen, and this appears to be the norm.

3.3 Staff development

3.3.1 Staff training

Based on interviews with providers, it did not appear that facilities organize regular training programs or have a formal training schedule for providers. Providers that were interviewed expressed a need for regular updates, and stated that while they would prefer that equipment and supplies be provided to accompany the training, they would still like an update even if equipment and supplies could not be provided.

Of providers interviewed, the following information was gathered:

- The nurse had had 2 refresher courses in the past 2 years, one about childhood illnesses (most likely integrated management of childhood diseases) and outreach for reproductive health, including some basic information about contraception.
- At the _________ MH, physicians had attended workshops on FP and midwives had attended workshops on general midwifery.
- One obstetrician/gynecologist had received three training sessions over the past two years: clinical practical training at the NIH (a few weeks), a WHO workshop on emergency obstetric care (5 days), and a training of trainers organized by Johns Hopkins University and Save the Children (7 days).
Some of the priorities for training defined by the providers interviewed include:
• Induction of labor,
• Management of hemorrhage,
• Partograph,
• Contraception, and
• General obstetric care.

Personnel do not appear to have a choice in the subject matter for their continuing education.
It appears that physicians are privileged in terms of numbers of personnel receiving continuing
education courses. There did not appear to be a mechanism for obtaining publications, journals, or
books for providers working at the facilities. Even the free publications did not seem to reach the
facilities.

3.4 Equipment of health facilities
3.4.1 Biomedical equipment of health facilities
Availability of biomedical equipment varies greatly, according to the type of material (see Table 1
below). All health facilities had a minimum of equipment, for instance; each consultation room
had one blood pressure cuff, one fetal stethoscope, one measuring tape, one adult scale, and one
mechanism to measure height. All facilities appear to have an insufficient supply of vaginal specula,
but it appears, by interview, that all women who require a speculum examination do receive one.

Table 1: Availability/Condition (A/C) and Quantity (Q) of
equipment for antenatal and postnatal care, by health facility

<table>
<thead>
<tr>
<th>Type of equipment</th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC -</th>
<th>MH/WC -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sphygmomanometer</td>
<td>A/S</td>
<td>S</td>
<td>A/S</td>
<td>S</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>A/S</td>
<td>S</td>
<td>A/S</td>
<td>S</td>
</tr>
<tr>
<td>Scale, adult</td>
<td>A/S</td>
<td>S</td>
<td>A/S</td>
<td>S</td>
</tr>
<tr>
<td>Scale, infant</td>
<td>A/S</td>
<td>S</td>
<td>A/S</td>
<td>S</td>
</tr>
<tr>
<td>Obstetrical stethoscope</td>
<td>A/S</td>
<td>S</td>
<td>A/S</td>
<td>S</td>
</tr>
<tr>
<td>Dry heat sterilizer or Autoclave</td>
<td>A/S</td>
<td>S</td>
<td>A/S</td>
<td>S</td>
</tr>
<tr>
<td>Speculum</td>
<td>A/S</td>
<td>I</td>
<td>A/S</td>
<td>I</td>
</tr>
</tbody>
</table>

A/C: Availability/Condition; Q: Quantity; A/S: Available and satisfactory; A/U: Available and
unsatisfactory; U: Unavailable; S: Sufficient quantity; I: Insufficient quantity

In-patient labor and birth care is only provided at the maternity hospitals. No births were observed
during any of the visits. One woman was undergoing a first trimester abortion during a visit to the
MH, but she refused the presence of any of the team members during the abortion.

Abortions are performed using mechanical vacuum aspiration. Vacuum extractors also have electric
pumps, and older, metal cups are being used. Given the low volume of patients, there appeared to
be an adequate number of equipment, though the equipment is out-dated and, by report, requires
frequent repairs.
The only protective clothing being worn is a plastic apron. There are no special shoes or eye shields
(goggles).
Based on WHO standards, the minimum equipment required for immediate newborn care includes a towel or cloth to dry the baby and a towel or blanket to cover the baby. The minimum equipment needed for basic newborn resuscitation includes a heat source, mucus extractor, self-inflating bag of newborn size, 2 masks (for normal and small newborns), and a clock. As seen in Table No. 3, both of the labor and delivery rooms had most of the basic materials for providing either immediate care for the newborn or for basic newborn resuscitation. All of the facilities were using an electric pump for suctioning, with disposable suction catheters. There was no resuscitation equipment in the operating theatre, but this equipment is, by report, brought to the operating theatre by the neonatologist and the midwife when a caesarean operation is being performed.

Only the MH had any stocks of generic medications to treat major infections (urinary tract infection, syphilis, pyelonephritis, postpartum sepsis, etc.), and these supplies were very limited. The labor and delivery rooms had 1% silver nitrate drops for prevention of blinding conjunctivitis due to gonorrhea, and potassium permanganate for cord care. The pharmacy in WC#4 had only two drugs, which were anti-hypertensives, neither of which are first-line drugs for the treatment hypertensive disorders in pregnancy. As seen in Table 4, facilities have only a very minimal stock of anti-infective drugs in their pharmacies, and patients must fill their prescriptions outside, mostly in private pharmacies.
UNICEF reportedly supplies all facilities with iron and folic acid tablets, and these were available in all of the facilities, except FAPs. It is important to note, however, that none of the pregnant women observed were either provided with iron/folic acid tablets or received a prescription for them. Looking at Table 5, it can be seen that all facilities had iron and folate tablets for prevention and treatment of anemia. None of the facilities reported stockouts of these products over the 6 months previous to the visit.

Table 4: Availability (A) and Quantity (Q) of medications for treating infections, by health facility

<table>
<thead>
<tr>
<th>Drugs in stock</th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC-</th>
<th>MH/WC-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin (capsules or injectables)</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Benzathine penicillin (injectable)</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Peni-G or Bi-Peni (injectable)</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Ceftriaxone (injectable)</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Gentamycin (injectable)</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Tetracycline 1% ointment</td>
<td>N/A</td>
<td>N/A</td>
<td>A</td>
<td>S</td>
</tr>
</tbody>
</table>

A: Available; U: Unavailable; S: Sufficient quantity; I: Insufficient quantity
N/A: Not applicable

Table 5: Availability (A) and Quantity (Q) of iron/folic acid tablets by facility

<table>
<thead>
<tr>
<th>Drugs in stock</th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC-</th>
<th>MH/WC-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron + folic acid</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>S</td>
</tr>
</tbody>
</table>

A: Available; U: Unavailable; S: Sufficient quantity; I: Insufficient quantity

Both MH had oxytocin in stock, but it was not kept in the refrigerator and providers did not appear to know that this it needs to be refrigerated. In ____________, ergometrine tablets were available in the antenatal inpatient and immediate postoperative ward, but injectable ergometrine was available only by prescription.

Both of the maternity hospitals had Lidocaine 1% and 2%, to be used for performing episiotomies, suturing in the postpartum period, and also for paracervical blocks during abortion procedures.

In Table 6, both of the MH have magnesium sulphate, which is reportedly the standard treatment for severe preeclampsia and eclampsia. The anti-hypertensive of choice appears to be hydralazine. All of the facilities had crystalloid IV solutions, though the MH in ____________ had only normal saline solution.
Only the MH in ____________ had steroids to be used to improve fetal lung maturity, in the case of premature labor.

Both of the MH had the capacity to provide blood transfusions, but do not have the capacity to check blood for Hepatitis B or HIV.

Table 6: Availability (A) and Quantity (Q) of drugs to treat complications, by facility

<table>
<thead>
<tr>
<th>Drugs in stock</th>
<th>MH/WC-</th>
<th>MH/WC-r</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Magnesium sulphate</td>
<td>Q</td>
<td>Q</td>
</tr>
<tr>
<td>Diazepam (injectable)</td>
<td>A</td>
<td>S</td>
</tr>
<tr>
<td>Hydralazine</td>
<td>A</td>
<td>S</td>
</tr>
<tr>
<td>Oxytocin</td>
<td>A</td>
<td>S</td>
</tr>
<tr>
<td>Ergometrine injectable</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Betamethasone or Dexamethasone</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Lidocaine 1 or 2%</td>
<td>A</td>
<td>S</td>
</tr>
<tr>
<td>Solutions (NS, Glucose, RL)</td>
<td>A (NS)</td>
<td>S</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

A: Available; U: Unavailable; S: Sufficient quantity; I: Insufficient quantity

3.4.2 Laboratory Services
As seen in Table 7, all of the facilities had a laboratory. By report, all of the laboratories were able to measure hemoglobin, perform wet mounts for vaginal smears, test for blood group and type and Rhesus factor, test for syphilis, perform a clotting time determination, hematocrit, sedimentation rate, and white blood count with differential. Additionally, in the ______________ MH, the laboratory could check for blood glucose, C-reactive protein, fibrinogen, and bilirubin.

The laboratories in all of the facilities had to send out for Chlamydia serology and PAP smear.

None of the laboratories could test for toxoplasmosis, HIV, or hepatitis. Although the above tests are theoretically available, the wet mounts in WC#4 were being prepared with distilled water, and it was impossible to make a diagnosis based on wet mounts viewed in the laboratory.
3.5 Physical and logistic infrastructure

3.5.1. Privacy

All of the WC had private rooms for antenatal and postnatal consultations. This would theoretically mean that confidentiality and the privacy of the patient were adequately respected. But in one case, 2 women were being cared for simultaneously. On all other occasions, only 1 patient was accepted into the room at a time, and, in most cases, the provider closed the door to provide privacy.

Both of the MH had delivery rooms with 2 to 3 beds. The beds in the ____________ MH could be separated by curtains. The ____________ MH had two standard delivery tables in the room, with no curtains or dividers between them. In both of the MH, women labored in a separate ward and were only brought into the delivery room when they were in the second stage.

The hospital wards are quite standard—up to 6 beds in the ward, with no dividers between the beds. Women remain alone in the wards, with strict visiting hours. Most of the beds had a bedside stand for each woman, and at least one sink in each room. If running water was not available, buckets and dippers were available.

As can be seen in Table 8, only the wards and the delivery room in ____________MH could improve on the privacy provided for their patients.

### Table 8: Maintenance of patient privacy, by facility

<table>
<thead>
<tr>
<th>Location</th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC</th>
<th>MH/WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal consultation room</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Delivery room</td>
<td>N/A</td>
<td>N/A</td>
<td>A</td>
<td>I</td>
</tr>
<tr>
<td>Ward</td>
<td>N/A</td>
<td>N/A</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>Postnatal consultation room</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

A: Adequate; I: Inadequate; N/A: Not applicable
3.5.2 Water and sanitation
As seen in Table 9, water is a major problem in all the facilities visited. This appears to be due to a municipal problem and an infrastructure problem. Water is not always available from the municipal water supply and, in some cases, the plumbing is old and too expensive to repair.

<table>
<thead>
<tr>
<th>Location</th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC-</th>
<th>MH/WC-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet facilities</td>
<td>A/U</td>
<td>A/U</td>
<td>A/S</td>
<td>A/A</td>
</tr>
<tr>
<td>Water supply</td>
<td>A/U</td>
<td>A/U</td>
<td>A/U</td>
<td>A/A</td>
</tr>
</tbody>
</table>

Table 9: Maintenance of patient privacy, by facility

U: Not available; A/S: Available and satisfactory;
A/A: Available but not satisfactory; N/A: Not applicable

3.5.3 Record keeping
There do not appear to be standard registers for antenatal and postnatal consultations, and information in these registers varied from structure to structure. In many cases, blank spaces were left in areas that should have been filled in.

No partographs were used, although there is a form that has been developed for use in __________ __. It appears that only 2 hospitals in ____________ actually use the partograph. There does not appear to be any written form used to monitor progress in labor or immediately postpartum.

3.6 Quality of Care

3.6.1 Infection prevention
Of the various facilities visited, all were relatively clean, but none had adequate infection-prevention practices in either the WC, the wards, or in the delivery room. Staff members spoke of the need for decontamination, but could not cite the appropriate dilution or process, washed their hands irregularly, and handled waste materials with bare hands.

In all of the facilities except WC#1, decontamination was being carried out using chlorhexidine gluconate. Only the WC#1 was using chlorine for decontamination, and this was a 0.2% solution rather than the recommended 0.5%. Staff apparently knew that chlorine was necessary for decontamination, and that decontamination was important to protect health personnel, but said that chlorine was usually not available and that this was the reason they used chlorhexidine. In all of the facilities, instruments were rinsed in water before being put into the decontamination or disinfectant solution.

Blood spills on the floor were cleaned by cleaning personnel, and blood spills on equipment or beds were cleaned by the nurses and midwives. In the ____________ MH, pure chlorine that was allegedly bought by the staff with their own money, was being used to decontaminate blood spills on the floor. In WC#4, chlorine was used to clean blood spills. In WC#1 and in the ____________ MH, blood spills were cleaned either with chlorhexidine or hydrogen peroxide.

Cleaning, often without scrubbing, was being carried out by using a solution of hot water (50°C), hydrogen peroxide, and detergent. Sterilized vacuum cups were seen to have bloodstains on them. Nurses and midwives used disposable examination gloves to handle instruments while cleaning.
Surgical gloves are being re-sterilized and re-used. By report, the wearer of the gloves washes and rinses the gloves with soap and water before taking them off, they are then put in a chlorhexidine solution, left to dry, have talc applied, and then put into the autoclave. Also by report, providers indicated that gloves are being sterilized at less than 180°C, because the latex gloves could not withstand this high of a temperature.

Sterilization of equipment is being carried out using dry heat. All of the facilities set the temperature at 180°C, and time for 45 to 60 minutes. In one facility, the autoclave was set to 250°C. Gloves were neither individually wrapped nor completely wrapped, and were tightly packed into the individual drums.

Ward beds and bedside stands do not appear to be decontaminated between patients. In WC#4, the foot end of the consultation bed was cleaned with a hydrogen peroxide solution between patients. By report, delivery beds are cleaned with chlorhexidine or decontaminated with 0.2% chlorine solution between patients.

Electric pumps were used for suctioning, vacuum extraction, and mechanical vacuum aspiration. Some elements of the pumps did not appear to be sterilized according to recommended practices, for example, the rubber tubing was left in place between procedures.

The placentas are disposed of in a placenta pit. At the ________ MH, the placenta pit was on the hospital grounds; at the ________ MH, the placenta pit was reportedly far away from the MH and under lock and key, and was therefore not seen by the team visiting the site. From interviews, it appears that proper care is not always taken to handle the placenta with gloves.

None of the facilities had any kind of receptacle for sharps, and sharps were disposed of in the regular garbage bin. Waste was not separated, and general, medical, and hazardous chemical waste were all disposed of in the same place, picked up by the municipal garbage truck, and disposed of in the municipal landfill. In ____________, the person in charge of waste disposal indicated that waste was burned once a week by hospital staff, but when asked to be shown where this was done, the general garbage bin was indicated. Most of the facilities were relatively clean, as seen in Table 10.

### Table 10: General cleanliness in patient areas, by health care facility

<table>
<thead>
<tr>
<th>Location</th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC-</th>
<th>MH/WC-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal consultation room</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Delivery room</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Ward</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Postnatal consultation room</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

A: Adequate I: Inadequate

As seen in Table 11, none of the facilities visited had adequate quantities of sterile and non-sterile gloves, disposable needles and syringes, chlorine, soap, water, buckets for decontamination or washing, or utility gloves to wash instruments.
### Table 11: Availability (A) and Quantity (Q) of consumable supplies for infection prevention, by facility

<table>
<thead>
<tr>
<th></th>
<th>WC #4</th>
<th>WC #1</th>
<th>MH/WC-</th>
<th>MH/WC-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination gloves</td>
<td>A Q</td>
<td>A Q</td>
<td>A Q</td>
<td>A Q</td>
</tr>
<tr>
<td>Sterile gloves</td>
<td>A I</td>
<td>A I</td>
<td>A I</td>
<td>A I</td>
</tr>
<tr>
<td>Disposable needles and syringes</td>
<td>A I</td>
<td>A I</td>
<td>A I</td>
<td>A I</td>
</tr>
<tr>
<td>Chlorine</td>
<td>U A S</td>
<td>A I A</td>
<td>A I A</td>
<td>A I A</td>
</tr>
<tr>
<td>Soap</td>
<td>A I A</td>
<td>A S A</td>
<td>A I A</td>
<td>A I A</td>
</tr>
<tr>
<td>Running water</td>
<td>A I A</td>
<td>A S A</td>
<td>A I A</td>
<td>A I A</td>
</tr>
<tr>
<td>Bucket for decontamination</td>
<td>U A S</td>
<td>U U</td>
<td>U U</td>
<td>U U</td>
</tr>
<tr>
<td>Bucket for cleaning</td>
<td>A I A</td>
<td>A I A</td>
<td>A I A</td>
<td>A I A</td>
</tr>
<tr>
<td>Sterilizer</td>
<td>A S A</td>
<td>A S A</td>
<td>A S A</td>
<td>A S A</td>
</tr>
<tr>
<td>Utility gloves</td>
<td>U U U</td>
<td>U U U</td>
<td>U U U</td>
<td>U U U</td>
</tr>
</tbody>
</table>

A: Available; U: Unavailable; S: Sufficient quantity; I: Insufficient quantity

3.6.2 Monitoring of labor, assisting at birth, and monitoring in the immediate postpartum

As noted above, labor is not monitored with the partograph. When interviewed, the midwives and obstetrician/gynecologists said that fetal heart tones, uterine contractions, maternal vital signs, cervical dilation, and descent of the fetal presenting part were checked every two to six hours until the bag of waters ruptured, and then checked more frequently. When asked how they would evaluate uterine contractions, none of the midwives were able to respond appropriately.

Women are generally allowed to eat and drink during labor, and may ambulate freely except if they are leaking amniotic fluid or blood. When in the labor ward or the delivery room, no family member is allowed to accompany the woman, so she is generally left alone until she begins pushing. On admission, all women receive an enema and are routinely shaved, unless labor is advanced when they arrive. Also on admission, all women’s pelvises are measured, and assessed for “adequacy.” Women labor in one room and are then moved to the delivery room when they reach the second stage.

Women give birth in the supine position only, although personnel at the MH in ________ said that women were allowed to choose alternate positions in the second stage until the head was at the vulva, and then were put into the supine lithotomy position. By report, it did not appear that providers monitored fetal heart rate or maternal vital signs during the second stage. Active management of third stage is not practiced, and midwives and physicians alike spoke of physiological delivery of the placenta with a normal waiting period (with no signs of bleeding) being up to 2 hours after birth of the baby. All placentas and membranes are routinely examined for completeness. Episiotomies are not routinely done except in the case of suspected macrosomia or prolonged second stage. It is not clear whether routine catheterization is done post-delivery. Some of the providers said that they did this routinely, while others said that it was done only if necessary. Oxytocics are not provided unless the woman is bleeding. Some of the physician providers spoke of the necessity of providing oxytocin by IV push if there was severe bleeding.

As noted above, basic material for newborn resuscitation is available in the delivery rooms and
neonatologists are present at all the births should resuscitation be necessary. Babies are weighed and measured as soon as possible after birth. Although in theory babies are to be put to the breast right after birth, this is apparently not applied consistently. One percent silver nitrate is applied to the eyes immediately after birth. Cord care is done with an alcohol/potassium permanganate solution, and cords are covered with a bandage that is replaced when soiled. Babies are tightly swaddled to “keep them quiet.”

Women are kept in the delivery room for monitoring during the first 2 hours postpartum. If there are no problems, vital signs and assessment of uterine hardness/bleeding are done immediately following third stage and repeated after 2 hours. After 2 hours, the women are transferred to the postpartum ward, and then are evaluated daily.

3.6.3 Antenatal and postnatal consultations
The services provided are supposed to be integrated and antenatal and postnatal services were offered every day in all the women’s consultations. In reality, most of the postnatal visits occur at the maternity hospital where the woman gave birth.

Both antenatal and postnatal services appear to be quite ritualistic—all of the elements are carried out, but little clinical decision making was seen, and the majority of women were sent home with little or no counseling and simply the date of the next visit. No midwives or health care providers talked about danger signals, or birth and complication preparedness with pregnant or postpartum clients. In most cases, care was provided by many providers. The nurse checked the weight. The midwife checked the blood pressure. The obstetrician/gynecologist checked the fundal height and circumference, assessed lie and presentation of the fetus (even as early as 18 weeks), and listened for fetal heart sounds. Another physician assessed cardiac function and general well-being, including thyroid function, and the dentist checked the teeth. It does not appear that pregnant women are regularly being given breast examinations.

Anemia was generally assessed by checking the hemoglobin. Prevalence of anemia appears to be between 7% and 12%, but no women observed received iron/folic acid tablets or were given a prescription for them, and no women received counseling about iron- and folate-rich foods. In interviews with pregnant women, it seems that providers are advising that pregnant women should eat meat once a month, eggs once a week, and that it was all right to eat cheese every day. No Vitamin A is provided either antenatally or postpartally.

Prevalence of thyroid disorders is as high as 1%, but there is apparently no problem with cretinism. UNICEF reported that since a country-wide campaign for iodized salt was begun some 10 years ago, the cases of goiter and cretinism has greatly decreased or almost completely disappeared.

Vaginal smears are taken to check for trichomonas, Candida, bacterial vaginosis, and gonorrhea during the first and third trimesters. The reliability of these vaginal smears is, however, doubtful or certainly inadequate at times. Syphilis testing is performed during the first and third trimesters and where there are facilities available, blood samples are sent for Chlamydia serology at the first visit. All women’s blood group and type and Rhesus factor are checked and noted on the card.

The prevalence of syphilis in WC#1 is 0.5%. In contradiction to official MOH statements, the
________ municipality thinks that no interventions for STIs/HIV or adolescents are needed. Only providers in WC#1 felt that STIs were a major problem in both the pregnant and non-pregnant populations.

Women continue to be classified as either “high risk” or “low risk.” Risk category is apparently decided based upon previous obstetric complications, complications identified in this pregnancy (e.g., hypertension, previous cesarean operation), and other factors associated with complications (e.g., short stature, maternal age). So-called “high risk” pregnancies are theoretically supposed to be managed in Yerevan. In fact, most so-called “high risk” pregnant women are hospitalized well in advance of delivery to ensure that they are monitored during pregnancy and give birth at the facility. In the ________ MH, one woman was hospitalized at 34 weeks for obesity, and another woman was hospitalized at 36 weeks for mild preeclampsia.

By report, women, with or without identified complications, are apparently being asked to return for care every 2 weeks. A very brief chart review showed that most women did not return this frequently for antenatal care. Postnatal visits are being provided at the traditional 6-week visit. Nurses carry out home visits for new postpartum women, so it is not deemed important for them to return to the women’s consultation for a visit before 6 weeks, if no pathology is noted.

Women receiving care in WC that are not attached to a MH will be assisted at birth by new providers that did not provide their antenatal care. To facilitate transfer of information, the woman is given a home-based record of antenatal care at 28 weeks that she carries with her to the hospital when she goes into labor. The personnel at the MH fill in information about the birth and the baby, and the woman takes this with her to the facility that will provide well baby and postnatal care services.

3.6.4 Access
Providers at the MH and WC stated that women are coming later and later for care, and do not follow the recommended schedule of visits. Of 6 pregnant women interviewed (one was 4 months pregnant, 2 were 5 months pregnant, 2 were 6 months pregnant, and one was 8 months pregnant) at the _____ FAP, only the woman who was 8 months pregnant had ever received an antenatal visit, and this visit was received when she was 8 months pregnant. None of the pregnant women had received antenatal multivitamins or iron/folic acid tablets, or had received any counseling about birth preparedness, including complications readiness (awareness of danger signals and establishing a plan to receive care if they occur).

By report, there is an increase in the number of home births occurring, but it is extremely difficult to get any concrete information about where and why they exist. This appears to be an extremely sensitive issue and there is some official denial that the problem exists. And there is fear on the part of primary providers and community members to speak about it.

Poverty appears to be a major factor limiting access to all levels of care—antenatal, intrapartum, and postpartum care. Fees for service, the price of drugs, and even the need for nice clothes to go to the WC appear to be prohibitive for many women and are limiting access to care.

3.6.5 Client-Provider Interaction
In all of the consultation rooms, providers were seated behind a large desk and remained seated when
the woman entered. The woman was generally seated on a chair either across from the provider or next to the desk, or sat on the consultation table. There appeared to be very little counseling taking place during any of the visits. Clients did not appear to participate actively in the visit – clients asked very few questions, and providers did not appear to ask for clarification or to give clients the opportunity to speak. In general, the client received care, was given her chart, and then left the room.

