Jhpiego Corporation is an international, non-profit health organization affiliated with The Johns Hopkins University. For more than 36 years, Jhpiego has empowered front-line health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world’s most vulnerable populations.

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September 2010
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*Advanced Training Skills for Reproductive Health Professionals*. 2000. Schaefer L et al. Jhpiego Corporation: Baltimore, Maryland; and, to a lesser extent,


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Special thanks go to our Tanzania team (Natalie Hendler, Lemmy Medard Mabuga, Victor Mponzi and Gilbert Mauto) and to Emmanuel Otolorin and Willy Shasha in Nigeria for pilot-testing the product and providing valuable feedback for refining the materials.

We also thank all who have contributed their ideas, efforts and ongoing support to reinvigorate the principles that are at the heart of Jhpiego’s approach—making our Training Skills Course relevant to whole new generations of trainers and providers all over the world.
## ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>AMTSL</td>
<td>Active management of third stage of labor</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CBT</td>
<td>Competency-based training</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated management of childhood illness</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactational amenorrhea method</td>
</tr>
<tr>
<td>MC</td>
<td>Male circumcision</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, newborn and child health</td>
</tr>
<tr>
<td>NSV</td>
<td>No-scalpel vasectomy</td>
</tr>
<tr>
<td>OSCE</td>
<td>Objective structured clinical examination</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission [of HIV]</td>
</tr>
<tr>
<td>PPH</td>
<td>Postpartum hemorrhage</td>
</tr>
<tr>
<td>PPIUD</td>
<td>Postpartum intrauterine contraceptive device</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counseling and testing [for HIV]</td>
</tr>
</tbody>
</table>
FOREWORD

High-quality health systems rely on sufficient numbers of competent health care providers able to deliver a wide range of clinical services. In countries with health workforce shortages, systems for the rapid and sustainable preparation of a large number of such providers are required. Jhpiego’s Training Skills Course (formerly the Clinical Skills Training [CTS] Course1) is designed to help meet this need.

As our version of what is commonly termed a “training of trainers” (or “TOT”) event, this Training Skills Course is an “entry-level” course focused on developing the basic training skills needed to provide clinical training—in anything from infection prevention practices, to basic health counseling and preventive care, to complex management of diseases such as HIV/AIDS, malaria and tuberculosis. The Training Skills Course has evolved over the years to address changing needs and challenges in training, incorporate the latest evidence-based practices in training and respond to emerging global health problems.

KEY UPDATES IN THE TRAINING SKILLS COURSE

Reflecting our commitment to maximizing the flexibility, efficiency and effectiveness of training systems, Jhpiego has revised our Training Skills Course, which includes: ModCAL® for Training Skills, a computer-based knowledge update, as well as this manual and the related learning materials. This revision entails the following essential updates:

- **A shift from a heavy emphasis on psychomotor/hand skills to inclusion of clinical decision-making and communication skills.** This broader skill set is needed to achieve clinical competencies of a higher order, which are required to provide high-quality health services—including management of complex medical conditions.

- **A shift in emphasis from presentation skills to the broad array of skills involved in the facilitation of learning.** Use of this approach, both in the classroom and in the clinical environment, places adult learners in a more active/participatory role, involving them in the identification of their learning needs and assessment of their progress. The goal is to achieve a greater degree of transfer of learning and retained competency in the workplace.

- **Increased emphasis on the use of assessment to facilitate learning.** The new Training Skills Course introduces a variety of assessment tools that can be used to actively monitor and support the learner’s development toward competency, allowing both the trainer and learner to adapt the instructional methods to better meet the learner’s individual needs.

- **The importance of using only standardized tools, validated by subject matter experts, for final knowledge and skills assessments is also emphasized.** This helps to ensure that a strong evidence base and clear criteria guide the

---

1 Jhpiego’s Training Skills Course, which trains providers in the skills needed to train other providers, is fundamentally different from clinical skills courses, which train providers in the skills they need to perform specific clinical competencies. And yet similarities between the respective names of these courses have sometimes caused confusion. Therefore, Jhpiego’s Clinical Training Skills (CTS) Course is now termed the Training Skills Course. Users of these materials may still encounter the familiar course title and acronym as Jhpiego phases in the preferred terminology.
determination of whether a learner has *achieved the desired competencies* and can be qualified to provide safe, effective, beginning-level services.