3.6.6 Male Involvement

Male involvement in women’s RH appears to be absent. Men bring their wives for antenatal and postnatal visits, but are not invited into the consultation rooms. At the ward, husbands and family members generally must wait outside until they can enter the ward during the very restrictive visiting hours. Neither the ________ nor ________ MH allowed men to be with their wives during labor or assist at the birth.

Providers interviewed felt that:
• Restriction of visiting hours was important to allow women to rest, to allow providers to carry out their tasks, and also to prevent spread of infection; and
• Men could assist during delivery, but felt that most men and women didn’t desire this, and this was not offered as an option to couples.

When asked about male involvement in antenatal and postnatal consultations, providers seemed genuinely puzzled. It appears that male involvement is generally not encouraged or facilitated, mostly because care is being provided using a very traditional medical model.

3.6.7 Adolescent RH

Adolescent RH appears to be an extremely sensitive issue in _______. There appears to be some controversy among providers as to whether or not adolescent RH services are necessary. Some physicians and authorities interviewed at the municipality believe that adolescent girls do not require FP, SM services, or STI services. Other physicians, however, believe that adolescent girls do require these services, but do not feel comfortable seeking the services within the formal health care system.

When speaking about adolescent RH, providers and municipal authorities alike only spoke about RH as it related to adolescent girls. Some physicians and the municipal authorities felt that the only sexually active adolescent girls were ________ girls, or girls who are mildly mentally retarded. The issue of adolescent male sexuality was generally not addressed or discussed.

Review of data at the MH and the WC showed that very few adolescent girls actually seek care in the MHs or WCs. In addition, very few abortions and STIs occurred in girls less than 19 years old.

3.6.8. Caseload and client mix

Caesarean operation rates differed from one MH to the other. The ________ MH has a relatively high rate of caesarean births (13%), while the caesarean birth rate is only 3.5% at the ________ MH. The national average for caesarean operations is 6.3% (RH Survey – 1997). It is not clear why there is such a high rate in ________, but it is supposed that the low rate in ________ is probably due to the fact they are expected to refer caesarean cases to Yerevan. Although the MHs do not theoretically have the right to perform caesarean operations except in cases of unforeseen...
emergencies, both facilities are fully equipped for caesarean operations and perform them on a regular basis. Both of the MHs, however, had very old anesthesia equipment, which was not up to standard. Table 12 summarizes the number of births and maternal and newborn deaths.

### Table 12: Services provided and selected outcomes by facility

<table>
<thead>
<tr>
<th></th>
<th>MH/WC - ________</th>
<th>MH/WC - _______</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last 6 months</td>
<td>Last 6 months</td>
</tr>
<tr>
<td>Births</td>
<td>750</td>
<td>250</td>
</tr>
<tr>
<td>Instrumental births</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Caesarean births</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Ruptured uterus</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stillbirths</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Early newborn deaths (&lt;7d)</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

Of interest is the relatively high number of perinatal deaths (28 weeks gestation to 7 days old). Many of the early neonatal deaths are credited to congenital diseases. These congenital diseases, however, are ill-defined. It appears that any illness apparently present at birth—including congenital syphilis, toxoplasmosis, Chlamydia and pneumonia—are classified as congenital defects. The DHS figures, however, show a 1% prevalence of congenital defects, the same prevalence as in Western Europe and the United States. It is speculated that congenital defects are used to cover any early neonatal deaths to avoid recriminations. Very few autopsies are performed for perinatal deaths.

The absence of maternal deaths is not statistically significant. Given a maternal mortality ratio of 30 deaths/100,000 live births, it is expected, statistically, that a facility that has 1,500 births per year would have only 1 death every 2 years.

**RECOMMENDATIONS**

In conclusion, it was evident that the SM program has many needs. For the action plan in the _______ to respond to these needs, the strategic plan for the Marz must include the following components:

1) **Updating of RH policies:**

At present, there do not appear to be clear RH policies available to guide delivery of RH services. To facilitate access to care and to increase the efficiency of care being provided at facilities, the following components of RH policies need to evaluated and developed:

- Liberalization of policy to allow both nurses and midwives an expanded role (and a new job description) to increase access to services;
- Formalization of a transparent payment system;
- Rationalization of all levels of personnel at all facilities.

2) **Development of standards for the provision of SM services:**

At present, care provided is not standardized and, in many cases, does not follow recommendations of the WHO. This appears to be largely due to the fact that there are no established SM standards.
or, where they are available at a country level, they are not widely disseminated.

The first task will be to identify and coordinate all of the organizations currently developing standards for various components of SM care. Once all of the standards have been identified, these will need to be harmonized and missing components identified and developed.

Standards should be developed by a large representation of stakeholders, policy makers, MOH officials, and clinicians. Once developed, they should go through a process of review, revision, pretesting, revision, finalization, and dissemination.

3) Updating of personnel:
All providers require knowledge and skill updates in the following areas to ensure that care being provided is evidence-based, state-of-the-art, and in conformity with soon-to-be established ________ standards of care:

- Antenatal care: Basic care, care for complications, emergency care;
- Intrapartum care: Basic care, care for complications, emergency care;
- Postpartum care: Basic care, care for complications, emergency care; and

To assist providers in acquisition and maintenance of new skills and knowledge, job aids should either be developed or adapted for the ________ context and widely disseminated.

In addition to providing updates, to ensure that providers have access to new information as it evolves, it would be beneficial to:

- Install medical libraries at medical centers; and
- Develop a system of ordering and disseminating journals, publications, and books.

4) Provision of equipment, supplies, and drugs:
To provide quality care, all of the facilities require functioning, modern equipment and a system to ensure that equipment is not only properly maintained, but also replaced when necessary. In addition to equipment, facilities need to have a management system that enables facilities to stock and order necessary supplies and drugs.

Because it is not XXXXXXXXXXX’s mandate to supply or equip health facilities, it will be necessary to collaborate with organizations working in ________ that can both supply equipment, supplies, and drugs, and also assist facilities to develop systems to ensure adequate stocks and properly functioning equipment.

5) Community mobilization:
Given the increasing number of home births and the fact that women are either choosing not to seek antenatal care, or are doing so very late in their pregnancies, efforts need to be made to work with communities to

- Develop community mechanisms to establish funds for emergency care and transport;
- Develop community mechanisms to establish a transport system for emergency care; and
- Develop a system to bring physicians to the village level to provide preventive care services, such as antenatal care and postnatal care.
XXXXXXX will need to work closely with its partner, __________, who has broad experience in the area of community funds and transport systems.

6) Male involvement:
Although male involvement does not yet appear to be a priority in ________, the working group (with Dr. _________________ as coordinator) believes that male involvement is important to increase the effectiveness and impact of SM care on maternal and neonatal morbidity and mortality. Male involvement should therefore be included as a component in all women’s RH subjects.

7) Adolescent health:
Surveys and anecdotal data show that female adolescent sexual activity is very rare, however, data about sexual activity among adolescent boys is much less clear. It is advisable that all national and international organizations working in RH should be aware of any ongoing studies in ________ that can help clarify the state of adolescent sexual and reproductive health in ________. 
Participant Handout 3.1: Steps in Developing a Training Implementation Plan

<table>
<thead>
<tr>
<th>Questions</th>
<th>Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the problem?</td>
<td>Identify Training Topics</td>
</tr>
<tr>
<td>2. Who are the participants?</td>
<td>Choose participants.</td>
</tr>
<tr>
<td>3. What will participants be able to do after the training?</td>
<td>Develop training objectives.</td>
</tr>
<tr>
<td>4. What will they be trained on?</td>
<td>Decide on the training content.</td>
</tr>
<tr>
<td>5. What methodologies will be used?</td>
<td>Identify the training methodologies.</td>
</tr>
<tr>
<td>6. What materials/training aids will be needed?</td>
<td>Prepare training materials and training aids.</td>
</tr>
<tr>
<td>7. When/where will the training be conducted?</td>
<td>Decide on the time and location.</td>
</tr>
<tr>
<td>8. How will the training be evaluated?</td>
<td>Decide on the methods of evaluation.</td>
</tr>
<tr>
<td>9. Who will be the trainers?</td>
<td>Choose the trainers.</td>
</tr>
<tr>
<td>10. Where will funding be allocated?</td>
<td>Identify the source of funding.</td>
</tr>
</tbody>
</table>
Participant Handout 3.2: Questions for Planning Training

The 10 planning questions should be used as a planning aid. The questions should be addressed in a sequential order, since each question builds on answers from the previous question.

1. What is the problem or opportunity?
   You should clearly define the problem and ascertain that training will help solve the problem.

2. Who are the trainees?
   You should identify whose job performance contributes to the problem. Once you know who the trainees will be, you can target learning objectives to the trainees’ current level of knowledge and skill and develop appropriate training methods and materials.

3. What do I want the trainees to be able to do after they’ve finished the training?
   You should write clear goals and learning objectives, determine the training content, select appropriate training methods and materials, and establish criteria and methods for training evaluation. The key is focusing on what the trainee must know.

4. What will they be trained on?
   You should determine the training content, select appropriate training methods and materials, and establish criteria and methods for training evaluation. The key is focusing on what the trainee must know.

5. Where and for how long will the training take place?
   You should select a training site that is convenient and appropriate to the trainers and trainees. Training resources and constraints are identified in this process.

6. What training methods will I use?
   You should use methods that directly relate to the problem. They should build on trainees’ previous experience, provide practice in the areas specified in the learning objectives, and be consistent with the available time, facilities, and other resources.

7. What training materials do I need?
   You should use training materials that directly relate to the problem. They should use the learning experience of the trainees, transfer or reinforce knowledge, be suitable to the resources and constraints, and support the use of the selected training methods.

8. When and where will the training be conducted?
   You should decide on a time and location for the training.

9. Who will be the trainers?
   You should decide on the trainers based on their expertise and the knowledge and skills you expect the trainees to gain during the training.

10. How will I know how effective the training was?
    You should use appropriate evaluation methods and measures that address specific job
performance problems, measure the trainees’ mastery of the learning objectives, and use methods and materials from the training in the evaluation.

The information gathered from answering these 10 questions should be used to develop a training implementation plan.

Participant Handout 3.3: The Training Implementation Plan

The training implementation plan does not have to be elaborate. It simply identifies:

- The purpose of the training;
- Goals and objectives;
- Who will be trained;
- Selection criteria for participants;
- Type of provider;
- Type of facility the providers are practicing in;
- Who will be the trainers;
- Selection criteria for trainers;
- Names of trainers;
- Where will the training take place;
- Training site criteria;
- Training site selection;
- Clinical training site criteria;
- Clinical training site selection;
- Plans for development of the clinical training site, if necessary;
- What will be accomplished (the learning outcomes for the participants);
- Knowledge, attitude, and skill learning outcomes;
- What will be said or presented (the content of training);
- What will be communicated (the training methods and materials);
- An estimate of the length of training;
- How the learning will be assessed; and
- How the training will be evaluated.
Participant Handout 3.4: Selecting Participants

Common Problems
There are several problems in selecting participants that occur often:
- There may be too many or too few.
- They may not come with the necessary skills to be able to use the training (For example, nurses coming to learn IUD insertion who have never done a pelvic examination).
- The participants won’t or can’t stay for the whole day or the whole training.
- The participants have different skill levels or different professions so the training may not be appropriate for some or some may have to wait while others catch up.
- Participants can’t practice their skills following the training. (For example, a midwife is taught IUD insertion, but has no physician in her clinic to supervise her, or is simply not allowed to practice the skill.)
- Trainees move or are reassigned after training.

Solutions to Some of the Common Problems
- Provide written criteria for the selection of participants.
- Make sure the selected participants have an interest in providing reproductive health services and that they have the appropriate clinical background to learn the new skills.
- Get commitment from those more senior to the participant, that they will be able to practice their new skill. This may be the clinic manager, the supervisor, or someone even higher in the private or public sector.
- Commit to rejecting inappropriate participants based on the selection criteria.
- Make selection of participants competitive based on submission of a proposal or written document.
- Try to accommodate different groups of participants by staggering times. (For example, physicians start and leave early, nurses and midwives overlap, but come late and leave late.)
- Send some participants home, but offer training at a later time.
- If there are too many participants, structure the training to accommodate them by creating group work and exercises.
- Be flexible and creative in trying to solve problems related to selection.
- Motivate participants by rewarding them with technical material and certificates.

Selection Criteria
Before any training takes place training staff must develop criteria for selection of participants. These include:
- Level of competency, length of service in the topic area that is included in training.
- Trainees should be able to participate in the whole training course.
- The trainee should continue to practice in the topic area of training.
- The trainees should work in a setting where they can practice their new skills. This means that in addition to being permitted to provide the skill, the new trainee must have the equipment and support necessary.
UNIT 1:
AN OVERVIEW OF THE IUD

Introduction:
At the end of this module, the participant will be able to describe the IUD as an effective child spacing method; counsel and screen clients seeking IUDs; provide insertion and removal services for IUD clients; manage side effects and provide follow up care for IUD acceptors.

Unit Training Objective:
To prepare participants to describe the IUD as an effective child spacing method and counsel, screen and select, refer for insertion/removal, and manage and follow up IUD clients.

Specific Learning Objectives:
By the end of the unit, participants will be able to:
1. Explain key messages related to the IUD as a safe and effective child spacing method.
2. Describe the types of IUDs available, the mechanism of action, and effectiveness of the IUD.
3. Explain major advantages and disadvantages of the IUD.
4. Describe indications for using the IUD and rationale for each.
5. Identify eligibility criteria for initiating use of the IUD, and explain rationale for each.
6. Using an assessment checklist, screen a potential IUD client, and refer for insertion or removal.
7. Discuss when to insert and remove an IUD.
8. Using general terms, describe IUD insertion and removal procedures to clients.
9. Describe the early warning signs of IUD complications.
10. Recognize and manage common IUD side effects.
11. Demonstrate effective IUD counseling in role play exercise.

Simulated Skill Practice:
- Discuss and solve IUD case studies related to client selection, screening, and management of common side effects and complications.
- Through role play exercises using counseling and history checklists, demonstrate method specific counseling of a family planning client: to include pre and post insertion counseling and instructions, client screening and selection, and counseling when managing a client with common side effects and complications.

Clinical Practicum Objectives:
During the clinical practicum, participants will be able to:
- Counsel potential IUD clients using the IUD counseling skills checklist, including pre/post insertion and follow up counseling.
- Screen potential IUD clients using the Case History Checklist for IUD Users.
- Manage IUD clients experiencing common side effects or other problems, and refer if necessary.
- Document counseling services and other pertinent information on IUD clients seen in the clinic.

Note: No minimum number of clients is specified for certification. The number will vary, and the
practicum will be considered complete when the trainer is satisfied and prepared to certify that the participant is proficient.

Training/Learning Methodology:

- Trainer Presentations
- Class Discussions
- Required Reading
- Case Studies
- Case History Checklist for IUD Users
- Learning Guide for IUD Counseling
- Counseling Role Plays
- Clinical Practicum

Major References And Training Materials:


Resource Requirements:

- Hand held IUD models
- IUD samples
- Flipchart
- Marking pens
- Masking tape
- Overhead projector
- Large picture of female pelvic organs (or Transparency 1.2)
- Large picture of female pelvic organs with IUD in place (or Transparency 1.3)
• Life size pelvic models
• Hand held uterine models

**Evaluation Methods:**
• Pre- and post-test
• Observation and assessment of participant during role-play, utilizing Learning Guide for IUD Counseling Skills
• Observation and assessment of participant during clinical practicum, utilizing Checklist for IUD Counseling and Clinical Skills

**IUD Counseling and Clinical Skills**
• Trainer administered examination
• Verbal feedback
• Participant reaction questionnaire

**Time Required:**
Unit 1: 7.5 hours
Clinical practicum: Up to 6.0 hours (estimated)

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**Materials For Trainers To Prepare In Advance:**

1. Unit 1 Transparencies
2. Participant Handouts
3. Samples of IUDs, pelvic models, and uterine models
4. Prepare flipcharts on:
   • Key messages
   • Times for IUD insertion

---

After the needs assessment has been completed, the next step is to design the training program. The first step in this process is to write the learning objectives.

The learning objectives are outcomes of what the trainee will be able to do at the end of the training. The learning objectives serve as the basis for the design of the whole instructional plan. No training material can be written until the objectives are in place.

**Why should we use learning objectives?**
- To provide direction.
- To provide guidelines for testing.
- To convey the intent of learning to others.

**Levels of objectives**
There are 2 levels of learning objectives: general and specific.

A general objective describes the task participants will be able to do after training. General objectives are related to professional jobs or tasks.

A specific objective describes what the participant will know or be able to do after the completion of a section of training. This is also known as the KAS, or knowledge and skills, required to achieve the primary objective.

**How do you write a learning objective?**
There are 4 main components to writing a specific learning objective.

1. Identify when the knowledge or performance is to be demonstrated.
   - Specify the section of training to be completed in order to demonstrate the expected level of knowledge, behavior, or performance
     - After completing this chapter,
     - After completing this module,
     - After completing this course,
     - After completing these four sessions, and
     - After completing this lesson.

2. Identify who is to demonstrate competency.
   - The trainee is stated as part of the specific objective. This may be a participant, trainee, or clinician.

3. Provide a description of the expected performance.
   - This portion of the objective states what the individual will know or be able to do. These are the major knowledge, skills, and attitudes identified during a needs assessment. The statement should begin with an action verb which is followed by the object of that action, such as:
     - Counsel a client,
     - Insert an IUD,
• Perform an MVA procedure for postabortion care,
• Sterilize instruments using a steam sterilizer, or
• Identify indications and precautions in the use of DMPA.

4. Describe how well the performance must be demonstrated.
   When participants will be tested or evaluated to measure their acquisition of the knowledge and skills presented in the section of training, a standard for performance must be included in the objective.
   Examples:
   • With 90% accuracy.
   • As outlined in the competency-based checklist.
   • By scoring 85% or more on the midcourse questionnaire.

   The part of the objective indicating the standard typically begins with the following statement: “Competency will be demonstrated by....”

   Example: After completing this session, the participant will be able to demonstrate the recommended infection prevention practices to use when inserting Norplant capsules. Competency will be demonstrated by correctly performing all infection prevention procedures.

   If both knowledge and skills are going to be assessed, then the standard for both should appear in the objective.

   The formula below can be used to begin writing objectives:

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

   _______(an action word) __________________________
   _______(item) __________________________
   _______(condition) __________________________
   _______(standard) __________________________
Example:

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

Load (the action word)
The Copper T 380A (item)
While it is still inside the sterile package (condition)
Without touching it directly (standard)

It is not always possible to include the condition and standard in the learning objective. For some objectives related to training trainers, there is not a standard or condition.

There are different objectives for the 3 areas of skill development.

Attitude: The objectives that address attitude relate to feelings, attitudes, and values. Use these when you want to change people’s attitudes or increase their awareness or sensitivity to certain issues or ideas.

The key action verbs for attitude are:
adjust analyze assess
choose criticize decide
evaluate pick select

Skill: The objectives that address skill relate to behavior. They focus on being able to perform a task or procedure.

The key action verbs for skill are:
assemble compute construct
count demonstrate design
develop draw measure
prepare process prove
record repair solve

Knowledge: The objectives that address knowledge have to do with content or cognitive learning. They relate to the ability to demonstrate what has been learned, to understand information, and to analyze concepts.
The key action verbs for knowledge are:

- analyze
- assess
- compare
- contrast
- describe
- differentiate
- enumerate
- explain
- list
- name
- relate
- repeat
- summarize
- define
- distinguish
- identify
- recognize
- reproduce

There are certain words to **avoid** using as action verbs because they are not objective and cannot be measured: appreciate, believe, internalize, know, realize, understand, discriminate, or estimate.

It is important when writing learning objectives that for each objective, you identify one significant attitude, skill, or piece of knowledge that will be learned in the training. Refrain from writing learning objectives that are so detailed or numerous that they are not useful. Do not break down objectives to such a minute level that they are not comprehensive. For example, “By the end of the session, the trainee will be able to properly fill out a training registration form.” This is not really a learning objective since most trainees will already have the skills and knowledge needed to fill out such a form. In addition, the level of detail is too specific. A better example of a learning objective would be, “By the end of the session, the trainee will be able to explain the interaction between HIV infection and STDs.”
Participant Handout 3.7: Examples of Objectives

A general objective describes the task participants will be able to do after training. General objectives are related to professional job or tasks.

**Examples:**

From an Infection Prevention Course:
After attending this course in infection prevention, the participant will be able to use simple, inexpensive infection prevention practices and will have the knowledge and skills needed to establish or improve infection prevention practices in her/his home institution. The participant will have a positive attitude toward the benefits of using appropriate infection prevention practices.

From a Norplant Training Course:
After attending this session of the Norplant implants training course, the participant will be able to identify indications and precautions (warnings) for Norplant implants use. Competency will be demonstrated by scoring at least 85% on the Indications and Precautions section of the midcourse questionnaire.

A specific objective describes what the participant will know or be able to do after the completion of a section of training. This is also known as the KAS, or knowledge and skills, required to achieve the primary objective.

**Examples:**

From a DMPA Training Course:
After completing this session, the participant will be able to demonstrate the recommended infection prevention practices to use when disposing of needles used for injection.

From a TOT:
By the end of this unit, the participant will be able to:
- Describe how to develop a training plan,
- Develop pre and post-tests,
- Demonstrate advanced brainstorming techniques, and
- Develop competency based checklists.

From an IUD Training Course:
By the end of this unit, the participant will be able to:
- Explain the major advantages and disadvantages of the IUD;
- Using general terms, describe IUD insertion and removal procedures to clients; and
- Recognize and manage common IUD side effects.
Participant Handout 3.8: Training Methods and Materials

Once the curriculum developer has developed the training goals, objectives, and activities the next step in the design process is to select the methods for the actual training. There are many methods to choose from, but it is important that the method chosen matches the objectives. When selecting a training method, answer the following questions:

1. Is this method appropriate for the objectives?
   If the objectives are in the knowledge area, selecting a method related to the skill area may be inappropriate.

2. Are there sufficient trainers available to use this training method?
   Some methods require more than one trainer and could pose a problem in a single-trainer situation.

3. Are there resources available to use this training method?
   Some methods of training require additional materials, supplies, and equipment.

4. Are clinical facilities required?
   Many clinical training courses have a need for clinic sites. Is client load sufficient to support the clinical training requirements? Are there adequate quantities of equipment and supplies at the clinical sites to conduct training?

5. What is the projected size of the group to be trained?
   Some methods are more appropriate for a small group than for a larger group. This is an important consideration, because selection of an inappropriate method can have a negative impact on the training environment. For example, a training skills workshop could have as many as 15 to 20 participants, while the ideal size for a clinical skills course (e.g., IUD insertion or Norplant implants) is 10. The size of the group that can be accommodated is, of course, ultimately dependent upon the number of trainers, caseload, and the training facilities.

6. Is a special classroom arrangement required?
   Some methods require a special classroom arrangement. Not only must the room be able to accommodate this arrangement, but the trainer must be aware of the special setup in advance.

7. Is this method appropriate for group training, individualized training, or both?
   A method must be appropriate either for group or individual training before it can be effectively used for that purpose.

8. What times are available for training?
   Will training be conducted during the workday? After hours? One-hour periods? All day? On the job? The times available for training affect the design, training methods, and trainer’s attitude as well as the attitudes of the participants. For example, when training lasts all day it is important to build in several small-group activities.

9. What is the background of the participants?
   The design of a course for participants receiving refresher training in laparoscopy will differ from a training course for preservice students in anatomy and physiology. The trainer must gather as much
information as possible about the participants to select the most appropriate training methods.

10. **Will the methods selected stimulate interest and provide variety?**
Even the most exciting training method becomes boring if it is over used. The trainer should select methods that will stimulate interest and should change methods as needed to provide variety.

To select training methods:
- Read the training objectives,
- Review the definitions of the various training methods, and
- Consider the appropriate area(s) for each method and the advantages and limitations of each.

The designer should use the matrix to consider:
- Requirements for more than one trainer,
- Additional equipment and materials required,
- Need for a clinic site,
- Group size, and
- Special classroom arrangements.

This information, coupled with the type of training, will ensure that appropriate training methods are selected for the course. The following example illustrates how various factors influence the selection of training methods. In each example there is an objective, a specific course format, and other factors that must be taken into consideration when selecting appropriate training methods.

**Example:**
**IUD Insertion**
Objective: After completing this course the clinician will be able to provide method-specific counseling and insert an IUD. Competency will be demonstrated by correctly counseling the client and competently inserting an IUD following the steps outlined in the competency-based checklist.

Factors to consider: This objective is the basis for a set of trainer’s notes used by 1 trainer to conduct training for groups of 4 clinicians.

**Training Methods**
The trainer may:
- Select the illustrated lecture to present facts and knowledge.
- Use a discussion to follow the illustrated lecture and focus on areas where the participants have prior knowledge and experience.
- Use case studies with clinical examples similar to those the clinicians will face on the job. A discussion may be used following the case study method.
- Practice counseling using role play.
- Organize a panel discussion, focusing on appropriate client selection for IUD.
- Use demonstration, coaching, and guided practice with a pelvic model until competency is demonstrated. Then the participants will work with actual clients.

Training Materials
Training materials are critical in the delivery of training. Their effective use can ensure that a variety of learning stimuli are used during training. Integrating different types of materials into training will help maintain the interest and attention of Px. Also, each person in a training course will have a different learning style. By using a variety of training materials the trainer is more likely to meet the needs of all Px.

Some concepts and principles are best presented through the use of specific materials. When selecting training materials, the instructional designer should keep in mind that, just as for training methods, the excessive use of any one type of material will decrease its effectiveness.

There are five general classifications of training materials. These include:

- Printed materials,
- Non-projected materials,
- Projected materials,
- Audiovisual materials, and
- Computer-based materials.
Participant Handout 3.9: Course Description

Course goals:

Participant learning objectives:

Training/learning methods:

Training materials:

Participant selection criteria:

Method of evaluation:

Participant:

Course:

Course duration:

Selected course composition:
## Participant Handout 3.10: Sample Course Outline

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives / Activities</th>
<th>Training / Learning Methods</th>
<th>Resource Materials</th>
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Participant Handout 3.11: Sample IUD Course Topics

IUD Training Course

Unit 1: An Overview of the IUD  Total Time 7.6 Hours

- Introduction 10 min.
- Pretest 30 min.
- Key Messages 15 min.
- Types of IUDs 30 min.
- Major Advantages and Disadvantages 30 min.
- Appropriate Users of the IUD 20 min.
- Eligibility Criteria for the IUD 30 min.
- Screening Potential IUD Clients 60 min.
- When to Insert and Remove IUDs 30 min.
- Describing IUD Insertion and Removal to Clients 15 min.
- Early Warning Signs of IUD Complications 20 min.
- Common IUD Side Effects 1 hour
- IUD Counseling 60 min.
- Summary 20 min.
- Post-test 30 min.

Unit 2: Providing IUD Services  Total Time 11.75 Hours

- Taking a History for IUD Screening 90 min.
- Load a TCu 380A in the Sterile Package 30 min.
- Steps in IUD Insertion and Removal 4 hours
- Infection Prevention for IUD Services 45 min.
- Follow Up Management for IUD Clients 2.5 hours
- Facilities and Recordkeeping for IUD Services 1 hour
- Pre- and Postinsertion Counseling 2 hours

Clinical Practicum  6 hours (estimated)


Pre- and Post-test

- Unit 1 Participant Copy 145
- Unit 1 Answer Key 149
- Unit 2 Participant Copy 153
- Unit 2 Answer Key 155

Participant Evaluation Form 157
NOTES TO THE TRAINER

PURPOSE

This training manual is designed for use as part of the comprehensive family planning and reproductive health training of service providers. It is designed to be used to train physicians, nurses, and midwives.

This manual is designed to actively involve the participants in the learning process. Sessions include simulation skills practice, discussions, case studies, role plays, and clinical practice using objective knowledge, attitude, and skills checklists.

At the end of this module, the participant will be able to describe the IUD as an effective family planning method, counsel and screen clients seeking IUDs, provide insertion and removal services for IUD clients, manage side effects, and provide follow-up care for IUD acceptors.

DESIGN

The training curriculum consists of 15 modules.

1. Introduction/Overview
2. Infection Prevention
3. Counseling
4. Combined Oral Contraceptives and Progestin-only Pills
5. Emergency Contraceptive Pills
6. DMPA Injectable Contraceptives
7. Intrauterine Devices
8. Breastfeeding and Lactational Amenorrhea Method
9. Condoms and Spermicides
10. Voluntary Surgical Contraception
11. MVA for Treatment of Incomplete Abortion
12. Reproductive Tract Infections
13. Postpartum/Postabortion Contraception
14. Training of Trainers
15. Quality of Care

Included in each module is a set of knowledge assessment questions, skills checklists, trainer resources, participant materials, training evaluation tools, and a bibliography.

SUGGESTIONS FOR USE

• The modules are designed to provide flexibility in planning, conducting, and evaluating the training course.
• The curriculum is designed to allow trainers to formulate their own training schedule based on results from training needs assessments.
• The modules can be used independently of each other.
• The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
• In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, the overall objective, general, and specific objectives are presented in terms of achievable changes in these three areas.
• Training references and resource materials for trainers and participants are identified.
• Each module is divided into a Trainer’s Module and Appendix section.
• The Trainer’s Module presents the information in two columns:
  1. Content, which contains the necessary technical information.
  2. Training/Learning Methods, which contains the training methodology (lecture, role play, discussion, etc.) by which the information should be conveyed and the time required to complete each activity.
• This module is divided into two units. Unit 1 provides an overview of the IUD, while Unit 2 covers the clinical procedure. A training design section is included at the beginning of each unit. It includes the following: an Introduction to the unit, the unit training objectives, specific learning objectives, a simulated skills practicum section, clinical practicum objectives, the training/learning methodology, major references and training materials, resource requirements, evaluation methods, time required, and what materials need to be prepared in advance.
• The Appendix section contains:
  o Participant handouts,
  o Transparencies,
  o Pre- and post-tests (participant copy and master copy with key), and
  o A participant evaluation form.
• The participant handouts are referred to in the Training/Learning Methods sections of the curriculum and include a number of different materials and exercises, ranging from recapitulations of the technical information from the Content of the module to role play descriptions, skills checklists, and case studies.
• The participant handouts should be photocopied for the trainees and distributed to them in a folder or binder to ensure that they are kept together as a technical resource after the training course has ended.
• Transparency masters have been prepared where called for in the text. These should be copied onto clear overhead sheets for display during the training sessions.
• The participant evaluation form should also be copied to receive the trainees’ feedback to improve future training courses.
• The Methodologies section is a resource for trainers for the effective use of demonstration/return demonstration in training.

To ensure appropriate application of learning from the classroom setting to clinical practice, clinical practicum sessions are an important part of this training. For consistency in the philosophy of client’s rights, the following should be shared with participants, in preparation for their clinical practicum experiences:

CLIENT’S RIGHTS DURING CLINICAL TRAINING

The client’s right to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination it should be carried out in
an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g., service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).

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

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

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and be conducted without reference to the client by name (AVSC, “Tips for Trainers-8,” September 1994; NSV Trainer’s Manual).

DEMONSTRATION TECHNIQUE

The Five-Step Method of Demonstration and Return Demonstration is a training technique useful in the transfer of skills. The technique is used to make sure that participants become competent in certain skills. It can be used to develop skills in cleaning soiled instruments, high-level disinfection, IUD insertion, pill dispensing, performing a general physical examination, performing a breast or pelvic examination, etc. In short, it can be used for any skill which requires a demonstration. The following are the 5 steps:

1. **Overall Picture:** Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed according to the steps in the skills checklist, on models in the classroom and practiced until participants become proficient in each skill and before they perform them in a clinical situation.

2. **Trainer Demonstration:** The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role playing participant as s/he would to a real client.

3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while the
participant verbally repeats the step-by-step procedure.

*Note:* The trainer does *not* demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.

4. **Participant Talk-Through:** The participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.

5. **Guided Practice:** In this final step, participants are asked to form pairs. Each participant practices the demonstration with her/his partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.
DO’S AND DON’TS OF TRAINING

The following “do’s and don’ts” should ALWAYS be kept in mind by the trainer during any learning session.

DO’S

• Do maintain good eye contact.
• Do prepare in advance.
• Do involve participants.
• Do use visual aids.
• Do speak clearly.
• Do speak loud enough.
• Do encourage questions.
• Do recap at the end of each session.
• Do bridge one topic to the next.
• Do encourage participation.
• Do write clearly and boldly.
• Do summarize.
• Do use logical sequencing of topics.
• Do use good time management.
• Do K.I.S. (Keep It Simple).
• Do give feedback.
• Do position visuals so everyone can see them.
• Do avoid distracting mannerisms and distractions in the room.
• Do be aware of the participants’ body language.
• Do keep the group on focused on the task.
• Do provide clear instructions.
• Do check to see if your instructions are understood.
• Do evaluate as you go.
• Do be patient.

DON’TS

• Don’t talk to the flip chart.
• Don’t block the visual aids.
• Don’t stand in one spot—move around the room.
• Don’t ignore the participants’ comments and feedback (verbal and non-verbal).
• Don’t read from curriculum.
• Don’t shout at participants.
Participant Handout 3.12: Pilot Testing a Curriculum

Before you implement training, it should be pilot tested in 1 location. When you pilot test a training curriculum, you are implementing it on a small scale. This allows you to evaluate:

1. **Whether the training materials are effective:** Are goals and objectives for the training course met? Were materials easy to use for both trainers and participants? Were the learning activities appropriate for helping participants acquire knowledge, skills, or attitudes outlined in the particular goal or objective?

2. **If the time allocated for different activities is sufficient:** Was time allotted for classroom activities sufficient? Was too much time allotted? Was time allotted for clinical activities sufficient? Was too much time allotted?

3. **Whether changes need to be made to the content:** Was all essential content included to meet the goals and objectives? Was there content included that was not essential and could be deleted?

4. **Whether tools developed to assess participants’ progress are appropriate:** Did knowledge tests reflect the knowledge objectives? Did checklists reflect skills that were being assessed?

The trainer should keep good notes of the training times and exercises or content that need to be changed. After the pilot test is conducted and evaluated, changes should be made to the training curriculum to address problem areas.

Keep the following **points in mind** when pilot testing:

1. Develop a plan for pilot testing the new curriculum. Plan to meet any deadlines listed as part of the plan.

2. Develop forms that can be filled out by the trainers and participants to evaluate the curriculum.

3. Appoint a person or subcommittee to tabulate the results of the pilot test, interpret the findings, and make recommendations to the appropriate curriculum committee based on those findings. This information should be summarized in a brief report (1 or 2 pages).

4. Use the results of the pilot test process! If changes are recommended by users, plan to revise the curriculum before it is developed, duplicated, or re-printed. If comments are made that would be useful to people developing similar publications, be sure to share these results. When you are working with the feedback from the pilot test forms, be fair with the results you receive. If you do receive negative feedback, approach it as objectively as possible and plan to use this feedback to improve this curriculum and also to produce better publications in the future.

5. Pilot testing not only provides necessary information for the approval of a curriculum, it also is a valuable method of measuring impact achieved from programs and the curricula used in them.
Participant Handout 3.13: The Importance of Developing Tools to Assess Knowledge and Skills

Why assessment is needed?
• To determine whether training achieved its objectives.
• To assess the value of training programs.
• To identify areas of the program that need improvement.
• To identify the appropriate audience for future programs.
• To review and reinforce key program points for participants.
• To sell the program to managers and participants.

What to assess?
Assessment must focus on the 3 aspects of training, knowledge, attitude and skills. Attitudes are the most difficult to measure because they are like opinions or prejudices, and are generally part of a person’s background and personality, hidden below the surface. Attitude that can be measured is shown by communication skills, counseling skills, or clinical skills.

When do we assess?
• On a daily basis.
• During the training program.
• At the end of the training program.
• After participants have returned to their work sites.

Characteristics of Knowledge-Based Assessment Instruments
Measuring an individual’s acquisition of knowledge using an assessment instrument or test is a complex process. To measure knowledge acquisition effectively, a test must be well-designed. A good test
• Measures accurately what it is supposed to measure (validity),
• Measures consistently what it is designed to measure (reliability),
• Is objective (objectivity),
• Differentiates between participants who do and do not know the information (discrimination),
• Contains a liberal sampling of items across all training objectives (comprehensiveness), and
• Is easy to use (ease of administration and scoring).

Assembling a Knowledge-Based Assessment
After a group of test items has been reviewed and edited, selected items are organized to form the knowledge test or questionnaire. For this to be done properly the designer must decide the number of items that will be included and the order in which the items will be presented to the participants. Directions for the participants and a scoring key must be developed. Each of these steps must be taken carefully for the test items to realize their maximum value.
• Test items should be organized on the basis of 1 or more of 3 characteristics: the subject matter, type of item, and level of difficulty.
• The participants need a complete understanding of the ground rules under which they will take the test.
After the test is assembled and the directions are written, it is a good policy to review each part critically. The designer should consider each item from the participants’ point of view. The grammar should be checked and the following questions asked:

- Are there questions that cover all the objectives covered by this test?
- Does the number of test items adequately reflect the amount of time spent per objective?
- Is the number of items included in the test in direct proportion to their importance in training?
- Does each item really measure the participants’ attainment of the objective? If not, how could it be revised to do so?
- Is each set of directions clear? Do the directions apply to every item in the group, or do some items require specific directions?
- Is there plenty of space to write the response?
- Are tricky, obvious, or irrelevant questions avoided?
- Is each item separate and independent from the rest of the items?
- Are similar items grouped together?
- Is the test designed so that it is easy to score?
- Will participants be provided with meaningful feedback about their answers?

When possible, the test should be pilot tested before it is used in regular training programs. After the test has been administered to 1 or 2 groups of participants, the designer needs to analyze and improve it. The weaknesses that are revealed should be corrected and the test continually revised.
Learning Guide and Checklist for Bimanual Compression

LEARNING GUIDE 4.1 BIMANUAL COMPRESSION OF THE UTERUS
(To be completed by participants)

Rate the performance of each step or task observed using the following rating scale:
1. Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted.
2. Competently Performed: Step or task performed correctly in proper sequence (if necessary) but learner does not progress from step to step efficiently.
3. Proficiently Performed: Step or task efficiently and precisely performed in the proper sequence (if necessary).

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
<td></td>
</tr>
<tr>
<td>1. Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>2. Provide continual emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td>3. Put on personal protective barriers.</td>
<td></td>
</tr>
<tr>
<td>BIMANUAL COMPRESSION</td>
<td></td>
</tr>
<tr>
<td>1. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>2. Put high-level disinfected or sterile surgical gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>3. Clean the vulva and perineum with antiseptic solution.</td>
<td></td>
</tr>
<tr>
<td>4. Insert one hand into the vagina and form a fist.</td>
<td></td>
</tr>
<tr>
<td>5. Place the fist into the anterior vaginal fornix and apply pressure against the anterior wall of the uterus.</td>
<td></td>
</tr>
<tr>
<td>6. Place the other hand on the abdomen behind the uterus.</td>
<td></td>
</tr>
<tr>
<td>7. Press the abdominal hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.</td>
<td></td>
</tr>
<tr>
<td>8. Maintain compression until bleeding is controlled and the uterus contracts.</td>
<td></td>
</tr>
<tr>
<td>POSTPROCEDURE TASKS</td>
<td></td>
</tr>
<tr>
<td>1. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out.</td>
<td></td>
</tr>
<tr>
<td>• If disposing of gloves, place them in a leak-proof container or plastic bag.</td>
<td></td>
</tr>
<tr>
<td>• If reusing surgical gloves, submerge them in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>2. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>3. Monitor vaginal bleeding and take the woman’s vital signs:</td>
<td></td>
</tr>
<tr>
<td>• Every 15 minutes for 1 hour,</td>
<td></td>
</tr>
<tr>
<td>• Then every 30 minutes for 2 hours.</td>
<td></td>
</tr>
<tr>
<td>4. Make sure that the uterus is firmly contracted.</td>
<td></td>
</tr>
</tbody>
</table>
### BIMANUAL COMPRESSION OF THE UTERUS
(To be used by the **participant** for practice and by the **trainer** at the end of the module.)

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

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

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

**Not Observed:** Step or task not performed by learner during evaluation by teacher.

<table>
<thead>
<tr>
<th>LEARNER __________________________</th>
<th>Date Observed________________</th>
</tr>
</thead>
</table>

#### CHECKLIST FOR BIMANUAL COMPRESSION OF THE UTERUS
(Many of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>2. Provide continual emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td>3. Put on personal protective barriers.</td>
<td></td>
</tr>
<tr>
<td><strong>S K I L L / A C T I V I T Y P E R F O R M E D S A T I S F A C T O R I L Y</strong></td>
<td></td>
</tr>
<tr>
<td><strong>BIMANUAL COMPRESSION</strong></td>
<td></td>
</tr>
<tr>
<td>1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.</td>
<td></td>
</tr>
<tr>
<td>2. Clean vulva and perineum with antiseptic solution.</td>
<td></td>
</tr>
<tr>
<td>3. Insert fist into anterior vaginal fornix and apply pressure against the anterior wall of the uterus.</td>
<td></td>
</tr>
<tr>
<td>4. Place other hand on abdomen behind uterus, press the hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.</td>
<td></td>
</tr>
<tr>
<td>5. Maintain compression until bleeding is controlled and the uterus contracts.</td>
<td></td>
</tr>
<tr>
<td><strong>Skill/activity Performed Satisfactorily</strong></td>
<td></td>
</tr>
<tr>
<td><strong>POSTPROCEDURE TASKS</strong></td>
<td></td>
</tr>
<tr>
<td>1. Remove gloves and discard them in leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.</td>
<td></td>
</tr>
<tr>
<td>2. Wash hands thoroughly.</td>
<td></td>
</tr>
<tr>
<td>3. Monitor vaginal bleeding, take the woman’s vital signs, and make sure that the uterus is firmly contracted.</td>
<td></td>
</tr>
<tr>
<td><strong>Skill/activity Performed Satisfactorily</strong></td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 3.15: Clinical Practice Sites

The success of a competency-based training program depends upon having a site where Px are exposed to adequate numbers of cases and are practicing in a supportive environment that reinforces standards taught in the training program.

Clinical sites should be selected based on the following criteria:

- Patient mix and volume;
- Equipment, supplies, and drugs;
- Staff (number of staff, skills needed);
- Transportation accessibility; and
- Other training activities. (If there are other trainings going on, predict possible obstacles/ barriers. What are possible solutions?).
Participant Handout 3.16: Steps in Developing a Clinical Training Site

1. Discuss the process that will be needed to prepare the site for a clinic practicum with the clinic staff.
   • Select an appropriate team to make the site assessment.
   • The purpose of the assessment will be to determine what needs to be done to prepare the site for a clinical practicum.
   • Brief the assessment team on what you plan to do.
   • Discuss the steps in the performance analysis.

2. Decide what you will need at the facility to make it a practicum site (all of the things listed in the previous objective).
   • Patient mix and volume
   • Equipment, supplies, and drugs
   • Supportive staff
   • Protocols and correct procedures
   • Transportation
   • Clinical supervisors

3. Conduct an analysis of the current situation in the facility.
   • Site assessment—what is currently available?
   • Look at existing performance data and review records.
   • Use inventory checklists.
   • Use observation checklists to observe procedures and staff performance.

4. Define the gap between the current situation at the facility and what is needed to make it a good practicum site.
   • Meet with assessors and clinic staff.
   • Define what will be needed.

5. Perform a cause analysis.
   • Work with clinic staff to find the reasons for the gap.

   • Work with the staff to decide on interventions and prioritize them.

7. Plan interventions
   • Create an action plan.
   • Include who will do it, the resources needed, a deadline, and determine how to monitor progress.

8. Make the changes.

9. Monitor and supervise the changes.
Participant Handout 4.1: Role-Plays

Why Use Role-Play?
A well-constructed role-play exercise promotes effective learning. Participants practice skills they have been taught, demonstrating their knowledge and understanding of the content through their application in a role-play situation. They have an opportunity to gain insight into their own behavior. Role-play is a good method for teaching attitude, counseling skills, and sometimes problem-solving.

Types of Role-Plays
There are several types of role-plays:

The Scripted Role-Play is prepared by the trainer, who writes a script and asks for volunteer participants to read their lines in front of the entire group while the rest observe. After the script is read the trainer conducts a general discussion with the entire group. This type of role-play should be used fairly early in the session to demonstrate desired behavior or undesirable behavior. Participants must be able to identify what they should do or not do.

The Coaching Role-Play involves both the trainer and the participants. It gives the participants an opportunity to use information already presented and demonstrate how well they understand it. The trainer creates the story and explains it to both the role-playing group and to the rest of the participants. The trainer plays the role of the person whose skills are to be developed. While the trainer is demonstrating a skill, such as hand washing, the other players ask questions of the trainer doing the demonstration. For example, while the trainer is demonstrating putting her hands under running water, another role-player may say, “In my facility we have no running water, what should I do?” The trainer can answer or refer the question to the rest of the participants. Throughout the role-play the trainer may stop from time to time to ask the group what to do next. The trainer takes the groups suggestions and continues the role-play. The trainer repeats the technique of stopping and asking the groups opinion several times. At the end of the role-play the trainer leads a discussion about what skills or principles were applied in the role-play.

The Spontaneous Role-Play is used during a general group discussion. For example, the trainer may want to communicate ways of dealing with a trainee who is defensive or resistant to training. Instead of telling the group how to handle the situation s/he begins a spontaneous role-play to demonstrate how to deal with the difficult trainee. The trainer asks one of the participants to disagree or argue. Because the role-play does not seem to be planned, the participant playing the other role doesn’t even realize they are playing a role. The role-play may also be changed so that the trainer plays the role of the person who disagrees.

The Rotating Trio Role-Play gives each participant a chance to try out his or her skills. This kind of role-play should be used at the end of a session to bring everything together. The trainer organizes the participants into groups of 3. The role-play consists of 3 different rounds. Each round may be the same and acted out in a different way or a different scenario can be created for each round. The participants in each group take turns being the main character who demonstrates the skill, the secondary character who plays opposite the main character, and an observer. Each person assumes a different role for each round. The trainer can either create the roles or ask the participants to create them.
Tips for Conducting a Role-Play

- Be clear about the objectives of the role-play and communicate them clearly to the participants. Make sure they understand that the purpose of the role-play is to practice the skills they have learned.
- A role-play can never be successful if participants are afraid or embarrassed. Make sure that participants understand what the correct behavior they are demonstrating should be. For example, if a counseling role-play is presented, make sure participants know what good counseling should be like.
- Never use a role-play to demonstrate incorrect behavior. People often remember what they see and may remember the behavior, but may not remember that it is incorrect behavior.
- Review the steps or skills that have been presented during the session before the role-play begins.
- Prepare an observer sheet that helps the observers focus on each role-player’s behavior.
- Ask for feedback, first from those who participated as actors and then from the observers before giving your own input.
- During the discussion focus on the process or how the role-play was conducted, not on the content of the role-play.
Participant Handout 4.2: Checklist for Evaluating Role-Plays

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

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

**Unsatisfactory:** Does not perform the step or task according to standard procedure or guidelines.

**Not Observed:** Step or task not performed during evaluation.

<table>
<thead>
<tr>
<th>Task / Step</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator is clear about objectives of the role-play.</td>
<td></td>
</tr>
<tr>
<td>The parts to be played by &quot;actors&quot; are well defined.</td>
<td></td>
</tr>
<tr>
<td>Time limits and scope of role-play are clear to participants and observers.</td>
<td></td>
</tr>
<tr>
<td>Facilitator is clear about which skills are to be practiced.</td>
<td></td>
</tr>
<tr>
<td>Facilitator ensures the group understands what the correct behavior is.</td>
<td></td>
</tr>
<tr>
<td>Facilitator is clear about the roles of all participants (audience, primary role-player, supporting roles).</td>
<td></td>
</tr>
<tr>
<td>Instructions (or an observation sheet) are given to observers about what to observe.</td>
<td></td>
</tr>
<tr>
<td>Actors have adequate time to prepare.</td>
<td></td>
</tr>
<tr>
<td>Discussion after the role-play focuses on process of role-play, not content.</td>
<td></td>
</tr>
</tbody>
</table>
Problem statement: Think of how many ways there are to use a paper clip.

<table>
<thead>
<tr>
<th>Name</th>
<th>Idea 1</th>
<th>Idea 2</th>
<th>Idea 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Participant Handout 4.4: Case Study

A case study is a written account of a problem, generally a real situation and how it is handled. The situation may be a medical situation or any other real situation. In one type of case study participants may be asked to analyze and discuss how the case illustrates learning points from the training session. In another type of case study, participants are given a written description of the situation or problem and are asked to analyze the situation, evaluate the alternatives, and recommend an appropriate approach or solution.

Case studies, like other types of experiential learning activities, enhance retention, recall, and application of knowledge in real work situations.

Case studies are more complicated than they first appear. Many participants read the case study and come to a conclusion quickly without addressing the underlying problem. This is why it is important to give very specific instructions when addressing the problem.

Guidelines for Writing Case Studies

The most interesting aspect of writing case studies is that you are completely in charge. You can create any story or medical case you choose. Make the case simple or complex. The following are some guidelines for writing case studies:

- **Write in story form.** Create the story and then write what you imagine. Make it as realistic as possible. Using a medical case you are familiar with will make it more realistic.
- **Create characters.** Give the characters names that fit the role. In medical case studies, don’t use names that participants may laugh at.
- **Create realistic dialogue.** This makes the story more interesting and realistic.
- **Provide as many specific details as are appropriate and necessary in order for the participants to analyze the case.** You may or may not want to provide background information. If the detail enhances the case study or provides essential information then include it. Don’t include information that may confuse the participants or side track them from the main task.
- **Be descriptive.** Create a picture in the minds of the participants. If necessary, describe the character’s emotional state.
- **Make the story easy to follow.** Shorter case studies are more easily read and understood.
- **Provide discussion questions or guides for participants to follow.** This guides the participants and prevents time from being wasted.
Participant Handout 4.5: Checklist for Case Studies

Place a check in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

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

**Unsatisfactory:** Does not perform the step or task according to standard procedure or guidelines.

**Not Observed:** Step or task not performed during evaluation.

<table>
<thead>
<tr>
<th>Task / Step</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The objective of the case study (what the problem is and how it is to be “solved”) is clear.</td>
<td></td>
</tr>
<tr>
<td>The facilitator gives a reasonable amount of time for discussion.</td>
<td></td>
</tr>
<tr>
<td>The facilitator keeps the groups on track and on time.</td>
<td></td>
</tr>
<tr>
<td>The case study is relevant and meaningful to the topic.</td>
<td></td>
</tr>
<tr>
<td>The case study is understandable, interesting, and easy to follow.</td>
<td></td>
</tr>
<tr>
<td>All needed information is included in the case study.</td>
<td></td>
</tr>
<tr>
<td>The case study can be read and understood quickly.</td>
<td></td>
</tr>
<tr>
<td>The case study includes discussion questions or guides, making it clear what participants are to discuss or create.</td>
<td></td>
</tr>
<tr>
<td>Participants have an opportunity to ask clarifying questions.</td>
<td></td>
</tr>
<tr>
<td>The trainer is clear about time limits and content of presentations to larger group.</td>
<td></td>
</tr>
<tr>
<td>The trainer encourages discussion within both the small and larger groups.</td>
<td></td>
</tr>
<tr>
<td>The trainer summarizes the discussion at the end of the exercise.</td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 4.6: Mind Mapping

What is a Mind Mapping?
Mind mapping is a form of brainstorming. Just like regular brainstorming, the purpose is to generate as many ideas as possible without worrying about the quality of the ideas. The difference is that in this form of brainstorming the ideas are mapped out, rather than written in linear fashion. There are several ways to do mind mapping. One way is to put 2 large pieces of flip chart paper together to form a square. You will need a large space to write on. Begin by writing the problem in the center and drawing a circle around it. Then identify the major components of the problem by brainstorming, and write each of these on a line coming out of the circle like the spokes on a wheel. As the brainstorming about each of these major components continues and becomes more detailed, draw branches off of these lines to record the details. If you want, add images next to your main line that illustrate what each line means to you. (Some people think better with pictures, others with words.) You can do the brainstorming very systematically from the center outward, 1 spoke at a time or jump from place to place as ideas develop. Ideas that are linked should be recorded off of the same line or near each other.

There is another form of mind mapping that works very well when you have 2 main components like the advantages and disadvantages of something. In this form of mind mapping the shape of a tree is used with the main topic as the trunk and the 2 main branches as the advantages and disadvantages. It can also be used to map out more than 2 major components but the space is more limited because of the shape of the tree.

Tips for Mind Mapping
• Use just key words, or wherever possible, images.
• Start from the center of the page and work out, or from the bottom up if you are using a tree.
• Make the center a clear and strong visual image that depicts the general theme of the map.
• Underline or highlight the things you want to stand out.
• Leave lots of space.
• Create sub-centers for sub-themes.
• Put key words on lines.
• Print rather than write in script.
• Anything that stands out on the page will stand out in your mind.
• Use arrows, icons or other visual aids to show links between different elements.
• Don’t get stuck in one area. If you can’t think of anything else in one area, move on to another.
• Put ideas down as they occur, wherever they fit. Don’t judge or hold back.
• Be creative. Creativity aids memory.
• Get involved. Have fun.

Uses of Mind Maps
• Notes.
• Recall.
• Creativity.
• Problem solving.
• Planning.
• Presentations.
Advantages of Mind Maps
• Mind maps work the way the brain works—which is not in nice neat lines.
• Memory is naturally associative, not linear. Any idea probably has thousands of links in your mind. Mind maps allow associations and links to be recorded and reinforced.
• The mind remembers key words and images, not sentences—try recalling just one sentence from memory! Mind maps use just key words and key images, allowing a lot more information to be put on a page.
• Because mind maps are more visual and show associations between key words, they are much easier to recall than linear notes.
• Starting from the center of the page rather than top-left corner allows you to work out in all directions.
• The organization of a mind map reflects the way your own brain organizes ideas.
• Mind maps are easy to review. Regular review reinforces memory.
• We remember what stands out. The way mind maps are laid out allows you to make key points stand out easily.

Steps for mind mapping
• Take a sheet of plain paper and turn it sideways (if using flipchart paper you don’t need to turn it sideways—it is large enough).
• Using colored felt pens, draw a small picture (or write a phrase, or circle the phrase) in the centre of the paper representing the issue you want to solve.
• Draw lines out from the main problem. (It helps to use different colors for each line.)
• Each line should represent a different aspect of your problem or issue.
• Begin the brainstorming and write down participants’ ideas either on top of, or on the line.
• If you want, add images next to your main line that illustrate what each line means to you (some people think better with pictures, others with words).
• Add other lines flowing off these main lines.
• When the ideas have stopped flowing, begin organizing the ideas into main subtopics. If you are a quick thinker this can be done as the brainstorming ideas are being thrown out.
• When you have the main subtopics or groupings, determine which pieces of information are “need-to-know” or “nice-to-know.” Eliminate the “nice-to-know” topics and then organize the rest of the brainstorming ideas around the main subtopics. You can write them on a new flip chart or attach them to the main subtopics using different colored markers.

Example:
An example of mind mapping is shown on the following page. This map illustrates how infection can be transmitted in a clinical setting.
Participant Handout 4.7: Encouraging Participation

Instructions: Read the situations below and write down what you would do in each case to encourage participation of the whole group. Write down specifically what you would do and say.

1. You started the training course a half an hour ago and the participants are still very quiet. No one responds when you ask a question. How will you stimulate discussion?

2. The group has been discussing a topic for a while, but they are not making much progress. There are no new ideas being added. You want to cut off the discussion and move on. What will you say to do this?

3. Someone in the group has a good idea. You would like the whole group to explore the idea further. How would do this and what would you say?

4. You sense that the whole group is resistant to discussing the topic. You want to bring their feelings out into the open. What would you do and say?

5. Two participants have been arguing about a point. It is clear they have opposite views and they won't come to any agreement. You want to take some action to get the discussion back on track. What would you say and do?

6. Give an example of a difficult training situation you encountered relating to group participation. Write down the situation and explain what you did and said.
Participant Handout 4.8: Lecture Variations

The Card and Chart Technique is a combination of lecture and brainstorming. It’s a way to organize brainstorming ideas into categories or components. This technique is used for the quality of care framework.

A Mock Interview is a technique that is a useful way to obtain information from technical experts. The mock interview can be done several different ways:

- Provide a volunteer with a list of questions or a script. Have the volunteer ask the questions and the technical expert provide the answers. Allow the interviewer to deviate from the script and allow other participants to ask questions as well. The participants can ask the questions verbally or pass slips of paper with questions to the volunteer interviewer.
- The exercise can be set up like a talk show. Technical experts form a panel. Either the trainer or a volunteer can facilitate the process. Participants can ask questions of the panel of technical experts.

The Multiple Choice Lecture is done by giving each trainee 4 pieces of different colored paper (for example, red, green, blue, yellow). Label each piece A, B, C, or D (red=A, green=B, blue=C, yellow=D). Before the lecture, prepare a series of multiple choice questions related to the lecture and put each question on a transparency. During the lecture show the questions as they relate to the content. Ask the trainees to hold up the appropriate piece of paper that relates to the multiple choice answer A, B, C, or D. If a number of trainees give the wrong answer, review the content.

Key Words can be used to highlight the important words in a lecture. As you speak, write single key words on a flip chart. The key words should eventually create an emerging content outline. Write no more than 7 key words on a flip chart. When you have written 7 words on the page, tear it off and post it on the wall. When you have finished the lecture, use the key words to review the content of the lecture. The review can be conducted with the whole group or using smaller discussion groups.

The Cartoon Lecture stimulates interest and helps participants remember the lecture content. Find cartoons that relate to the content of your lecture. Transfer the cartoons to overhead transparencies and use them to illustrate key points from your lecture. Always describe the content verbally and then show the cartoon. When you have finished the lecture show each of the cartoons one at a time and use them to review content. The review may be done with the whole group or with smaller discussion groups.

Using Examples is a good way to clarify teaching points. Good lectures often contain examples, analogies, and metaphors. You can vary the use of examples:

1. After you have delivered a lecture, divide the trainees into small groups and ask them to create an example or analogy of specific points you have selected.
2. Ask small groups to create exceptions to points you have selected.
3. During the lecture, encourage the trainees to use situations from their own experiences as a source of examples, where possible. This technique works especially well when discussing hospital or clinic situations or patients, but warn trainees not to violate the privacy of individual patients.
The following considerations should be considered when using examples:
• Use examples only as necessary to clarify teaching points.
• Create examples that are relevant or interesting to the trainees.
• Make the example simple.
• Make certain the connection between the example and the teaching point is clear.
• Make the example realistic to the trainees in their clinic or hospital situation.
• Don’t overdo it and tell too many stories.
Participant Handout 4.9: Discussion Variations

A discussion is an exchange of ideas on a topic of mutual concern. The discussion can be leaderless or moderated by a leader. It can be totally unstructured and spontaneous or it can be highly structured. Discussions can be held in a large group or the group can be broken into smaller discussion groups.

The “66” Discussion Technique
The “66” discussion technique is a way of structuring small group discussions. Divide participants into groups of 6. (Groups could have different or similar topics.) Identify one recorder. Allow groups 6 minutes to talk about the issue. Tell the group when there are 2 minutes left, then 1 minute, and suggest they wrap up. Post results on flip charts.

The Fishbowl
The fishbowl is a modification of the discussion in which a large group is divided into 2 smaller groups. One group will form an inner circle (the fish bowl) where they discuss a topic. The remaining participants form an outer ring around the fish bowl. The outer ring listens and observes while those in the fish bowl discuss a topic. After an allotted time, those in the fishbowl switch places with those in the outer ring. After both groups have had a chance to be in the fishbowl, reconvene the larger group and debrief.

Teams
An interesting training exercise used to explain definitions is to divide participants into teams. Use different colored paper for each team and write (or photocopy and paste) the individual definitions on pieces of the colored paper. Put the matching word for each definition on the front of an envelope. Give each team 3-4 minutes to put the correct definition in each envelope. After the time is up ask 1 team to read their words and matching definitions. Award a prize to the winning team.
Opener or Ice Breaker

1. Lifelines

Purpose: To help participants get to know each other
Time Required: 20 – 30 minutes
Materials Required: Flip chart paper and markers
Description: Ask participants to draw a line on a piece of flip chart paper turned sidewise. If needed, they may use additional paper. At one end is their date of birth. Along the line participants should record the important events in their life that shaped the person they have become today. The events may be personal, professional or simply interesting.

After each participant completes their “lifeline” they should explain it to the group.

2. What’s Your Name?

Purpose: To help participants and the trainer learn each other’s name.
Time Required: 15-20 minutes
Materials Required: None
Description: Ask each participant to introduce themselves to the group by giving their name and one unusual thing about themselves. For example, “My name is Elizabeth and I drove a tank.” The next person repeats the name and information about the first person and adds his or her own name and fact. Each person follows the same procedure, recalling all of the names and facts.

3. Shout, Whisper, Sing

Purpose: To help participants remember new names.
Time Required: 10 minutes
Materials Required: None
Description:
• Ask participants to stand in a circle.
• Explain that you are going to call out someone’s name as you cross the circle towards him or her. The person whose name you called should then take your place in the center of the circle.
• The person who is now in the center should call out someone else’s name and that person moves to the center.
• When your name is called again, continue the game, but this time everyone must whisper the person’s name.
• Finally when your name is called out again, continue the game, but this time everyone must sing the person’s name.

4. The Interview

Purpose: To introduce participants and learn something about them.
Time Required: 20-30 minutes
Materials Required: Pen and paper for note taking
Description: Ask participants to choose a partner they don’t know.
• Give 5 minutes for each person to interview his/her partner. Instruct them to find out as much about their partner as possible. Notes may be taken.
• After the interviews ask each person to introduce their partner to the rest of the group.
Note: This introduction works best when the group is less than 20 people.

5. The Cocktail Party

Purpose: For larger groups to get acquainted with as many people in the group as possible.
Time Required: This is up to the trainer. Each introduction takes 1 minute.
Materials Required: None
Description: Ask person to introduce themselves to someone and spend a minute learning about each other.
• After 1 minute ask everyone to find a new person to get acquainted with for 1 minute.
• Continue changing every minute as long as you have time. The longer you spend at the exercise the more people each person will meet.

6. Common Ground

Purpose: This introduction works for small groups, especially for a small group working as a team. It also works well when there are several small groups that make up a larger group.
Time Required: 10-15 minutes
Materials Required: Pen and paper
Description: Instruct each group to list everything they can find that they have in common. Give them a time limit (5 minutes or so) and tell them to avoid the obvious things like, we are all in this workshop, etc.
• Ask each group to assign one person to write down the things the group has in common.
• When the time is up, ask each group to read the things on their list.

7. Who is Who?

Purpose: To help participants and the trainer to learn something about each other. It works best when people already know each other, at least by name.
Time Required: 20 minutes
Materials Required: A slip of paper for each participant and a bowl
Description:
• Hand out a slip of paper to each participant.
• Ask each participant to write several things about themselves that would help other participants recognize them such as tall, thin, hair, glasses, etc.
• Ask participants to fold the slips of paper and put them into a bowl.
• Ask each participant to pick a slip of paper from the bowl.
• One at a time ask participants to identify the person described on their slip of paper.
8. Catch the Ball!

Purpose: To help participants learn each others names
Time Required: 30 minutes
Materials Required: A ball, preferably large and easy to catch
Description:
- Have participants form a circle.
- Begin the exercise by throwing the ball to someone else in the circle.
- The person who catches the ball must name the person who threw it.
- The person who caught the ball throws it to another person who names him or her and the game continues.

Variation: With small groups it is possible for each person who catches the ball to recite the names of all the people who have already thrown the ball.

9. Pass the Fruit

Purpose: To help participants learn something about each other
Time Required: 20 minutes depending on the size of the group
Materials Required: A piece of fruit big enough for participants to pass to each other without using their hands.
Description:
- Arrange participants in a circle.
- Give the first person a piece of fruit and ask hi or her to pass the fruit to the next person without using his or her hands.

10. Two Truths and a Lie

Purpose: To help participants who already know each other get to know more about each other.
Time Required: 12- 30 minutes, depending on the number of participants
Materials Required: One small prize
Description:
- Each participant should first give their name and designation and then tell the rest of the group 3 interesting things about themselves. The facts should be things the rest of the participants are not likely to know.
- The group has to decide which piece of information is the lie.
- After everyone has introduced themselves and their lie, ask the group to vote on the best or most imaginative lie.
- Give the person who wins a small prize.

11. Two Loves and One Hate

Purpose: To help participants who already know each other get to know more about each other.
Time Required: 12- 30 minutes, depending on the number of participants.
Materials Required: One small prize
Description:

- Ask participants to write down two things they really love and one thing they really hate on a piece of paper. Encourage participants to write unusual things, not ordinary everyday things.
- Instruct participants to put their paper face down and not show other participants.
- Ask each person to take a turn reading their two loves and one hate to the rest of the group. Participants should present each item by saying “The first thing I love or hate is-----“
- Ask the rest of the group to guess which things the person loves and what is the one thing the person hates. At the same time the person tells the things they love and hate, they should also briefly introduce themselves to the other participants.
- At the end of the exercise ask participants to vote on which was the most interesting or outrageous “hate” and give a prize.

12. Mix and Match

Purpose: To match up participants for mutual introductions.
Time Required: 30 minutes
Materials: Whatever you use, you will need one for each pair of participants. You may use holiday greeting cards or IE&C, or BCC material related to the course.
Description:

- Collect the holiday greeting cards or IE&C or BCC material you have decided to use.
- If you use greeting cards, cut off everything except the first page with the picture on it. Whatever you use, you will need one picture for each pair of participants. Each pair should have a different picture if possible.
- Cut each picture in half. If you don’t have a different picture for each pair of participants, then cut the pictures in half in different ways.
- Distribute one half of a picture to each participant.
- Instruct participants to mix with each other until they find the person holding the other half of their picture.
- When they find a partner, each person should find out enough interesting information about their partner to introduce their partner to the rest of the group.
- Gather the group together and have each pair introduce their partner to the rest of the group.


13. The Walking Billboard

Purpose: To provide an interesting way of having a new group of participants mix with each other and share information about themselves.
Time Required: 30 minutes
Materials Required: A half of a piece of flip chart paper for each participant, masking tape, markers for each participant

Description:

- Ask participants to think of some things they would like to learn about other participants.
- Write these on a flip chart. These might include things like where they work, their favorite food, how many children they have, their hobbies, etc.
- Have the group agree on 5-6 favorite items.
• Ask them to take the flip chart paper they have been given, write their name on the top and then answer the questions about themselves.
• Now, ask them to take their flip chart paper and attach it to their back or shoulders using masking tape.
• Ask them to walk around the room and discover who everyone is.


14. Self Disclosure

Purpose: To introduce participants to each other. This is useful as an opening exercise for participants who already know each other.
Time Required: Two minutes for each person
Materials: None

Description:
• Ask each person to take two items from their purse or pocket. Suggest that they take out things that are important to them for some reason or another.
• Ask each person to introduce themselves and explain why the item is important to them.
Note: You can also relate this exercise to a specific training. For example, ask “How does this item relate to you as a potential trainer?”

Expectations

1. Dreams and Nightmares:

Purpose: This exercise is a fun way to determine course expectations.
Time Required: The time depends on the number of participants. Allow approximately 1 minute for each participant.
Materials Required: None

Description:
Ask each person to state 1 “dream” about something positive that will happen during the course.
• Ask each person to also give 1 “nightmare” about something they hope will not happen during the workshop.
• Put the “Dreams” and “Nightmares” in separate columns on the flip chart.

2. The Question Tree

Purpose: The exercise is a creative way to determine the technical content participants have questions about before the training begins. It can also be used at the end of the course as a review.
Time Required: Approximately 15 minutes
Materials Required: A large piece of flip chart paper (or several taped together). Markers and colored paper.
Description:
- Draw a picture of a tree on the flip chart paper and tape it to the wall.
- Give participants pieces of colored paper. These can be cut into rectangles or other shapes.
- Ask participants to write questions related to the subject matter of the course on the pieces of paper (1 question on each piece).
- The trainer should review the questions before training begins and be sure to cover each question during the training.
- At the end of the training, review the questions and answers with the trainees.


**Energizer**

1. TV Shows

Purpose: To energize participants and have them break into groups
Time Required: 10 minutes
Materials Required: Slips of paper prepared in advance

Description:
Select a popular TV show to represent each group you would like to form. For each group, write slips of paper with the names of characters in the TV show. Have at least one name for each of the participants you want in the group. If you don’t have enough names, repeat some of the names twice. Ask participants to draw slips of paper from the envelope and have them find the sign with the name of the TV show they belong to.

2. Group Leaders

Purpose: To select group leaders
Time Required: 5 minutes
Materials Required: None

Description:
The following are several ideas for selecting group leaders.
- Ask participants to add the total number of feet they have in their household. (Dogs and cats have 4.) The people with the highest number are the leaders.
- Ask everyone to write his or her middle name on a piece of paper. The ones with the longest middle names become the group leaders.
- Ask people their mother’s or father’s first name. The participants who have written names that appear earliest in the alphabet are selected as group leaders.
- Write group and leader assignments on individual pieces of paper. Have participants draw the slips of paper from a bag.

3. Line Up

Purpose: To energize participants. This can also be used as a communication exercise.
Time Required: 10-15 minutes
Materials Required: None

Description:
Ask participants to line up according to age without speaking.

4. Numbers in the Air

Purpose: Energizer
Time Required: 5 minutes
Materials Required: none

Description:
Ask participants to put their hands on their shoulders and follow your lead. Ask them to trace the numbers 1-10 in the air with their elbows, while keeping their hands on their shoulders.

5. Hand Holding

Purpose: Energizer
Time Required: 10 minutes
Materials Required: none

Description:
• Have participants line up facing each other.
• Have 1 line face the other with hands in front of them and palms facing up.
• Have the participants in the other line place their hands on their partners.
• The partners should then feel each others hands, exploring them by touch.
• Have 1 line change partners and do the same with several partners.
• Then, ask one line of participants close their eyes while the other line changes places.
• Keeping their eyes closed, the first line must guess who their new partner is by feeling their hands.

6. Mime the Lie

Purpose: Energizer
Time Required: 5-10 minutes (as short or long as you need it to be)
Materials Required: None

Description:
• Ask everyone to stand in a circle.
• Begin the exercise by going into the middle of the circle and mime an action such as getting dressed.
• Ask the person who was next to you in the circle to ask you out loud what you are doing.
• Reply by saying another action out loud. For example, “I am digging a hole.”
• Next, ask that person to come into the circle and mime what you said you were doing.
• When the next person asks what s/he is doing s/he also lies.
7. Fruit Salad

Purpose: Energizer
Time Required: 5-10 minutes (as short or as long as you need it to be)
Materials Required: None

Description:
- Arrange chairs in a circle.
- Stand in the middle of a circle. Everyone in the circle should be sitting on a chair.
- Ask participants to choose 3 different fruit names.
- Go around the circle and name each of the participants the name of 1 fruit. For example, name the first person mango, the second person banana, and the third person orange. Continue in that order until every participant including you has a name.
- Explain that you are going to call out 1 of the fruit names. When the name of their fruit is called everyone with that name must get up and find another place to sit. The person who doesn’t have a place to sit will have to sit in the middle and call out the next fruit. Add that if someone calls out “fruit salad,” everyone must find a new place to sit.
- To begin the game, call out the name of your fruit and quickly find a new place to sit, leaving someone new without a chair.

8. Sitting on Knees

Purpose: Energizer
Time Required: 5 minutes
Materials Required: None

Description:
- Ask everyone to stand closely in a circle. Including you.
- Ask everyone to turn to their right, so that each person in the circle is facing the back of someone else.
- Ask everyone to put their hands on the shoulders of the person in front of them.
- Explain that you are going to call out “1,2,3, SIT!” and everyone should carefully sit down on the lap of the person sitting behind them while still holding the shoulders of the person in front of them.
- If the participants are really brave you can shuffle around in a circle while still staying in this position.

9. Jane Bear Hunter

Purpose: Energizer
Time Required: 15 minutes
Materials Required: None
Description:
- Demonstrate 3 poses for the group.
  - Jane poses with her hands up as if she is afraid of the bear.
  - The hunter holds up is long gun as if he is aiming at something.
  - The bear holds up his claws and growls.
- Have pairs stand back to back
- Explain that you will count to three. At the count of three everyone should strike a pose, jump and turn to face their partner
- When partners are facing each others one pose is the winning pose and the other the losing pose:
  - Hunter beats bear.
  - Bear beats Jane.
  - Jane beats hunter.
- The loser from each pair sits down.
- New pairs are formed from the winners and the process is repeated.
- The person left standing is the winner.

10. Body Writing

Purpose: To energize participants and get them laughing
Time Required: 5 minutes
Materials Required: None

Description:
- Ask everyone to stand and write their name in the air using their body.
- A variation is to ask participants to write the word COCONUT with their body.

11. Drawing a Face

Purpose: To energize participants. This is also a good communications exercise.
Time Required: 20 minutes
Materials Required: Flip chart, markers, and one blindfold for each team

Description:
- Set up one flip chart for each team and draw a large circle on each flip chart.
- Divide participants into teams.
- Explain the exercise. The purpose of the exercise is for each team to draw a face on their flip chart. One at a time team members will be blindfolded. Each participant will add one feature to the face. Other team members may give minimal instructions, like up, down, right, left, etc.

12. 7-Up

Purpose: Energizer
Time Required: 10 minutes
Materials Required: None
Description:
• During this exercise participants will count off from 1-7.
• Ask participants to form a circle.
• The leader starts by touching his/her right hand to his/her left shoulder and saying “1.”
• The next person does the same but counting “2.”
• This continues until the 7th person who says “7-Up” rather than just 7. The person who says 7-Up can continue with right hand to left shoulder or change hands.
• The next person in line must do exactly as number 7. If number 7 has changed hands, so must the next 6 people in line.
• Anyone who makes a mistake must sit down.
For the exercise to work the leader must move the counting along very quickly, so the participants barely have enough time to think.

13. Balloon Tag

Purpose: Energizer
Time Required: 1 minute
Materials Required: Enough round balloons for each participant and one rubber band for each participant.

Description:
Note: This game can get a bit rough. Allow plenty of space. It may not be the right game for every group.
• Give each participant a balloon and rubber band.
• Instruct each participant to first take off their shoes and move them out of the way.
• Have each participant blow up their balloon, tie it and then attach it to the outside of their ankle, using the rubber band.
• The purpose of the game is to pop the balloon of other participants while keeping your own intact.
• The last participant with an intact balloon wins the game.

Dividing Participants into Groups

1. TV Shows

Purpose: A variation on counting 1, 2, 3 to divide groups
Time Required: 5 minutes
Materials Required: None

Description:
• Think of a popular TV show that everyone is likely to know.
• Choose the name of one of the show’s characters for each team.
• Go around the room as if you were counting off groups, but use the names of the characters rather than a number.
2. Cards

Purpose: Using a deck of cards to divide participants into groups.
Time Required: 10 minutes
Materials Required: At least 1 deck of cards. Two decks might be necessary if there are many participants.

Description:
- Preselect cards, depending on the number of groups you will need. For example, if you need 3 groups with 8 people in each group, remove all of the 3s, 4s, 5s, 6s, 7s and 8s.
- Shuffle the cards you have selected and have each participant pick a card.
- Explain that all of the 3s and 4s will be together, the 5s and 6s, etc.
- To choose a group leader, pick a suit and number. For example, the group leader will be the 3, 5, and 7 of hearts.

Review

1. Share What You’ve Learned

Purpose: To share and review what participants have learned.
Time Required: 15 minutes
Materials Required: A box or bag to use to collect “ideas.”

Description:
- Use this exercise at the end of a session or topic.
- Ask each participant to write 1 valuable concept they learned from the session and how they can use it.
- Put all of the pieces of paper with ideas written on them into the hat or bag.
- Mix up the pieces of paper and have each participant select 1. If a participant selects his/her own paper, return it to the bag and have him/her select a new one.
- Ask each participant to read aloud the paper they have selected and comment on it.
- The exercise ensures that everyone leaves with at least one useful concept and a way to use it.


2. Fruits of Knowledge

Purpose: To review highlights and useful information participants have learned from the previous day.
Time Required: 15 minutes
Materials Required: Flip chart and colored paper cut into circles or fruit shapes (one for each participant).

Description:
This is a good exercise to review work and information from the previous day.
• Draw a large tree on a flip chart.
• Hand out one piece of paper “fruit” to each participant.
• Ask each participant to write down a key piece of information they learned the day before that they will be able to use in their work.
• Ask participants to come up 1 at a time and stick the fruit on the tree while explaining their key piece of information and how they will apply it in their work

3. The Daisy

Purpose: To review technical information learned during the course.
Time Required: 30 minutes
Materials Required: Flip chart paper (1 piece), colored paper, pen, scissors, tape

Description:
• Cut out a circle to be the center of the flower.
• Cut as many petals as will fit around the circle.
• Write a review question on the back of each petal. Or write the questions on pieces of paper and attach one to each petal.
• Arrange the petals around the circle to look like a daisy.
• Ask each participant to take a petal, read the question, and answer it.

4. Find a Word Review

Purpose: To stimulate retention of key words and concepts.
Time Required: 10 minutes
Materials Required: A matrix with 20 rows across and 20 rows down, similar to a cross-word puzzle.

Description:
• Select approximately 20 words from the lesson that you want to emphasize.
• Fit them into the matrix with some going left to right and others going from top to bottom.
• Complete the matrix with miscellaneous letters and blank spaces.
• Hand out the matrix.
• Ask participants to identify the 20 words.
• Give prizes based on the number of words each participant identifies.


5. Quickie Review

Purpose: To provide a quick review of topics covered and participant learning. Can be done before a coffee or lunch break.
Time Required: 5 minutes
Materials Required: None

Description:
• After a session, explain to participants that you are going to do a quick review
• Explain that you want to hear 10 things that they have learned during the session.
• Ask participants to respond as quickly as possible.
• Thanks participants and number each response until 10 responses have been given.
Note: The number of responses you ask for is up to you.


**Team Building**

1. Tied in Knots

Purpose: To energize participants and get them moving. Increases team spirit through problem solving.
Time Required: 10-15 minutes
Materials Required: None

Description:
Ask participants to stand and form a fairly tight circle. Ask participants to raise their left hand in the air and their right hand to the center of the circle. Next have each participant lower his or her left hand and grab someone else’s right hand. Instruct participants that they are not allowed to let go of the person’s right hand. Tell participants that they must untangle themselves without breaking their grip. When they are untangled they will again form a circle. It doesn’t matter that some will be facing outwards.

2. Wishing Exercise

Purpose: To show participants how they can achieve more goals if they work together than compete with each other.
Time Required: 5 minutes
Materials Required: none

Description:
• Ask the members of the group to form pairs.
• Tell the pairs to face each other and hold their partner’s right hand with their own right hand. This will be like a handshake.
• Now tell them to think of as many wishes as they possibly can in the next 30 seconds.
• After 30 seconds, tell them they can be granted 1 of their wishes each time they touch their right hip with their right hand. They must remain holding hands with their partner. They now have 30 seconds to have as many wishes granted as they can.
• At the end of this 30 second period, ask how many pairs didn’t have any wishes granted between them. Then ask how many pairs had between 1 and 5 wishes granted. Finally, ask how many pairs had all of their wishes granted, plus some time to spare.
• Ask a pair from each category (few wishes granted or many) to demonstrate how they tried to gain their wished. Start with the 0 scores and work up to the higher scores. By demonstrating this way, the group will be able to see that the pairs that cooperated got far more wishes granted than those who didn’t.
Discussion points:
1. Why was it that some pairs didn't have any wishes granted?
2. Are we naturally competitive? Why?
3. How can we cooperate?

Variation: Have all of the participants close their eyes or be blindfolded.

Adapted from: Kroehnert, G., 100 Training Games, McGraw-Hill Book Company, New York

4. Desperately Seeking the Real Person

Purpose: Team building and to get to know more about participants by the end of the workshop.
Time Required: Ongoing throughout the course
Materials Required: Paper and pen for recording, plain paper for the “newspaper advertisement”
Description:
At the beginning of the workshop have each person draw the name of another participant from a hat. Instruct them to keep these names a secret.
• Instruct each person to listen to their assigned person throughout the workshop and write down their likes, dislikes, sayings, and expressions.
• At the end of the workshop ask each person to make a poster about the person they were assigned.
• The newspaper advertisement should say: Desperately seeking __________ (name) because……… Include interests, likes and dislikes, frequent sayings, etc.
• As part of the closing session each person introduces their newspaper advertisement and the person they have been assigned to observe.

5. The Longest Line

Purpose: To encourage team building and problem solving as a team.
Time Required: 15 minutes
Materials Required: None
Description:
Divide participants into 2 or more groups. The purpose of the exercise is to see which group can make the longest unbroken line.
• Don’t give further instructions. The group can be creative and make their line longer by adding belts, pencils, ties, etc. Anything to make the line longer as long as the line is not broken.

6. What’s our Name? Logo? Slogan?

Purpose: To allow task groups the opportunity to develop working relationships before confronting their “real” tasks.
Time Required: 30 minutes
Materials Required: Flip chart paper and markers for each group
Description:
• Form participants into the small groups that they will stay in for the duration of the workshop. Allow them a few minutes to meet and introduce themselves.
• Ask each group to take 5 minutes and choose a team name.
• Ask them to develop a logo for their group that will portray who they are to others in the workshop.
• Allow 10 minutes for this and then ask each group to explain their name and logo to the rest.
• Then ask each group to develop a slogan (12 words or less) that identifies the assets or attributes the group thinks are important about them.

Discussion Questions:
1. How do you feel about your group?
2. How was your work together?
3. Will you be successful in working together?
4. Is there anything you need to change in order to work together?


Brain Teasers

1. Adding Numbers

Purpose: To energize people and get their brains working
Time Required: 15 minutes
Materials Required: A paper and pencil for each participant

Description:
• Ask participants to write down 3 numbers from 1 to 9 (example: 248).
• Ask participants to reverse the 2 end numbers (example: 842).
• Now subtract the smaller number from the bigger one (example: 842-248=594).
• Now reverse the numbers in the answer the same way (495).
• Now add the 2 together (594+495=1089).
• ?

2. Mr. and Mrs. Clutter

Purpose: To energize people and get their brains working
Time Required: 15 minutes
Materials Required: None

Description:
• Ask participants the following riddle: Mr. and Mrs. Clutter have 5 children. Half of them are boys. How is this possible?
• Answer: They are all boys.

3. Above and Below the Line.

Purpose: To energize people and get their brains working
Time Required: 15 minutes
Materials Required: White board or flip chart

Description:
• Write the following letters on the board:

A  E  H  I  K  L  M  N                T  V  W  X  Y
 B  C  D  G  J                        O  P  Q  R  S  U

• Ask participants: Where does the Z go?
• Answer is above the line because all of the letters above the line have straight lines.

**Experiential Learning Exercises**

1. Evaluate Your Partner

Purpose: To sensitize new trainers to the experience of evaluating and being evaluated by others, based on criteria which are largely unknown.

Time Required: 15 minutes

Materials Required: None

Description:
• Provide everyone with a slip of paper.
• Divide participants into partners.
• Ask each person to observe their partner briefly and then to grade them on a scale from 0-100%.
• Ask participants for the frequency distribution and reported numbers. Ask questions like “How many were at 50%, or what was the highest number, the lowest number, etc.”
• Discuss the following questions with participants:
  1. How did it feel to grade your partner on this basis?
  2. How did you feel when you knew you were going to be graded?
  3. What was your first thought when you received your grade?
• Use this as a way to launch a discussion on the essential elements needed for evaluation.

2. Put Your Jacket On

Purpose: To show participants that their instructions may not always be as clear as they think.

Time Required: 15-20 minutes

Materials Required: A large sweater or jacket

Description:
• Before the exercise brief someone to help you. Tell them to follow the instructions given to them, but find other ways to interpret them. For example, if they are told to put their arm in the sleeve, they can do it with the jacket upside down.
• Ask for a volunteer to give instructions.
• Ask both participants to come to the front of the room and face away from each other so they cannot see each other.
• Ask the volunteer to give detailed, step-by-step instructions to the volunteer with the jacket on how to put the jacket on.
• When the instructions have finished, let the participants face each other. Explain that the instructions were given using 1-way communication and that it is easy to misunderstand instructions when they are given this way.
• If you have time, repeat the exercise, but allow the participant putting on the jacket to ask questions to clarify the instructions.
• Use this example to discuss 1-way and 2-way communication. This exercise can also be used as an introduction to exercises that require participants to create lists of instructions or checklists.

3. Providing Positive Feedback

Purpose: To introduce the concept of giving and receiving positive feedback.
Time Required: 15 minutes
Materials Required: A small piece of notepaper for each participant

Description:
• Divide participants into pairs and give each participant a piece of notepaper.
• Ask each participant to write 4-5 positive things they have noticed about their partner.
• When the writing is completed ask each person to share with their partner what they have written.
• Use the following questions for discussion:
  1. Were you comfortable with this exercise? If not, why?
  2. What would make it easier to give positive feedback to others? (Possible answers might include developing a relationship with someone first, choosing an appropriate time, giving specific evidence.)
  3. What would make it easier for us to receive positive feedback? (Possible answers might include practice accepting it with grace, resolving to think about the validity of it before challenging it, allowing yourself to feel good about it.)

4. Actions Speak Louder Than Words

Purpose: To illustrate that actions usually speak louder than words.
Time Required: 5 minutes
Materials Required: None

Description:
• Ask participants to stand and face you.
• As you demonstrate, ask the participants to extend their right arms parallel to the floor.
• Say, “Now make a circle with your thumb and forefinger.” Demonstrate this as you say it.
• Then say, “Now bring your hand to your chin.” But, this time, as you say it, bring your hand to your cheek and not to your chin.
• Pause with your hand on your cheek. Most of the participants will have brought their hand to their cheek. Look around, but don’t say anything.
• After a few seconds some of the participants will realize they made a mistake and move their hands to their chins.
• Use the exercise to reinforce the point that actions speak louder than words and that trainers need to keep this in mind when communicating with trainees and demonstrating clinical
5. But I’ve Always Done it That Way

Purpose: To illustrate how easy it is to develop and continue using unconscious habits.
Time Required: 10 minutes
Materials Required: Participants should have a jacket or sweater

Description:
• Ask one or more participants who are wearing a coat, jacket, or sweater to stand and remove their coat, sweater, or jacket.
• Ask them to put the coat, sweater, or jacket back on, taking note of which arm goes first.
• Ask them to take off the jacket, etc.
• Ask them to put it on again, but this time to do it with the other arm first.

Discussion Questions:
1. How did it feel to reverse your normal pattern of putting on your jacket?
2. Was it difficult or awkward to do it the new way?
3. What prevents us from doing things in a new way?
4. How can we make changes without having old habits interfere?
5. How can we make ourselves more open to changes in a program and accept the fact that the new way may be just as good, or better than the old way?

Participant Handout 5.1: Evaluating Training

Why we Evaluate Training

- To determine whether training achieved its objectives.
- To assess the value of training programs.
- To identify areas of the program that need improvement.
- To identify the appropriate audience for future programs.
- To review and reinforce key program points for participants.
- To sell the program to managers and participants.
- To revise or refine training design for future use.
- To judge success or failure of the training.
- To persuade funding agencies to continue or replicate the training, etc.

Who Should Evaluate?

Possible answers:
- Trainers,
- Participants,
- An unbiased outsider, or
- Funding agency.

Useful Definitions

- **Inputs** include trainers, participants, training materials, funding, and location.
- **Process** includes training methods, facilitation skills, and participation.
- **Outputs** include trained participants, objectives met, and workshop products like visual aids.
- **Impact** is the final result, including: changed behaviors, and improved quality of services by those trained.

What Parts of a Training System should be evaluated?

Answer: All parts. Different evaluators will be interested in evaluating different parts of the training. For example, trainers may be more interested in the process and outputs, while the funding agency may just want to know what the cost (input) and impact of training will be.

When do we Evaluate Training?

On a daily basis: This allows the trainer to respond immediately to feedback, problems, or concerns and adapt the training program to meet the participants’ needs and the training objectives.
- By using the exercise “Where Are We?” problems can be identified during the session that should be resolved before continuing on with the day’s work (whenever possible).
- By using the exercise “Reflections,” participants and trainers’ feedback, ideas, and concerns during the discussion can be used to revise the next days’ lesson plans.

Mid-way through the training program: This allows the trainer to refine the process and correct small problems before they become big ones so participants can benefit from findings during the same training event.
- A midcourse questionnaire helps the trainer identify how well the participant has grasped concepts taught up to that point.
- An evaluation form can be passed out to participants to get feedback on how they perceive the
training activities, what is working well, and what suggestions they may have for improving the training program.

At the end of the training program: This allows the trainer to refine future training activities and plan for supporting and following-up on participants who have been through the training program.

• A post-test and checklists are used to evaluate if the training program led to the desired participant knowledge, skills, and attitude acquisition.
• An evaluation form can be passed out to participants to get feedback on how they perceive the training activities, what is working well, and what suggestions they may have for improving the training program.
• An evaluation form can be passed out to trainers to inventory what worked and what needs improvement.

After participants have returned to their work sites:
• Checklists, interviews, and questionnaires can assist trainers in evaluating how well the training program prepared participants to apply new knowledge, skills, and attitudes in their workplace.

What is the Hardest Part of Training to Evaluate?
Answer: Impact, because it requires on-site visits and special care to identify other influences on the impact of training. For instance, no matter how well a health worker is trained, s/he cannot perform effectively without adequate support, supervision, etc.

<table>
<thead>
<tr>
<th>Method of Evaluation</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Questionnaires       | • Anonymous  
                      • A chance to reflect prior to answering  
                      • Hidden dynamics may be revealed | • Respondent must be literate  
                      • Cannot explore answer with participants  
                      • Possibility of misinterpretation by participants |
| Tests                | • Can evaluate K, A, S learning related to learning objectives | • Same as above  
                      • Some people do not do well in a written test situation  
                      • Requires skill in reliable and valid test construction |
| Interviewing         | • Interviewer can press for deeper answers  
                      • Can test meaning of an answer | • No anonymity  
                      • Requires skill  
                      • May require training to obtain unbiased data  
                      • Interviewee or interviewer affected by each other's personality  
                      • Participant may be reluctant to express views in a group or to an individual  
                      • Time consuming |
| Observation Performance | Based on experience or observations of individual's performance  
                      • Observer's perception can add dimension when guided by an observation tool | • Subject to observers seeing only one side of problem  
                      • No opportunity to get trainee's statement of own need |

(Past/Current)

Performance checklist
### Participant Handout 5.2: Measuring Training Results

<table>
<thead>
<tr>
<th>Level</th>
<th>What</th>
<th>Who</th>
<th>When</th>
<th>How</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Reaction: Did they like it?</td>
<td>Participants</td>
<td>End of program</td>
<td>“Smile Sheet”</td>
<td>Determine level of customer satisfaction. May indicate need for revision.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Learning: Did they learn it?</td>
<td>Participants, Trainer</td>
<td>During, before, after program</td>
<td>Pretest/post-test; Skills application through role-plays, case studies, exercises</td>
<td>Identify if the trainer has been successful in delivery of course content and achieving program objectives</td>
</tr>
<tr>
<td>Level 3</td>
<td>Application: Did they use it?</td>
<td>Participants, Bosses, Subordinates, Peers</td>
<td>3 to 6 months after program completion</td>
<td>Surveys, interviews, observation, performance appraisal</td>
<td>Determine extent to which they have transferred what they learned in the classroom to the actual work situation.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Results: Did it make a difference?</td>
<td>Participants, Control group</td>
<td>After completion of Level 3 follow-up</td>
<td>Cost-benefit analysis, tracking, operational data</td>
<td>Determine if benefits outweigh costs. Ascertain degree of contribution of program to organizational goals.</td>
</tr>
</tbody>
</table>
Participant Handout 5.3: Level 1: Reaction Evaluation

Level 1: Reaction
Level 1 deals with participant reaction, or “customer satisfaction.” Level 1 evaluations are often referred to as “Smile Sheets” because participant reactions are often based on how much fun they had during the training. But, level 1 is an important first step in determining the success of a training program and the evaluation form can be designed in a way that makes it an effective data collection tool. Participants reactions help determine the effectiveness of a program and how it can be improved. Kirkpatrick believes that you cannot bypass the first level because, “If they do not react favorably, they will not be motivated to learn.”

Level 1 can't measure the ability to apply the learning, the changes in attitude or beliefs, organizational impact, or the trainer's knowledge. The following reaction evaluation exercises are frequently used in Pathfinder training.

Daily participant evaluation forms (feedback sheets): Have these sheets photocopied in advance and hand them out at the end of each day. Include any information you would like to collect.

Pros and cons lists: At the end of the training day ask participants for the pros and cons or likes and dislikes for that day. Write these on a flip chart.

Suggestion boxes: Keep a suggestion box in the training room and encourage participants to use it. Read the suggestions at the end of the day. Try to ensure privacy for those making suggestions.

“Where are We?”: Each morning 1 person (either participant or trainer) reviews the highlights from the day before. The exercise is not a review of the previous day, but is used to get the most out of each day’s experiences. The person conducting the review should use it as an opportunity to share insights, clarify issues, resolve problems, or review important material. Problems identified should be resolved before continuing with the day’s work. The person conducting the exercise should provide each participant with 2 pieces of different colored paper. On 1 piece of paper each participant should write the topic they found most useful from the training the previous day. On the other piece of paper they should write how they will apply the information to their work. The person conducting the exercise can help group the second pieces of paper by topic. “Where Are We?” should be a regular feature of the beginning of each day during the training session.

Daily reflections: Explain that there are many ways to conduct this exercise. One way is to pass out 2 colored pieces of paper at the end of each day. Participants are asked to fill out the cards anonymously. On 1 card participants are asked to write what they liked about the day and what went well. On the other piece of paper they are asked to write the things that they hope will improve. When “housekeeping teams” are used in training, the “housekeeping team” and the training team review the results at the end of the day. The trainer announces the results the following day and explains how the training team responded to the suggestions. The exercise is an opportunity for the trainer and participants to share feedback on the day’s activities and identify areas that need reinforcement or further discussion.

A second option is the Plus (+)/Delta (∆) Exercise. The trainer may asks the group as a whole to
respond to the following questions:

- What did I like about today?
- What did I not like about today? What could be improved?

The trainer writes the responses under columns labeled + and Δ.

**Participant Reaction Forms:** Participant reaction forms are included with each module and are to be completed by each trainee at the completion of either a portion of the training or the whole training if only 1 topic was covered. A sample of this form can be found in the appendix.

**Designing a Level 1 Form**

**Categories** - Include many of the following categories: content, materials, instructional methods, trainer, environment, and logistics. The evaluation form should also include basic course information such as the title of the course, the names of the trainers, and the dates of the training.

**Format** - Use a variety of formats so that participants won’t respond the same way on every item. Formats may include the following:

- Choice questions with room for explanation or comments (yes/no, agree/disagree).
  Examples of choice questions might include some of the following:
  - The training objectives were clearly communicated and met to my satisfaction.
  - The pace of the training was appropriate for the topics covered.
  - The level of difficulty of the content was appropriate for me.
  - The instructor performed well overall.
  - The instructor is knowledgeable about the subject matter.
  - The instructor practiced effective time management.
  - I found the exercises valuable in helping me understand the concepts discussed and how to apply them.
  - The seating arrangement was appropriate for the content and duration of the training. Visual media and lighting were conducive to participation and learning.
  - Breaks, beverages, and snacks were ample for the session as it was scheduled.

- Short answer, open-ended questions
  - What part of the workshop was most useful to you? Why?
  - What topics would you have liked to have spent more or less time on?
  - What would you suggest the instructor do to improve his or her effectiveness?

- Complete the sentence. “What I want to know more about is…”

- Ratings—Rate from strongly agree to strongly disagree. List the numbers 1 through 5 next to each statement or question, associating the 5 with a high rating (agree) and 1 with a low rating (disagree).

- Rankings—“Please rank the topics in order of their importance.”

- Checklist—“Check the phrases that describe your reaction to today’s session.”

**Evaluation Form Guidelines**

- Keep the form brief.
- Create a balance among the various types of information being collected.
- Have participants complete the form immediately, before leaving the room so you get 100% of their feedback.
Participant Handout 5.3 continued: Evaluation Sample #1

Name of Program: 
Date: 
Trainer: 

1. The information presented in the session was:
   ___ Very useful to me.
   ___ Of some use to me.
   ___ Not of much use to me.

2. To what degree did this presentation give you a better overall view of the selection process? 
   (Please circle the appropriate number.)

   1    2    3    4    5    6    7    8    9    10
   Not at all   Somewhat   Very much

3. I particularly liked:

4. What is your overall rating of today’s session?
   ___ Excellent
   ___ Very good
   ___ Good
   ___ Fair
   ___ Poor

5. Other Comments:
Participant Handout 5.3 continued: Evaluation Sample #2

Title of Session:  
Date:  
Name of Trainer:  

General Instructions:  
- All the questions on this form deal with the trainer and the session.  
- Your answers will help us build better training programs in the future.  
- If you would like to make additional comments, please do so in the space provided.

1. Was the subject related to your needs and interests?  
   No ___ Some ___ Very much ___  
   Comment:  

2. How do you feel about the amount of lecture and the amount of discussion in the session?  
   Too much lecture ____  Just right ____  
   Too much discussion ____  Just right ____  
   Comment:  

3. How do you feel about the trainer for this session?  
   Excellent ____ Very good ____ Good ____ Fair ____ Poor ____  
   - How well did he/she state the objectives?  
   - How well did he/she keep the session alive and interesting?  
   - How well did he/she use charts and other visual aids?  
   - How well did he/she maintain a helpful, friendly manner?  
   - How well did he/she clarify points?  
   - How well was his/her summary at the close of the session?
4. Here is a scale describing how you might feel about the trainer. Please circle the number that is closest to the way you actually feel about the trainer.

Poor    1     2     3     4     5     6     7     Good

5. Now circle the number that is closest to the way you feel about the session itself.

Poor    1     2     3     4     5     6     7     Good

6. Will you do anything differently on your job as a result of this session?

Yes ___            No ___

If no,

7. What would have made the session more effective?
Participant Handout 5.3 continued: Evaluation Sample #3

Course:                                                  Date:

1. Course objectives                Yes                No
   • Were they fully explained?
   • Were they reviewed during the program?
   • Were they reviewed at the conclusion of the program?

Comments:

2. Do you feel there was sufficient time and opportunity for questions and discussions by the group?

3. What benefits do you feel you received from this program?
   ___ New knowledge that is pertinent to my current position.
   ___ Specific approaches, skills, or techniques that I can apply on the job.
   ___ Change of attitude that will help me in my job.

4. What do you feel are the major strengths of this course?

5. What is your evaluation of the materials that you received?

6. Would you recommend this course to others?
   If so, to whom?
   If not, why not?

7. What significant changes would you recommend for improving future programs?
8. Please add any other comments you would like to make about any aspect of the course (instructor, materials, topics covered, setting, visual aids).

9. Indicate your overall evaluation of the course.

12 11 10 9 8 7 6 5 4 3 2 1
Excellent Good Satisfactory Unsatisfactory

Optional:

Name:

Place of Work:
Participant Handout 5.3 continued: Evaluation Sample #4

Course:  
Instructor:  

Title:  
Location:  

Date:  

Instructions: Your comments and evaluations are extremely valuable to us in gauging the effectiveness of the workshop and helping to focus subsequent sessions on those issues of greatest interest to the participants. Please consider the following questions carefully and write your answers in the space provided.

1. What is your overall evaluation of the workshop? (Circle the appropriate number.)

   1                      2                  3                     4                          5
   Unsatisfactory       Marginal        Good           Very Good            Excellent

   Comments:  

2. What parts of the workshop were most valuable or beneficial to you?  

   Why?  

3. What parts of the workshop were least valuable or beneficial to you?  

   Why?  

4. What will you plan to do differently when you return to your job as a result of your attendance at this workshop?  

5. General comments:  

Participant Handout 5.4: Level 2 Evaluation

Level 2 deals with what the participants actually learned during the training session. Kirkpatrick defines learning as, “the extent to which participants change attitudes, improve knowledge, and/or increase skill as a result of attending the program.” Evaluating a change in attitude is the hardest to do.

There are 3 methods of evaluation in Level 2—objective tests, observation, and interviews.

Objective Tests
Types of Tests – Test questions may be subjective (short-answer or essay) or objective (multiple choice or true/false)

*Question Format* – All multiple choice questions should have a part that presents a problem and asks a question. All of the possible answers given should be plausible. The greater the number of items, the more reliable the test.

*Correct Answer* – The correct answer format asks a simple question, to which there is only one answer.

*Best Answer* – This type of question has more than one correct answer. This type of question requires a higher level of thinking, but is more easily challenged.

*Combined Response* – This type of question has a list of possible choices and a second list of possible combinations of answers. This type of question is difficult to write and difficult to answer.

Observation
Trainers may observe Px practicing and applying skills, tools, and techniques during the session. This can be done through role plays, simulations, or case studies.

Interviews
Shortly after the training, interview the Px and ask what they learned during the training session.
Participant Handout 5.5: Writing Test Questions

Developing test questions is not as easy as it seems. Occasionally when tests are given and the results are tallied we find that almost all of the trainees have gotten a few of the questions either all right or all wrong. It is unlikely that this is the fault of the training, but more likely that this is the fault of the test question.

There are several types of test questions. Test questions may be either subjective (short-answer, case study, or essay) or objective (multiple choice, matching, fill-in-the-blank or true/false). You can use one type of question or a combination of both. There are advantages and disadvantages to both types of questions. Objective tests are easy to score and quick to use, but the questions are more difficult and time consuming to write. Subjective tests are much easier to write, but grading them is both time consuming and subjective (open to interpretation). Because the subjective tests are open to interpretation, it makes it difficult to compare groups of trainees or to compare the original questions with those conducted later during a training evaluation. For these reasons, objective tests are preferable in Pathfinder training materials.

When writing test questions there are several rules to keep in mind:

• Include directions for the test and make sure they are clear, specific, and complete. If there are different sections, have directions for each.
• Instead of asking for simple information, ask questions that require participants to interpret or apply what they have learned.
• Link the questions to the specific learning objectives in the training material, at least one question for each learning objective. Link the questions to the action verb in the objective. For example, if you ask participants to identify something in the objective, follow through in the question.
• Maintain grammatical consistency for both the main part of the question and answer choices.
• Keep the sentences simple and limited to 1 idea.
• Arrange the questions in a logical order.
• Don’t give clues to the answers in the question.
• Avoid tricky or catchy questions.
• State the questions as specifically as possible and make sure there is only 1 correct answer.
• Make the incorrect answers plausible.
• Avoid including irrelevant or misleading clues.
• Scatter the correct responses and look over all the answers when you have finished, making sure they are scattered.
• Have a uniform number of choices if possible.
• Include rules for scoring the test for the trainer. Make sure the trainers don’t mark off for poor spelling or other irrelevant factors.
• Always pretest questions, both before and after a training. If you find that most participants get some items either wrong or right on both the pre- and post-test, then the test item is probably poor and should be thrown out.

Below are some definitions, examples, sample instructions, and simple guidelines for writing each type of question.
Multiple Choice Questions
These are test questions where several options or choices are given. Clear instructions should be given, such as:
• Circle the letter(s) of the answer(s) you consider correct.
Or
• Circle all the answers that apply. Some questions may have more than more than one correct answer.
It is also possible to ask multiple choice questions in a format where there is only one correct answer. An example of a multiple choice question is:

Bacterial endospores, which cause tetanus and gangrene are:
a. Reliably killed by soaking in Savlon.
b. Reliably killed by fumigation.
c. Reliably killed by boiling (high level disinfection).
d. Reliably killed by sterilization (autoclave).

Guidelines for writing multiple choice questions.
• Avoid “all of the above” or “none of the above” options.
• Have at least 4 possible answers.
• Try to create choices of equal length.
• Avoid ambiguity and reading difficulty by stating questions in the positive rather than negative.
• Use simple, conversational language when phrasing the item and its choices.
• All multiple choice questions should have a part that presents a problem and asks a question.
• All of the possible answers given should be plausible.

True/False Questions
These are test questions where the trainee is asked to decide whether the statement given is either true or false. Clear instructions should be given, such as:
In the space provided, print a capital T if the statement is true or a capital F if the statement is false.

An example of a true/false question is:
___ Antiseptics are chemicals which can be used safely on skin to kill or reduce the number of microorganisms.

Guidelines for writing true/ false questions:
• Don’t include obviously wrong choices. Make even the false answers plausible.
• For true/false questions make the questions clear and understandable and avoid words like more, few, large, several, or good.
• For true/false questions avoid words associated with true such as usually, frequently, generally, or customarily and avoid words associated with false such as only, never, none, or no.

Fill-in-the-Blank Questions
These are test questions where a part of the statement is missing. Trainees are asked to fill in the missing part of the statement. Clear instructions should be given, such as:
Fill in the blank spaces in the statement with the correct answer(s).
An example of a fill-in-the-blank question is:
Two common sources of reproductive health information for adolescents that can be inaccurate or misleading include ___________ and __________.

Guidelines for writing fill-in-the-blank questions:
• Make sure the main part of the question contains most of the information. Put blanks or fill-ins at the end.
• State questions in the positive rather than negative to avoid ambiguity and reading difficulty.
• The blank spaces should be related to key or important ideas.

Matching Questions
These are test questions where there is a list of possible choices and a second list of possible matching answers. Clear instructions should be given, such as:
Match the definition with the correct term by placing the correct letter in front of the matching term. See example in bold:

**Closed questions**

Reassurance  a. Invite the patient to give a longer answer. (Tell me more about your back pain. What else is troubling you?)

Direction   b. Use open- and closed-ended questions to get the information you need

Empathy     c. Showing your support

Partnership e. Require only a “yes” or “no” or very short answer. (Is your back painful? How old are you?)

Asking questions  d. Use open- and closed-ended questions to get the information you need

**Open questions**

g. Guiding a client back to the point of the visit

h. Offering your commitment to help

Guidelines for writing matching questions:
• Use simple, conversational language when phrasing the item and its choices.
• Keep the matching items short.
• For matching tests, have the whole matching section on 1 page so participants don’t have to refer to more than 1 page for answers.
• Provide several extra choices in the list of possible matches.
• For matching items have no less than 5 and no more than 20.

Case Study Questions
These are test questions developed to accompany a short medical case study. Clear instructions should be given, such as:
After carefully reading the case study, answer each of the questions.
An example of a case study with questions is the following:

A truck driver was away from home for many days last month. He had sex with 6 women during the month. One woman was his wife, who has no other sexual partner. Four were women working in bars along the road, and the sixth was a sex worker he met in the capital city.

**Question and Answer**

**Example:**

1. Of this man’s partners, which are the most vulnerable to getting a STD?
   **Answer:** They are all vulnerable to infection if he is infected, but those women with more partners have a greater risk of infection from other sources as well.

2. The man is found to have gonorrhea and is treated. The health worker advises him to bring all his partners to the clinic for treatment. Which of the women would he be most likely to bring? Why?
   **Answer:** He would be most likely to bring the women in the bars or the sex worker because he wouldn’t want his wife to know he had been unfaithful.

**Guidelines for writing a case study:**
- Keep the case study short and not overly complicated.
- Only use terminology the trainee is likely to be familiar with.
- Use examples that are plausible and realistic.
- Link the case study directly to the training. Don’t try to add additional messages.
Participant Handout 5.6: Using Objective Test Scores

Pre- and post-tests provide valuable information about both the participant and the training program.

When using individual scores, the trainer can
- Assess how well the participant has assimilated new knowledge acquired during the training program,
- Assess areas in which the participant has adequately understand knowledge content, and
- Assess areas in which the participant needs to focus more attention on.

The trainer can total up all of the participants’ scores and divide those scores by the number of participants to calculate the average score for the participants. This information can help the trainer
- Assess how well the participants, as a group, acquired the knowledge taught in the training program; and
- Assess how well the training course taught the knowledge outlined in the objectives.

The trainer can make a grid that allows the trainer to plot the number of points obtained by each participant for each question. This information can help the trainer
- Assess which areas all, most, or none of the participants had difficulty understanding; and
- Decide if a question is a problem if all or most of the participants missed it.
Participant Handout 5.7: Postpartum Care Test

Case studies:
For each mini case study below, decide if the findings indicate a

- Normal postpartum,
- Common discomfort of the postpartum,
- Life-threatening complication, or
- Non life-threatening complication.

Then decide if care can be provided by

- The Community Midwife (CMW),
- The CMW needs to write a referral to the Community Health Centre (CHC), or
- The CMW needs to facilitate immediate/emergency transfer to the District Women’s Hospital (DWH).

1. Ms. S___ comes to the CMW 6 weeks after giving birth. She is tired but has no complaints. Her conjunctiva, tongue, and palms are pink. Her pulse rate is 76 beats per minute.

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<thead>
<tr>
<th>Findings:</th>
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<td>□ Normal postpartum</td>
<td>□ Care can be provided by the CMW</td>
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<td>□ Common discomforts of postpartum</td>
<td>□ CMW needs to write a referral to the CHC</td>
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<tr>
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<td>□ CMW needs to facilitate immediate/emergency transfer to the DWH</td>
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<td>□ Non life-threatening complication</td>
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(2 points possible – Give 1 point for each correct answer; give 0 points if there are no correct answers.)

2. Ms. R___ gave birth 10 days ago and tells you that she has bad smelling vaginal discharge, a fever, and lower abdominal pain. You find the discharge is greenish and very foul-smelling, her uterus is tender, and her temperature is 38.5°C. Her pulse is 108 beats per minute, her Blood Pressure (BP) is 100/68.

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(2 points possible. Give 1 point for each correct answer. Give 0 points if there are no correct answers.)
3. Ms. T____ came for her 6-day postpartum visit and has no complaints. When you examine her, you find that her uterus is just below the umbilicus, her temperature is 38.1°C. Her pulse is 88 beats per minute, her BP is 120/68. Her lochia had turned to reddish/brown and now has returned to red and is abundant and somewhat foul-smelling.

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(2 points possible. Give 1 point for each correct answer. Give 0 points if there are no correct answers.)

4. Ms. P_____ gave birth 11 days ago and came to the CMW because she noticed that her lochia had changed from red to pink and was now white and was worried that she had an infection. When you examine her, you notice she has whitish, heavy but not bad smelling discharge and no other signs or symptoms.

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<td>□ CMW needs to write a referral to the CHC</td>
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<td>□ CMW needs to facilitate immediate/emergency transfer to the DWH</td>
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(2 points possible. Give 1 point for each correct answer. Give 0 points if there are no correct answers.)

5. Ms. K______ comes for a routine postpartum visit at 6 days postpartum. On physical examination you find:

- Uterus: About halfway between the xiphoid and the symphysis pubis, firm and not tender
- Breasts: Soft and full, nipples not cracked or sore
- Breastfeeding: Baby is passing urine 6-8 times and is gaining weight
- Lochia: Reddish/pink and no foul smell

Are these findings normal for a woman 6 days postpartum? (Circle the correct response)

Yes / No
6. You visit Ms. M________ 3 days after delivery. As part of the visit, you observe her breastfeeding her baby. You observe:

Is the baby well attached or not? (Circle the correct response) Yes / No

True / False Questions
7. During the first 2 hours after birth/delivery it is not appropriate to offer a woman fluids to drink because it may cause her bladder to become distended.
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

8. Breastfeeding should be initiated within 1 hour of delivery, assuming that the mother and infant are ready.
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

9. If a woman has not voided within 6 hours and she cannot void on her own and her bladder is full, the protocols suggest catheterizing her bladder to prevent distension.
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

10. If a woman is HIV positive and breastfeeding, encourage her to get her iron/folate needs from dietary sources rather than from tablets.
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

11. If a postpartum woman is due for a Tetanus Toxoid (TT) immunization and she plans to breastfeed, do not give the immunization.
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

Short Answer Questions
12. Ms C__ just gave birth. She did not void before delivery or at the time of the birth. Her bladder is distended. What is the potential hazard of a full bladder in the immediate postpartum period?
13. Ms B’s membranes have not broken. The cervix is fully dilated and cannot be felt. The baby’s head is low in the pelvis and visible with contractions. What conditions are met in Ms B’s labour for safe artificial rupture of membranes?
(3 points possible. Give 3 points if all of the answers are correct. If there are less than 3 correct answers, give 1 point for each correct answer. Give 0 points if there are no correct answers.)

14. Which oxytocic acts more quickly – oxytocin or ergometrine?
(1 point possible. Give 1 point if the answer is correct. Give 0 points if the answer is not correct.)

Multiple Choice Questions
Instructions: Circle the correct answer.

15. Ms B has just delivered a healthy baby. The perineum is intact. During third stage how often should the provider monitor the amount of vaginal bleeding and the consistency of the uterus?
   a. Every 10 minutes
   b. Every 15 minutes
   c. Continuously
(1 point possible. Give 1 point if the answer is correct. Give 0 points if the answer is not correct.)

16. One day after delivery, Ms C reports the sudden onset of vaginal bleeding heavier than a period. On rapid assessment you find that she is not in shock. What should you do next to care for this woman?
   a. Take a targeted history
   b. Massage the uterus and expel clots
   c. Check Ms C’s hemoglobin
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

17. Mrs Y has a fever and chills. She is 3-weeks postnatal. Her left breast is swollen, reddened, and tender. To find protocols for the recommended treatment for Mrs Y, what complication will you look up in the Clinical Protocols?
   a. Cystitis
   b. Mastitis
   c. Pelvic abscess
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)
Matching Questions

18. For each of the actions of the health care provider listed below (1-3), choose the infection prevention reason for this action from the list, (a-c).

- 18.1 Provider diagnoses and treats gonorrhea during pregnancy.
- 18.2 Provider provides Tetanus Toxoid (TT) during pregnancy.
- 18.3 Provider cuts and ties cord with clean hands, clean instrument, and clean cord tie.

   a. To prevent newborn acquiring blood born infection, septicemia.
   b. To prevent newborn acquiring eye infection that can cause blindness.
   c. To prevent newborn acquiring tetanus.

(3 points possible. Give 3 points if all of the answers are correct. If there are less than 3 correct answers, give 1 point for each correct answer. Give 0 points if there are no correct answers.)

Write the letter corresponding to the type of hypertensive disorder in the column next to the description of signs and symptoms.

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<tr>
<th>a. Chronic hypertension</th>
<th>b. Mild preeclampsia</th>
<th>c. Severe preeclampsia</th>
<th>d. Eclampsia</th>
<th>e. Pregnancy induced hypertension</th>
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19. A woman who has recently given birth is found unconscious or having convulsions (seizures), with diastolic BP 110 mm Hg or more, and proteinuria 2+ or more.  
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

20. Diastolic BP 90 mm Hg in a woman who was treated for hypertension before she got pregnant.  
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

21. Two readings of diastolic BP 90 mm Hg or more but below 110 mm Hg 4 hours apart, proteinuria up to 2+.  
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)

22. Diastolic BP 110 mm Hg or more, proteinuria 3+ or more.  
(1 point possible. Give 1 point for the correct answer. Give 0 points if the answer is not correct.)
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Percent (Total points divided by possible points)

Average (Add totals of all participants divided by the number of participants) 250/10 = 25
Participant Handout 5.10: Competency-Based Skills Checklists

A competency-based checklist is developed by breaking down the clinical skill or activity to be taught into its essential steps. Each step is then analyzed to determine the most efficient and safe way to perform and learn it. These checklists make learning the necessary steps or tasks easier and evaluating the learner’s performance more objective.

In addition to using checklists to learn a skill, participants and trainers keep track of progress in the clinical area by using checklists. The checklists contain enough detail to permit the trainer to evaluate and record the overall performance of the skill or activity.

Using checklists in competency-based clinical training

• Ensures that participants have mastered the clinical skills and activities, first with models, and then with clients;
• Ensures that all participants will have their skills measured according to the same standard; and
• Forms the basis for follow-up observations and evaluations.

Criteria for satisfactory performance by the participant are based on the knowledge, attitudes, and skills demonstrated and practiced during training. In preparing for formal evaluation by the trainer, participants can familiarize themselves with the content of the checklist by critiquing each other’s skills.

When evaluating the performance of a participant, the trainer will judge each step of the skill to be

• **Satisfactory:** Performs the step or task according to standard procedure or guidelines;
• **Unsatisfactory:** Unable to perform the step or task according to standard procedure or guidelines; or
• **Not Observed:** Step, task, or skill not performed by participant during evaluation by the trainer.

When determining **competence**, the judgment of a skilled trainer is the most important factor. Thus, in the final analysis, competence carries more weight than the number of presentations (which may be only 2 or less depending on the number of participants attending this course). Because the goal of this training is to enable **every** participant to achieve competency, additional training or practice in these skills may be necessary.

The checklist is first used to assess participants’ performance on models. After participants demonstrate competency, they can work with clients, and the checklist is once again used to assess their performance.

When completed, this checklist, together with the trainer’s and clinical preceptor’s comments and recommendations, provides objective documentation of the participant’s level of performance. Furthermore, it serves as one part of the process of attesting that the participant is qualified to provide the clinical service (e.g., active management of third stage of labor) or activity (e.g., counseling on family planning methods).
Participant Handout 5.11: Level 3: Behavior Evaluation

Level 3 evaluation answers the question, “How has the training affected the way participants perform their job?” But Level 3 Evaluation can be both time consuming and costly.

Purpose of Level 3 Evaluation
The purpose of level 3, or behavior, evaluation, is to
- Evaluate what happens to trainees after they leave training and return to their jobs;
- See how much transfer of knowledge, skills, and attitude has occurred;
- Measure lasting results from training;
- Identify areas in which trainees show greatest and least improvement; and
- Compare follow-up and end-of program responses.

In summary, level 3 evaluation measures the changes in job behavior that occurred because people attended the training program.

Guidelines for Level 3: Behavior Evaluation
- Allow time for behavior change to take place.
- Evaluations following clinical training are often conducted 6 months to 1 year after training.
- Prepare participants. At the end of the training, tell the participants that an evaluation will be conducted to see how they are using what they learned sometime in the future.
- If the training was not effective, find out why. Encourage the participants to identify reasons they haven't improved and what factors obstruct their progress. Often there are factors that make it difficult for the trainees to practice their new skills. For example, a nurse may be trained in IUD insertion, but there is no doctor in her facility trained and she is not allowed to practice what she has learned. Other barriers might include lack of equipment, the supervisor, or existing policies and procedures.
- Survey or interview one or more of the following: trainees, their immediate supervisor, and if possible the clients they serve. When deciding who to interview, answer the following questions: Who is best qualified? Who is most reliable? Who is most available? Are there reasons why 1 or more of these people shouldn't be interviewed?
- Share the evaluations with the trainee’s clinic manager or supervisor. Supervisors and managers should know the results of the evaluation because they are involved in how the trainee applies the training.

Observations
The trainee should be observed back on the job. If possible, it is preferable to have another clinical trainer do the observations rather than the trainer who conducted the training, to avoid bias. Create a checklist of the skills that you wish to observe. Ideally the competency-based training skills checklist that was used during training should be used in the observation. An example can be found in the participant handouts.

Interviews
Interview those who are closely associated with the trainee, including clinic managers, supervisors, coworkers, and clients. Design the interview questions carefully to focus on specific behavior changes such as counseling skills. Interviews of the trainees may include questions such as:
• What specific behaviors were you taught and encouraged to use?
• Did you feel confident in your IUD insertion skills?
• If you were not able to practice IUD insertion, why not?
• What suggestions do you have for making the training more useful?

Surveys
Surveys are a more efficient and less expensive way to find out if trainees are actually applying what they learned. As with interviews, design questionnaires for the different people you want information from (clinic managers, supervisors, coworkers, and the trainee). When using the survey method, it is also easy to include a control group of service providers who did not participate in training. Surveys usually include a rating scale because they are more objective and easier to analyze than written answers to questions.
Participant Handout 5.12: Competency-Based Training Skills Assessment Checklist for Combine Oral Contraceptives

Date of Assessment: _______________ Dates of Training: ________________

Place of Assessment: Clinic ___ Classroom ___

Name of Clinic Site: ______________________________________________

Name of the Service Provider: _____________________________________

Name of the Assessor: ____________________________________________

This assessment tool contains the detailed steps that a service provider should take in counseling and providing client instructions for Combined Oral Contraceptives (COCs). The checklist may be used during training to monitor the progress of the trainee as s/he acquires new skills and it may be used during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. It may also be used by the trainer or supervisor when following-up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the Assessor

1. Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe.

2. Begin the assessment when the trainee greets the client.

3. Use the following rating scale:
   - 2 = Done according to standards
   - 1 = Needs improvement
   - N/O = Not observed

4. Continue assessing the trainee throughout the time s/he is with the client, using the rating scale.

5. Observe only, and fill in the form using the rating numbers. Do not interfere unless the trainee misses a critical step or compromises the safety of the client.

6. Write specific comments when the task is not performed according to standards.

7. Use the same copy for several observations.

8. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.
### COC Checklist

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>COC COUNSELING</strong></td>
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<td>2</td>
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<tr>
<td>Ensures necessary privacy.</td>
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<tr>
<td>Obtains necessary biographical data (name, address, age, etc.).</td>
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<tr>
<td>If client has chosen COCs:</td>
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<tr>
<td>• Asks her what she knows about COCs. Corrects any myths, rumors, or misinformation she may express</td>
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<tr>
<td>• Asks if she has used COCs in the past. What was her experience?</td>
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<tr>
<td>• Gives client a package of COCs to look at and handle.</td>
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<tr>
<td>• Explains advantages of the COC, including non-contraceptive benefits.</td>
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<tr>
<td>• Briefly explains how the pills work and the importance of taking it every day.</td>
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<tr>
<td>• Explains potential common side effects of COCs. Stresses that she may experience some (or possibly none) of these and that they can all be managed:</td>
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<tr>
<td>• Amenorrhea/very scanty periods</td>
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<td>• Spotting or break-through bleeding</td>
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<td>• Nausea</td>
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<td>• Headaches</td>
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<td>• Breast tenderness/fullness</td>
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<td>• Mood changes/depression</td>
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<td>• Weight gain or weight loss</td>
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<td>• High blood pressure</td>
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<tr>
<td>• Reassures client that most side effects are not serious and will decrease or stop after about 3 months of use.</td>
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<tr>
<td>• Responds to any questions or concerns the client may have.</td>
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<td>• Explains that s/he will ask the client some questions and perform a minimal physical examination to be sure that the COC is medically appropriate.</td>
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<tr>
<td>Task/Activity</td>
<td>Cases</td>
<td>Comments</td>
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</table>
| - Screens client for COC precautions. Asks all questions on checklist and record responses.  
  o Do you think you are pregnant?  
  o Have you had any bleeding between periods?  
  o Do you have bleeding after intercourse?  
  o Any bleeding heavier than usual over the past 3 months?  
  o What is your age?  
  o Do you smoke cigarettes/use other tobacco products?  
  o Do you have high blood pressure?  
  o Do you have diabetes?  
  o Have you ever had a blood clot in your legs, lungs, or eyes?  
  o Have you ever had a stroke?  
  o Have you ever been told you have heart disease?  
  o Do you have severe chest pains and unusual shortness of breath?  
  o Do you think you have heart disease?  
  o Have you noticed a lump in your breast?  
  o To your knowledge, do you have liver disease?  
  o Have you ever been told you have a tumor of the liver?  
  o Have you ever developed yellow jaundice during pregnancy?  
  o Are you breastfeeding a child less than 6 months old at present?  
  o Are you fully or almost fully breastfeeding (no solid food supplements or liquids)?  
  o Have you had a menstrual period since your delivery? (Bleeding in the first 56 days following delivery is not considered a menstrual period.)  
  o Have you ever had a severe pelvic infection with chills, fever, pain in your womb area, and a vaginal discharge?  
  o Do you have any of these symptoms now?  
|               |       |          |
| • Reassures client of confidentiality and use your judgment concerning the necessity of asking the following question:  
  o Do you or your husband/partner have other sex partners?  
  o What medicines do you regularly take?  
  o Are you taking any medicines for seizures/convulsions? Tuberculosis (Rifampin)? Other medications?  | | |
<p>| • Manages or refers for follow-up any positive findings. | | |</p>
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
</table>
| • Physical Exam:  
  o Explain the procedure(s) you will perform and reassure the client of her safety.  
  o Check blood pressure: Is it elevated?  
    - Systolic over 190? Or  
    - Diastolic over 110? Or  
    - Blood pressure on three occasions consistently over 160/90?  
  o Check weight.  
  o Cardiovascular:  
    - Extreme shortness of breath observed?  
    - Severe pallor or cyanosis observed?  
    - Resting heart rate greater than 100, or markedly irregular?  
    - Legs edematous?  
    - Severe varicosities?  
  o Breasts:  
    - Any suspicious lumps?  
  o Is she jaundiced?  
  o Does she have an enlarged or tender liver?  
  o Records findings.  
| | | |
| • Manages or refers for follow-up any positive findings as recommended by local guidelines.  
• If COC is appropriate, gives the following client instructions:  
  o Start the pill on first day of your next menstrual period (or on fifth day of your menstrual period, or use local guidelines for this instruction). If the client starts the pill after day five of her cycle she should use a back-up method for the first 7 days.  
  o Explain to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following:  
    - If she misses 1 pill, she should take it as soon as she remembers. Take the next one at the regular time.  
    - If she misses 2 pills, the client should take 2 pills as soon as she remembers. She should take 2 pills the next day, and use a backup method for the next week. The client should finish the packet normally.  
    - If she misses more than 2 pills, the client should throw away the packet, and start a new one, and use a back-up method for the next week.  
| | | |
| • Cautions client that she may feel queasy or nauseated if she takes 2 pills in 1 day, but taking 2 pills reduces her chances of becoming pregnant.  
  o Shows client how to use spermicide if she has not previously used it.  
| | | |
| Task/Activity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cases | Comments |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Explains other situations in which a back-up method is needed:  
  o Diarrhea/vomiting: Start using a back-up method on the first day of diarrhea or vomiting, and use it for at least 7 days after the diarrhea/vomiting is over. Meanwhile, continue to take your pills as usual.  
  o If taking certain medications used in the treatment of tuberculosis and seizures (rifampin, phenytoin, carbamazepine).  
  • Stresses the importance of informing other doctors/health workers who may care for her, that she is using the COC.  
  • Asks the client to repeat back in her own words instructions for when to start the COC, which pill she will begin with, how she will take the second and subsequent pills, and what she will do if she misses a pill or pills.  
  • Explains in a non-alarming way the early signs of complications from the pill, stressing the rarity of these.  
  o Severe, constant pain in belly, chest, or legs and very bad headaches that start or become worse after she begins to take COCs,  
  o Brief loss of vision, seeing flashing lights or zigzag lines (with or without bad headaches), and  
  o Jaundice (skin and eyes look yellow).  
  • Asks client a few questions to ensure that she understands and remembers key instructions.  
  • Prescribes or provides client with at least a 3-month supply of COCs.  
  • Prescribes or provides client with at least a 3-month supply of spermicide.  
  • Reassures client that she may change the pills or try another method if she does not like these COCs.  
  • Reassures client that s/he is available to see her if she has any problems or questions or needs advice.  
  • Plans for a return visit and gives the client a definite return date.  
  o Asks the client to bring her pill packets with her on the return visit.  
  • Documents/records the visit according to local clinic guidelines.  
                                                                                           |       |          |
| RETURN VISIT COUNSELING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |       |          |
| 1. Asks client if she is satisfied with the COC.  
  2. Asks if she is having any problems or experiencing any side effects. If yes, manage these as appropriate (see INTRAH Guidelines).  
  3. Asks client how she is taking the COCs and to demonstrate with the package she is using.                                                                                                                                                                                                                                                                                                                                                     |       |          |
<table>
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<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
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<tbody>
<tr>
<td>4. Repeats the history checklist. If history suggests client has developed a precaution, does an appropriate physical examination to rule out or verify.</td>
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<td>5. Checks client’s blood pressure.</td>
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<tr>
<td>6. Briefly reviews key messages/instructions concerning missed pills, use of back-up method, and danger signs.</td>
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<tr>
<td>7. Asks client to repeat these back.</td>
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</table>
| 8. If she is satisfied with the COC, is tolerating the COC well, is not experiencing any serious side effects, and no precautions exist:  
  - Prescribes/provides at least another 3 cycles of COCs (she may be provided with up to 13-18 cycles).  
  - Provides her with a sufficient supply of spermicide. |       |          |
| 9. If client wants to discontinue the COC, helps her make an informed choice of another method. |       |          |
| 10. Encourages her to return at any time if she has questions or problems.   |       |          |

**Comments:**
Participant Handout 5.13: Competency-Based Training Skills Assessment Checklist for IUD Insertion

Date of Assessment: ______________  Dates of Training: _________________

Place of Assessment: Clinic ___  Classroom ___

Name of Clinic Site: ______________________________________________

Name of the Service Provider:_______________________________________

Name of the Assessor:____________________________________________

This assessment tool contains the detailed steps that a service provider should accomplish in counseling and providing client instructions for IUDs. The checklist is to be used after general counseling has been done and the provider has determined that the IUD is the client’s chosen method. The checklist may be used during training to monitor the progress of the trainee as s/he acquires the new skills and it may be used during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. It may also be used by the trainer or supervisor when following-up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the Assessor

1. Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe.

2. Begin the assessment when the trainee greets the client.

3. Use the following rating scale:
   2 = Done according to standards
   1 = Needs improvement
   N/O = Not observed

4. Continue assessing the trainee throughout the time s/he is with the client, using the rating scale.

5. Observe only, and fill in the form using the rating numbers. Do not interfere unless the trainee misses a critical step or compromises the safety of the client.

6. Write specific comments when the task is not performed according to standards.

7. Use the same form for several observations.

8. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling (Insertion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures necessary privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains biographical information (name, address, etc.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives the client information about the contraceptive choices available and the risks and benefits of each:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Shows where and how the IUD is used,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explains how it works and its effectiveness,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explains possible side effects and other health problems, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explains benign nature of the most common side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses the client’s needs, concerns, and fears in a thorough and sympathetic manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps the client begin to choose an appropriate method.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screens the client carefully to make sure there is no medical condition that would be a problem (completes client assessment checklist).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains potential side effects and makes sure that they are fully understood.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pre-Insertion Counseling (Examination/Procedure Area)**

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews client assessment checklist to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informs client about required physical and pelvic examinations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks that client is within seven days of last menstrual period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rules out pregnancy if beyond day seven (refers for medical care, if non-medical counselor).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describes the insertion process and what client should expect during and afterwards.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post-Insertion Counseling**

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completes client record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaches client how and when to check for strings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses what to do if client experiences any side effects or problems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides follow-up visit instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reminds client that the TCu 380A can be left in for 10 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assures client that she can return to the same clinic at any time to receive advice, medical attention, and, if desired, to have the IUD removed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the client to repeat instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answers client’s questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Cases</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Counseling (Removal)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Removal Counseling (Client Reception Area)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Greets client in friendly and respectful manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Establishes purpose of visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Asks client her reason for removal and answers any questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Asks client about her present reproductive goals (i.e., does she want to continue spacing or limiting births?).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Describes the removal process and what she should expect during the removal and afterwards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post-Removal Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Discusses what to do if client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Asks client to repeat instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Answers any questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If client wants to continue spacing or limiting births, reviews general and method-specific information about family planning methods.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Assists client in obtaining new contraceptive method or provides temporary method (barrier) until method of choice can be started.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Observes client for five minutes before sending her home.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 5.14: Competency-Based Training Skills Assessment Checklist for DMPA Injectable Contraceptive

Date of Assessment: _______________  Dates of Training: _________________

Place of Assessment: Clinic ___  Classroom ___

Name of Clinic Site: ______________________________________________

Name of the Service Provider:_______________________________________

Name of the Assessor:____________________________________________

This assessment tool contains the detailed steps that a service provider should accomplish in counseling and providing client instructions for DMPA. The checklist may be used during training to monitor the progress of the trainee as s/he acquires the new skills and it may be used during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. It may also be used by the trainer or supervisor when following-up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the Assessor

1. Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe.

2. Begin the assessment when the trainee greets the client.

3. Use the following rating scale:
   2 = Done according to standards
   1 = Needs improvement
   N/O = Not observed

4. Continue assessing the trainee throughout the time s/he is with the client, using the rating scale.

5. Observe only, and fill in the form using the rating numbers. Do not interfere unless the trainee misses a critical step or compromises the safety of the client.

6. Write specific comments when the task is not performed according to standards.

7. Use the same form for several observations.

8. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.
## DMPA Checklist

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After general counseling and the client has chosen DMPA as the method she wants to use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greets client respectfully.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers client a seat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assures privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes rapport by asking about client/family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses simple language.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to expect during the clinic visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains necessary information about the client’s ideas and fears.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains how DMPA works.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains potential side effects, especially those related to menstrual irregularities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains frequency of return visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures that the client understands.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to expect regarding the injection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourages the client to ask questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses open-ended questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses open-ended questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Displays visual aids.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows the client the injectable vial.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourages the client to return to the clinic if there are any questions or concerns.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Client Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains the procedure to client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers the screening checklist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes the client’s blood pressure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighs the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attaches completed screening checklist to the client’s record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refers the client to a physician, only if appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the client is less than 6 weeks postpartum and breastfeeding, encourages her to return when the infant is 6 weeks old.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administering The Injection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washes his or her hands with soap and water.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assembles all materials needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains the procedure to the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows the client the supplies to be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reassures the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Cases</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>Allows the client to choose the injection site.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If using DMPA, gently shakes the vial.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses sterile technique in assembling syringe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completely draws the fluid into the syringe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleans the injection site with antiseptic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows the site to dry before injecting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructs the client not to massage the site.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inserts the needle deep into the muscle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdraws the plunger.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injects the contents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers appropriate back-up method to the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records information on the client's card.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructs the client when to return.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INFECTION PREVENTION**

Washes his or her hands before and after procedure.

Air dries hands or uses a clean towel.

Drops the used needle into a bottle of 0.5% chlorine solution.

Does not recap, bend, or break needles before disposal.

Disposes of used needles and syringes by burning or burying.

*If syringes and needles must be reused the following procedures are followed:*

Decontaminates items in 0.5% chlorine solution.

Cleans items with soap and water and rinses each with clean water.

If sterilizing items, wets the lumen of the needle, and heats in autoclave at 121°C for 20 minutes if unwrapped, or 30 minutes if wrapped

If high-level disinfecting items, covers items with water and boils for 30 minutes.

Removes items when dry with sterile or H high-level disinfected LD forceps

Stores items in a covered, sterile container.

*If this is the client’s first visit, the following tasks should be performed and observed:*

Gives an appointment card with the date.

Gives verbal instructions.

Allows the client to repeat these instructions.

Instructs the client to return early if she has questions or concerns.

Provides a back-up method if appropriate.

*If this is a follow-up visit for the client, the following tasks should be performed and observed:*

Asks the client about her experience with the method.
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross checks the appointment date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks and records the client’s weight.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records any other relevant information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives the satisfied client supportive counseling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives a date for the client’s next return visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examines the client if she has complaints, and takes her history.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reassures her and provides further counseling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manages side effects appropriately.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refers the client when appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps the client choose another method if not satisfied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a client returns early, administers DMPA up to 4 weeks early.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a client returns late, administers DMPA up to 2 weeks late.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a client returns after the 2-week grace period, rules out pregnancy before next injection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows-up with defaulters or drop-outs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 5.15: Level 4: Results (Impact) Evaluation

Level 4, or results evaluation, measures the impact of training on the program or organization. It shows how the training contributed to accomplishing the goals or objectives of the program or organization. This type of evaluation is both difficult and time consuming. It is difficult to measure the impact of training because so many variables may come into play. It is difficult to determine whether a change was the result of the training, or another variable. Because of the complexity of this type of evaluation, it is rarely used.

Guidelines for Evaluating Results

- If possible and practical, use a control group to eliminate factors other than training that could have cause the observed changes to take place. In the case of a clinical training it should not be difficult to find other care providers who did not undergo training.
- Allow time for the results to be achieved. It is impossible to say exactly how much time is necessary, but newly-trained providers must have a chance to practice their skills long enough to show a change in the program.
- Measure both before and after the training, if practical. This is easier to do when you are evaluating results than it is when you are measuring behavior. There are usually records and statistics available to determine the situation before the program.
- Repeat the measurement at appropriate times. Each program or project must decide how often to evaluate. Results may change in either a positive or negative direction. For example, a service provider newly trained in IUD insertion may conduct many IUD insertions when s/he first returns from training, but do fewer as time goes by.
- Consider the cost of results evaluation verses the benefits. How much will it cost to conduct an evaluation of this type? Results evaluations are usually extremely costly and time-consuming. The amount of money spent on this type of evaluation should be determined by the amount of money the training costs. The higher the number of trainees the more important it is to conduct a results evaluation to determine the cost-effectiveness of the training and whether the program should continue.

Return on Investment

Return on Investment (ROI) measures the compares the (monetary or other) benefits of the program with the program costs. Level 4 evaluation involves costs also, but doesn’t compare the monetary value of the results to the cost of the program.

Calculating the Training Program Costs

To calculate the cost of a training program, include:
- The cost to design and develop the program;
- The cost of the program materials for each participant;
- The cost for the instructor/facilitator, including preparation time, travel, and lodging;
- The cost of the facilities for the training program;
- The cost of travel, lodging and meals for participants (or per diem);
- Salaries of the participants while they are attending the program; and
- Administrative and overhead costs of the training.
Calculating the Benefits of the Program
This is the most difficult part of ROI. The benefits are related to the impact observed in the level 4 evaluation. It is almost impossible to apply a monetary value to program benefits. What is the value of improved service delivery?
Participant Handout 6.1: Training Follow-Up

Before every training course, those implementing training must agree on a plan describing the follow-up of the trainees. Training follow-up is the link necessary to change the knowledge and skills acquired during training into actual improvement in performance. Follow-up is essential in order to:

- Determine whether the trainee is providing the service he or she was trained for.
  - Review log books to assess the type and mix of clients the trainee is seeing.
  - Develop a checklist with the skills learned during the training program and write in the number of times the trainee has practiced each skill following the training course.

- Ensure that the trainee is correctly performing his/her newly acquired skills.
  - Develop checklists for the new skills the trainee has acquired and observe the trainee performing the skills.
  - Review patient records using a review tool.
  - If there are no cases available, develop case studies that can be used to assess how the trainee responds to emergencies/cases.

- Ensure that the clinic environment continues to support the use of the trainee’s new skills. This includes making sure that equipment is in place, that available clinical standards support the newly acquired skills, that clinic management supports the trainees use of new skills, and that clinic systems (especially financial) support the use of new skills.
  - Develop a checklist to review the clinic environment.

- To help the trainee solve problems that might have occurred since the training.
  - Develop a tool to note areas where the trainee has performed well and areas where improvement is needed.
  - Sit down and develop an action plan to address any of the areas that need improvement.

- To obtain feedback from the trainee on ways to improve future training.
  - Develop a questionnaire to obtain feedback.
  - Sit down and have an open-ended interview with the trainee to talk about what parts of the training worked well and what parts could be improved.
Participant Handout 6.2: Example of Skill List for Active Management of the Third Stage of Labor

Date of Assessment: Month:_____________ Year:______________

Assessment Conducted by:______________________________________________

Name of Trainee:_________________ Dates of Training:__________________

Location:__________________________________________________________

NOTE TO ASSESSOR: If no clients are present during the time you visit this facility, you should ask the service provider to describe to you all of the elements of active management of the third stage of labor. You should mention that the service provider should include both active management of the third stage and post management procedures. You should not coach the service provider, nor remind him or her of items she neglected to mention. Only record items spontaneously mentioned by the service provider. Use this form to record this description, but please check the box below that this information was collected by interview rather than by observation.

( ) Data on this form was collected by interviewing a service provider, not by observing the provider’s work.

( ) Each item was recorded based on the observations of the assessor.

BASIC MATERNAL HEALTH CARE CLINICAL PROCEDURE - ACTIVE MANAGEMENT OF THE THIRD-STAGE

Evaluate participant’s performance on each clinical step using the following scale:

1. Need improvement: clinical step was not done or incorrectly done or not according to its sequence (if it should be done in sequence)

2. Competent: clinical step was done and according to its sequence (if it should done in sequence), but still needs correction with/without trainer’s help / reminder on not very critical step.

3. Proficient: clinical step was done correctly and according to its sequence without any trainer’s help or reminder

4. N/P Clinical steps were not performed
<table>
<thead>
<tr>
<th>Activity</th>
<th>Case</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THIRD-STAGE ACTIVE MANAGEMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Informs the mother that she will have an injection</td>
<td></td>
</tr>
<tr>
<td>Gives 10 IU i.m. oxytocin injection as soon as possible after the infant delivery, using appropriate antiseptic procedure.</td>
<td></td>
</tr>
<tr>
<td>If there is no oxytocin available, asks the mother or his husband to do nipple stimulation to promote natural oxytocin production.</td>
<td></td>
</tr>
<tr>
<td>Waits until the blood stops pulsating before cutting the umbilical cord</td>
<td></td>
</tr>
<tr>
<td>Milks the cord towards the placenta and applies both cord clamps correctly</td>
<td></td>
</tr>
<tr>
<td>Waits for signs of placental separation</td>
<td></td>
</tr>
<tr>
<td>After separation, places one hand above the symphisis, supporting the uterus, while holding the umbilical cord with gauze approximately 5-10 cm from the perineum.</td>
<td></td>
</tr>
<tr>
<td>With the other hand, holding onto the cord, gently guides the placenta gently down and outward.</td>
<td></td>
</tr>
<tr>
<td>If the placenta was not delivered in 15 minutes, using steady controlled cord traction:</td>
<td></td>
</tr>
<tr>
<td>• Gives another 10 IU i.m. oxytocin injection.</td>
<td></td>
</tr>
<tr>
<td>• Examines for a full bladder, does urine catetherization if needed</td>
<td></td>
</tr>
<tr>
<td>• Keeps the mother and baby warm</td>
<td></td>
</tr>
<tr>
<td>• Informs the family for a possibility for a referral.</td>
<td></td>
</tr>
<tr>
<td>When the placenta was seen at the vulva, uses both hands to help the delivery of the placenta and prevents partly separation of the amnion.</td>
<td></td>
</tr>
<tr>
<td>As soon as the placenta has been delivered, performs the uterine fundal massage until appropriate uterine contraction is felt.</td>
<td></td>
</tr>
<tr>
<td>Educates the mother about how to perform fundal massage and how to evaluate the uterine contraction.</td>
<td></td>
</tr>
<tr>
<td>Examines the completeness of the placenta and amnion.</td>
<td></td>
</tr>
<tr>
<td>Examines for any possibility of vaginal laceration, and sutures if needed.</td>
<td></td>
</tr>
<tr>
<td><strong>POST MANAGEMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Examines uterine contraction for every 1-2 minute during the first 10 minutes of delivery, then every 15 minutes for the first hour, followed by every 20 minutes for the next hour. Does fundal massage if the fundus does not contract well enough.</td>
<td></td>
</tr>
<tr>
<td>Evaluates patient for excessive bleeding.</td>
<td></td>
</tr>
<tr>
<td>Wears gloves when handling placenta</td>
<td></td>
</tr>
<tr>
<td>Decontaminates placenta with 0.5% chlorine solution and puts in the placental container, or disposes of by burning or burying</td>
<td></td>
</tr>
<tr>
<td>Soaks all contaminated instruments in 0.5% chlorine solution.</td>
<td></td>
</tr>
<tr>
<td>Collects and disposes of all contaminated used materials in the contaminated disposal bags.</td>
<td></td>
</tr>
<tr>
<td>Soaks hand gloves in 0.5% chlorine solution.</td>
<td></td>
</tr>
<tr>
<td>Washes hands with soap, under running water.</td>
<td></td>
</tr>
<tr>
<td>Completes medical record.</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: *Health Service Quality Improvement after Normal Delivery Competency-Based Training Package: Research Project Proposal*, S. Hadijono, Indonesia
Participant Handout 6.3: Example of Checklist for Postabortion Care  
MVA Procedure

Date of Assessment: Month:_____________    Year:______________

Assessment Conducted by:_________________________________

Name of Trainee:________________   Dates of Training:____________________

Location:__________________________________________________

NOTE TO ASSESSOR: If no clients are present during the time you visit this facility, you should ask the service provider to describe to you all of the elements of the visit, which s/he would include in a labour admission. You should mention that the service provider should include counselling/client education as well as the relevant physical examination and procedures. You should not coach the service provider, nor remind him or her of items she neglected to mention. Only record items spontaneously mentioned by the service provider. Use this form to record this description, but please check the box below that this information was collected by interview rather than by observation.

( )  Data on this form was collected by interviewing a service provider, not by observing the provider’s work.

( )  Each item was be recorded based on the observations of the assessor.

Evaluate participant’s performance on each clinical step using the following scale:
1. Need improvement: clinical step was not done or incorrectly done or not according to its sequence (if it should be done in sequence)
2. Competent: clinical step was done and according to its sequence (if it should done in sequence), but still needs correction with/without trainer’s help / reminder on not very critical step.
3. Proficient: clinical step was done correctly and according to its sequence without any trainer’s help or reminder

N/P Clinical steps were not performed

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Greets the woman respectfully and with kindness and introduces self.</td>
<td></td>
</tr>
<tr>
<td>2. Offers the woman a seat.</td>
<td></td>
</tr>
<tr>
<td>3. Tells the woman what is going to be done and encourages her to ask questions.</td>
<td></td>
</tr>
<tr>
<td>4. Tells the woman she may feel discomfort during some of the steps and that s/he will tell her in advance.</td>
<td></td>
</tr>
<tr>
<td>5. Listens to what the woman has to say.</td>
<td></td>
</tr>
<tr>
<td>6. Prepares the necessary equipment: • Determines that required sterile or high-level disinfected instruments and cannulae are present. • Checks MVA syringe and charges it (establishes vacuum).</td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>7. Puts on apron.</td>
<td></td>
</tr>
<tr>
<td>8. Washes hands thoroughly with soap and water and dries with clean cloth or air dries.</td>
<td></td>
</tr>
<tr>
<td>9. Puts new examination or high-level disinfected gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>10. Arranges sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

**MVA PROCEDURE**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explains each step of the procedure prior to performing it.</td>
<td></td>
</tr>
<tr>
<td>2. Performs bimanual pelvic examination to confirm uterine size, position, and degree of cervical dilation.</td>
<td></td>
</tr>
<tr>
<td>3. Checks the vagina and cervix for tissue fragments and removes them.</td>
<td></td>
</tr>
<tr>
<td>4. Applies antiseptic solution to the cervix (particularly the os) and vagina 2 times.</td>
<td></td>
</tr>
<tr>
<td>5. Puts single tooth tenaculum or vulsellum forceps on lower lip of cervix.</td>
<td></td>
</tr>
<tr>
<td>6. Correctly administers paracervical block (if necessary).</td>
<td></td>
</tr>
<tr>
<td>7. Dilates the cervix (if needed).</td>
<td></td>
</tr>
<tr>
<td>8. While holding the cervix steady, inserts the cannula gently through the cervix into the uterine cavity.</td>
<td></td>
</tr>
<tr>
<td>9. Attaches the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other.</td>
<td></td>
</tr>
<tr>
<td>10. Evacuates contents of the uterus by rotating the cannula and syringe and moving the cannula gently and slowly back and forth within the uterine cavity.</td>
<td></td>
</tr>
<tr>
<td>11. Inspects tissue removed from uterus for quantity and presence of product of conception and to assure complete evacuation.</td>
<td></td>
</tr>
<tr>
<td>12. When the signs of a complete procedure are present, withdraws the cannula and MVA syringe and removes forceps or tenaculum and speculum.</td>
<td></td>
</tr>
<tr>
<td>13. Performs bimanual examination to check size and firmness of uterus.</td>
<td></td>
</tr>
<tr>
<td>15. If uterus is still soft or bleeding persists, repeats steps 4-11.</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
<table>
<thead>
<tr>
<th>Teask/Activity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POST-MVA TASKS</strong></td>
<td></td>
</tr>
<tr>
<td>1. Before removing gloves, disposes of waste materials and soaks instruments</td>
<td></td>
</tr>
<tr>
<td>and MVA items in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>2. Immerses gloved hands in 0.5% chlorine solution:</td>
<td></td>
</tr>
<tr>
<td>• Removes gloves by turning them inside out.</td>
<td></td>
</tr>
<tr>
<td>• If disposing of gloves, places in leak-proof container or plastic bag.</td>
<td></td>
</tr>
<tr>
<td>• If reusing surgical gloves, submerges in 0.5% chlorine solution for 10</td>
<td></td>
</tr>
<tr>
<td>minutes to decontaminate.</td>
<td></td>
</tr>
<tr>
<td>3. Washes hands thoroughly with soap and water and dries with clean, dry</td>
<td></td>
</tr>
<tr>
<td>cloth or air dries.</td>
<td></td>
</tr>
<tr>
<td>4. Checks for amount of bleeding and if cramping has decreased at least once</td>
<td></td>
</tr>
<tr>
<td>before discharge.</td>
<td></td>
</tr>
<tr>
<td>5. Instructs woman regarding postabortion care (e.g., when the woman should</td>
<td></td>
</tr>
<tr>
<td>return to clinic).</td>
<td></td>
</tr>
<tr>
<td>6. Discusses reproductive goals and, as appropriate, provides family</td>
<td></td>
</tr>
<tr>
<td>planning.</td>
<td></td>
</tr>
<tr>
<td>7. Records all relevant information on the woman’s record/card.</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

Participant Handout 6.4: Example of Normal Delivery Record Review
(Partograph)

Date of Assessment: Month:_____________    Year:______________
Assessment Conducted by:_________________________________
Name of Trainee:_________________ Dates of Training:____________________
Location:__________________________________________________

<table>
<thead>
<tr>
<th>Calculate the number of hours from time of admission until time of delivery. For example, if the patient was admitted at 8:00 AM and delivered at 6:00 PM, enter “10.”</th>
</tr>
</thead>
</table>
| **Record number of hours.**  
**Round fractions down.**  
If the patient was admitted before onset of labor, start counting hours from the time of onset of labor.  
If delivery occurred less than 1 hour after admission, enter 1.  
*If not available, enter 0.* |
| | How many vaginal examinations are recorded on the card?  
**Enter number of examinations recorded.**  
*If none, enter 0.* |
| | How many fetal heartbeat readings are recorded on the card?  
**Enter the number of recording.**  
*Do not enter actual readings.  
If none, enter 0.* |
| | How many times was the Blood Pressure (BP) measured and recorded on the card?  
**Enter the number of recordings.**  
*Do not enter actual BP readings.  
If none, enter 0.* |
| | Is the birth weight of the baby recorded on the card?  
Circle one.  
**Yes**  
**No** |
| | Is any assessment of the condition of the baby recorded on the card (e.g., APGAR score)?  
Circle one.  
**Yes**  
**No** |
| | Is any antenatal care recorded on the card?  
Circle one.  
**Yes**  
**No** |

**Participant Handout 6.5: Example of Case Study for Postpartum Care**

Note to assessor: Read the case study to the trainee and ask them to list the steps they would take to manage the problem. If the trainee lists the step, put a check in the “yes” column; if the trainee omits the step, put a check in the “no” column.

<table>
<thead>
<tr>
<th>Case study: Postpartum pyrexia</th>
<th>Notes</th>
<th>Management of postpartum metritis</th>
</tr>
</thead>
</table>
| Mrs. A is a 35 year-old gravida 3 para 3. She gave birth in the maternity hospital 2 days ago. Her husband brought her to the maternity hospital today because she has fever and chills. After performing a complete history and physical examination, you find the following:  
• Temperature: 39.8 C;  
• Pulse: 136 beats per minute;  
• Blood Pressure: 100/70;  
• Respiration: 24 per minute;  
• Mrs. A is pale, lethargic, and slightly confused; and  
• She has lower abdominal pain, her uterus is soft and tender, and she has foul-smelling vaginal discharge. Based on these findings, how would you manage Mrs. A? | Yes | 1. Treat for shock:  
• Turn the woman on her side.  
• Keep the woman warm but do not overheat.  
• Elevate the legs.  
• Start an IV infusion. Collect blood for estimation of hemoglobin, immediate cross-match just before infusion of fluids.  
• Rapidly infuse IV fluids (normal saline or Ringer’s lactate) initially at the rate of 1L in 15-20 minutes. Give at least 2L of these fluids in the first hour.  
• Continue to monitor vital signs every 15 minutes.  
• Catheterize the bladder and monitor fluid intake and output.  
• Give oxygen at 6-8L per minute by mask or nasal cannulae. |
| | No | 2. Transfuse as necessary. Use packed cells if available. |
| | | 3. Give a combination of antibiotics until the woman is fever-free for 48 hours:  
• Ampicillin 2 g IV every 6 hours; plus  
• Gentamicin 5 mg/kg body weight IV every 24 hours; plus  
• Metronidazole 500 mg IV every 8 hours. |
| | | 4. If retained placental fragments are suspected, perform a digital exploration of the uterus to remove clots and large pieces. Use ovum forceps or a large curette if required. |
| | | 5. If there is no improvement with conservative measures and there are signs of general peritonitis, perform laparotomy to drain the pus. If the uterus is necrotic and septic, perform subtotal hysterectomy. |
| | | 7. Encourage bed rest. |
| | | 8. Ensure adequate hydration by mouth or IV. |
| | | 9. Use a fan or tepid sponge to help decrease temperature. |

**Comments:**

Participant Handout 6.6: Example of Clinic Environment Assessment - Antenatal Care

NEEDS ASSESSMENT TOOL

General Note: Use day 1 to gather data only. Refrain from providing feedback unless absolutely necessary.

Date of Assessment: Month _____________ Year________________
Assessment Conducted by:_________________________________
Name of Facility:___________________________________________
Location:__________________________________________________

Instructions to assessor: Please complete this form through discussion with the in-charges and through visiting various areas of the facility. Feel free to make notes on this form about any additional relevant information that is collected during the course of this facility assessment.

You may need to see delivery records, admission/discharge registers, mortality registers, monthly reports, and/or log books for the past 12 months or a 12 month period, i.e., January 1999 through December 1999. Feel free to make notes on this form about any additional relevant information that is collected during the course of this facility assessment and any comments you may have.

TOOL A: ANC CLINIC SITE

<table>
<thead>
<tr>
<th>Infrastructure/Equipment/Supplies/Drugs</th>
<th>Availability</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - Available and satisfactory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 - Available but not satisfactory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 - Not applicable for this facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Availability</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet facilities or latrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination room or area providing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table or stool for gynecological examinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refrigerator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone or radio transmitter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance or vehicle to refer an obstetric emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical management guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal care register</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>Quantity</td>
<td>Adequate for Demand</td>
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<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>Sphygmomanometer</td>
<td></td>
<td></td>
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<tr>
<td>Stethoscope</td>
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<td></td>
</tr>
<tr>
<td>Fetal stethoscope</td>
<td></td>
<td></td>
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<tr>
<td>Clinical oral thermometer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measuring tape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal speculums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine dip sticks (or proteinuria test supplies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal cards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile or HLD gloves</td>
<td></td>
<td></td>
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<tr>
<td>Examination gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal swabs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable syringes and needles (or vaccination needles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis test kits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cotton</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauze</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron and folate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-helminthics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mebendazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albendazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-malarials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloroquine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sulfadoxine - Pyrimethamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-infectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ampicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzathine penicillin or Procaine Benzylpenicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefazolin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td></td>
<td></td>
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<tr>
<td>Cloxacillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythromycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>Quantity</td>
<td>Stock-out</td>
</tr>
<tr>
<td>------------------------------</td>
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<td>-----------</td>
</tr>
<tr>
<td>Gentamicin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kanamycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitrofurantoin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procaine Penicillin G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pencillin G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethoprim + Sulfamethoxazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-hypertensives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methyldopa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydralazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nifedipine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labetolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-convulsives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium sulfate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus toxoid vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disinfectants and antiseptics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorhexidine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical spirit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soap</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General Conditions**

<table>
<thead>
<tr>
<th></th>
<th>Adequate</th>
<th>Below Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>General cleanliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy for patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Staffing/Facilities**

- How many beds are there in this facility for inpatient antenatal care? Enter number.
- How many outpatient antenatal clients did you have? Enter number
  - In the past month:
  - In the past six months:
- At this facility how many full-time and part-time occupied posts are there for? Enter number of posts occupied
  - Full-time
  - Part-time
- Registered midwives and nurse-midwives
- Enrolled midwives
- Physicians (both generalist and obstetrician/gynecologist)
At this facility how many full-time and part-time occupied posts are there for:

<table>
<thead>
<tr>
<th></th>
<th>Enter number of posts occupied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-time</td>
</tr>
<tr>
<td>Anesthetists and nurse-anesthetists</td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
</tr>
<tr>
<td>Are blood transfusions available?</td>
<td>Yes</td>
</tr>
<tr>
<td>Which laboratory facilities are available:</td>
<td></td>
</tr>
<tr>
<td>Hematocrit/Hemoglobin</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood group and Rh Factor</td>
<td>Yes</td>
</tr>
<tr>
<td>Malaria smears</td>
<td>Yes</td>
</tr>
<tr>
<td>RPR</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Once you decide to refer an obstetric emergency case, about how long does it take for her to arrive at the referral facility and receive care? 

How far is the nearest referral facility, in kilometers?

Do you have a radio or telephone system and an ambulance to transport the woman?

Multiple Choice Questions
Instructions: Circle all of the correct answers in each question.

1. Pilot testing a new training curriculum allows you to determine:
   a) If the training materials are effective.
   b) If the time allocated is sufficient.
   c) If trainees will adopt the new material and techniques after the training.
   d) Whether trainee assessment tools are appropriate.

2. Competency-based training is a method to help participants:
   a) Enhance problem solving skills.
   b) Enhance job satisfaction.
   c) Develop attitude.
   d) Develop clinical skills up to a specific standard.

3. Clinical checklists are used:
   a) To assess skill level prior to training.
   b) In demonstration and return demonstration during training.
   c) In trainees self assessment.
   d) During evaluation.

4. The factors that are important in helping staff do their jobs correctly are:
   a) Clear job expectations.
   b) Adequate working environment (equipment and supplies).
   c) Motivation and incentives to do the job correctly.
   d) Punitive feedback about incorrect performance.
   e) The knowledge and skills to do the job correctly.

5. The training methodology that requires trainees to use decision-making skills is:
   a) Group discussion.
   b) Role play.
   c) Brainstorming.
   d) Case study.

6. Training objectives should be based on:
   a) Materials available.
   b) The trainers’ level.
   c) Needs of trainees.
   d) Trainers’ expectations.

7. When using examples in training, the trainer should:
   a) Create examples as often as possible.
   b) Use complex examples to enhance participants’ creative thinking.
   c) Make connections between example and the teaching points.
   d) Point out a specific case with client’s name to help participant to internalize the points.
8. Clinical training sites should be selected based on the following criteria:
   a) Fancy, modern equipment is available.
   b) Staff are trained to give support to the trainees.
   c) It is very close to the participants’ dormitory.
   d) The use of protocols reflects the knowledge and skills covered in the training.

9. The following are objectives of training follow-up except:
   a) Providing feedback on the shortage of trainees.
   b) Improving the quality of services.
   c) Providing trainees with further knowledge.
   d) Ensuring that the trainees are applying the things they learned.

10. During training follow-up the trainer can determine whether the trainee is providing the service he or she was trained for by:
    a) Reviewing the log books to assess the type and mix of clients the trainee is seeing.
    b) Interview clients to see if they are satisfied with the level of service provided by the trainee.
    c) Evaluating the facility infrastructure.
    d) Developing a checklist with the skills learned during the training program and writing in the number of times the trainee has practiced each skill following the training course.

11. There are 4 levels in the most widely-used model to evaluate training. The third level measures:
    a) Reaction: Did the participants like the training?
    b) Behavior: Are the participants performing differently?
    c) Learning: What knowledge or skills did the participants retain?
    e) Results: What is the impact of training?

12. The disadvantages of objective tests (multiple choice, matching, true/false, fill-in) are:
    a) They are difficult to write.
    b) They are time-consuming to write.
    c) Grading is time-consuming.
    d) They are subjective and open to interpretation.

13. A level 1 training evaluation can be used to measure all of the following EXCEPT:
    a) Learning.
    b) Change in attitude or beliefs.
    c) Customer or trainee satisfaction.
    d) The trainer’s knowledge.

True or False Questions
Instructions: Circle the letter T for a true (correct) statement or F if the statement is false.

14. T   F  A training needs assessment identifies the gaps between the present performance and desired performance.
15. T   F  For consistency, a training needs assessment should assess only 1 type of data.
16. T   F  In classic brainstorming technique, it is useful to clarify the idea before listening to the next idea.
17. T  F  A case study that includes a lot of information will make it easier for the participant’s to analyze.

18. T  F  Case studies are very good tools for evaluating participants’ understanding of popular misconception.

19. T  F  During the feedback of role-play, the focus should be on the content.

20. T  F  During training follow-up, the trainer should check the facility to make sure the trainees are performing their skills correctly.

**Ordering Questions**

21-27. Place the following steps of a training needs assessment in the correct order:

<table>
<thead>
<tr>
<th>Develop assessment tools</th>
<th>Compile (organize) data</th>
<th>Identify Desired Performance</th>
<th>Collect the data</th>
<th>Identify possible (performance improvement) solutions</th>
<th>Analyze the data</th>
<th>Conduct a Cause Analysis (Determine root causes)</th>
</tr>
</thead>
</table>

**Short Answer Questions**

Instructions: Write in the correct answers for each question.

28. List 4 of the 5 basic components of a training curriculum:
   a) 
   b) 
   c) 
   d)

29. Give 3 reasons for doing training follow-up:
   a) 
   b) 
   c)

30. What is the hardest part of training to evaluate and why?
### Matching Question and Answers

Instructions: Write the letter from column B. that corresponds to the appropriate statement in column A.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. Demonstrate an IUD procedure</td>
<td>a. Knowledge objective</td>
</tr>
<tr>
<td>32. Listing 3 advantages of the IUD method</td>
<td>b. Skill objective</td>
</tr>
<tr>
<td>33. Following the sterilization procedure during IUD procedure</td>
<td>c. Attitude objective</td>
</tr>
</tbody>
</table>
Participant Handout 6.8: Participant Reaction Evaluation

Course: Advanced Training of Trainers Date:
Instructions: Please circle your answer. Your comments and explanations are valuable for improving the training, so please take the time to add them.

1. Course objectives
   • Were they fully explained? Yes No
   • Were they reviewed during the program? Yes No
   • Were they reviewed at the conclusion of the program? Yes No

Comments:

2. Do you feel there was sufficient time and opportunity for questions and discussions by the group?
   Yes No

Explain:

3. Instructors
   • Did the instructors perform well overall? Yes No
   • Did the instructors appear knowledgeable? Yes No
   • Did the instructors practice effective time management? Yes No

Comments:

4. What benefits do you feel you received from this program?
   • New knowledge that is pertinent to my current position. Yes No
   • Specific approaches, skills, or techniques that I can apply on the job. Yes No
   • Change of attitude that will help me in my job. Yes No

5. What do you feel are the major strengths of this course?

6. What parts of the workshop were most valuable or beneficial to you?

Why?

7. What parts of the workshop were least valuable or beneficial to you?

Why?
8. What will you plan to do differently when you return to your job as a result of your attendance at this workshop?

9. What is your evaluation of the materials that you received?

10. Would you recommend this course to others?  
If so, to whom?  
If not, why not?

11. What significant changes would you recommend for improving future programs?

12. Please add any other comments you would like to make about any aspect of the course (instructor, materials, topics covered, setting, visual aids).

13. Indicate your overall evaluation of the course.

   12  11  10  9  8  7  6  5  4  3  2  1
   Excellent  Good  Satisfactory  Unsatisfactory
Participant Handout 7.1: Hiring the Training Consultant

Training programs often use consultants to provide training. Not all clinicians make good trainers. Performing clinical skills and teaching clinical skills are two very different things. When hiring a training consultant, consider the following:

- The consultant should have expert clinical skills in the subject to be taught. Are the clinical skills current and how many years of clinical experience has the trainer had? Is the trainer up-to-date with current international guidelines and practices?
- Has the trainer had significant training experience and has s/he taught this particular course before? If possible, obtain training references.
- Will the trainer be acceptable to the trainees? Make sure the trainer has conducted training in developing countries and established a good rapport with past trainees.

The Hiring Organization’s Responsibility to the Training Consultant

The information provided to the training consultant is key to the success of the training. Consider providing the following:

- Make the scope of work detailed enough so that nothing is missing. If possible, provide the training objectives and the materials you expect the trainer to use.
- Provide the trainer with information about the participants. Details about each participant should include their name, designation (physician, midwife, nurse), the experience they have had that is relevant to the training (such as experience as a service provider), and other training related to the current training. Add any relevant personal information you think the trainer might need.
- If possible, provide a schedule for the training, or at the very least inform the trainer about the normal days and times for training in the country the training will take place.
- Provide the trainer with information about the country, the climate, and the accommodations.
- Provide the trainer with a description of the project to help her/him put the training in context.
- Be clear on the contractual responsibilities. The contract should be written, approved, and signed in advance. Your expectations should be clear in the contract. Include requirements for the training report and what you expect it to contain.
Participant Handout 7.2: Evaluating the Training Consultant
Following Training

What makes a good technical trainer? There are certain competencies a good technical trainer should have. Observe the training and determine whether the trainer met the following standards. Did the trainer:

- Analyze the course materials and try to learn information about the trainees? Did the trainer understand the training material being taught and did s/he attempt to learn about the participants and the conditions under which they work?
- Assure preparation of the instructional site? Did the trainer inform you about what s/he needed in terms of a training room, a site for clinical training, the training aids s/he needed and audio-visual equipment?
- Establish and maintain instructor credibility? Did the trainer demonstrate conduct, social practices, content mastery, and professional behavior befitting a professional trainer?
- Manage the learning environment? How well did the trainer engage the learners, manage time, promote group participation, and resolve behavior problems?
- Demonstrate effective communication skills? Did the trainer use appropriate verbal and non-verbal language and assess the degree to which learners understood?
- Demonstrate effective presentation skills? Did the trainer's voice, gestures, eye contact, props, and anecdotes effectively contribute to the delivery of the content?
- Demonstrate effective questioning skills and techniques? Did the trainer listen and question to assess learning?
- Respond appropriately to learners’ needs for clarification or feedback? Did the trainer demonstrate that s/he understood each participant’s unique needs? Was the trainer culturally sensitive?
- Provide positive reinforcement? Did the trainer assess the motivations of participants and positively respond to them during the course or workshop?
- Use instructional methods appropriately? Did the trainer choose and effectively implement a variety of instructional methods? Did participants respond positively to the methods chosen?
- Use media effectively? Did the trainer know how, why, and when to integrate different media into a presentation?
- Evaluate participant performance and the delivery of training? Did the trainer monitor the progress of participants during the course? Did s/he conduct an evaluation at the end of the course? At a minimum, a technical course should include a pre- and post-test and a participant reaction form. The participant reaction form should include an evaluation of the course materials, technical information, training methodology, and training location and schedule.
- Report evaluation performance? Did the trainer provide a comprehensive training report? At a minimum, a training report should include the following:
  o The scope of work,
  o Project background information,
  o Findings and recommendations,
o Training objectives,
o Training content,
o Training methodology used,
o Materials used and provided,
o The training evaluation results,
o The training schedule, and
o The list of participants.

Participant Handout 7.3: The Training Report

A training report should be much more comprehensive than a trip report. It should document the kind of training that took place, the processes, the results, and recommendations for next steps and actions. The following is a checklist of what information to include:

I. Cover sheet: This includes the name of the project, the date of training, the trainer, the place, and the agency (Pathfinder International). A brief statement of the purpose of the training should also be on the cover.

II. Executive Summary: This should include a brief background of the project, including the purpose of training, a very brief summary of the training and key findings and recommendations.

III. Details of the training, including:
   - The time span;
   - The number of trainees (their names and designations should be in an appendix);
   - The names of the training team;
   - Planning, preparation, and logistics;
   - The purpose and objectives;
   - Methodology;
   - Materials;
   - Evaluation results, including pre- and post-tests, participant reaction, participant self evaluation, or any other evaluation techniques used during training.

IV. Appendices might include:
   - The names and designations of trainees,
   - The training schedule,
   - Results of special activities or exercises, and
   - Pictures.