- **Increased emphasis on managing and documenting clinical practice experiences ensures that, following the classroom component of training, learners receive a quality training experience in the clinical setting as well.** Provision of health care services requires integration of a complex set of knowledge, skills and attitudes that cannot occur without a strong clinical training component. The trainer’s ability to actively manage learning within the clinical environment, and to share this experience with program staff and relevant others, is critical to ensuring that this essential component of training is effective for learners.

- **An expanded range of clinical examples ensures that training will be relevant and interesting to all learners and trainers.** The new Training Skills Course provides interesting illustrations that span a wide range of health care issues, making its lessons relevant to a whole new audience.

These materials are intended for use by a broader audience—including any programs, organizations or institutions interested in trainer or faculty development, and they are generic enough to be used to develop a variety of clinical skills in both in-service (in the workforce) and pre-service (in educational institutions) settings. These materials may also be used to reinforce or update the training or facilitation skills of experienced trainers and faculty. Regardless of how the new Training Skills Course materials are used, Jhpiego is confident that programs all over the world will find them helpful in their training- and education-related initiatives.

**OVERVIEW OF THE TRAINING SKILLS COURSE**

The Training Skills Course includes the following main components, which are also presented graphically in Exhibit F-1 on page xii:

- **First, competency standardization** is fundamental to Jhpiego’s training approach. The standardization activity\(^2\) can be implemented in a variety of different ways—before (which is ideal), during or after the Training Skills Course. Competency standardization is the process of ensuring that candidate trainers (Training Skills Course learners) will teach the desired clinical competencies (whether management of antiretrovirals, emergency obstetrical skills, etc.) in the same way. Such standardization is critical because:

  - Although they should be proficient in the skills they will be teaching, candidate trainers may perform the same tasks differently (based on local protocols, cultural issues, resources available, even personal style); all may be “correct,” but consistency is important for future clinical skills course participants, who will just be starting to learn new skills.

  - Clinical skill proficiency is essential to ensure that the trainers can safely supervise and coach the skills course participants during clinical practice; this is especially crucial for surgical procedures or other health care services that carry any potential risk to the client.

\(^2\) After the skills standardization activity occurs, standardization continues as a process, as the correct way to teach a skill is continually reinforced throughout the course.
Lack of standardization makes it difficult for trainers to objectively assess skills course participants’ progress and determine whether they have achieved competency and can be qualified in the desired clinical skills.

Second, Training Skills Course learners will begin the Jhpiego Training Skills Course with a knowledge update that introduces, demonstrates and explains the knowledge, skills and attitudes needed for training. If a blended learning approach is used (Box, below), learners will complete this component of the course using the self-directed ModCAL for Training Skills, which (via a flash drive or the Web) provides a flexible, interactive learning experience. If a blended approach is not used, the knowledge update will be incorporated into the group-based practice session or mentored co-training (further discussed below). Either way, the knowledge update is followed by a Final Knowledge Assessment, on which learners must receive a passing score before proceeding.

What Is Blended Learning?
Innovative, technology-supported learning tools and methods can be mixed with more traditional training approaches to increase the efficiency and effectiveness of a learning event—the ultimate goal being to minimize the amount of time providers must spend away from the job, in a group-based learning activity. This “mix” of training approaches is called “blended learning” and can be constructed many different ways. It can be a formal learning arrangement—such as a computer- or Web-based program to be completed—or more informal, such as through relationships, conversations, self-study and independent research.

ModCAL for Training Skills was designed precisely to work as part of a blended learning approach. Clinical skills courses may also benefit through use of this approach, when possible and appropriate. If ModCAL for Training Skills is part of your training package, decision-makers in the sponsoring program/organization have determined that this approach is appropriate in the context of this particular Training Skills Course—that is:

- There is a need—Customers have demanded training efficiencies or to shorten training;
- Resources are available—Necessary technologies and equipment, as well as people who know how to use them, are available;
- Learners are deemed willing and able to commit to self-paced learning—Although independent learning is a hallmark of adult learning theory, this remains a serious consideration; and
- Learners have the experience and technical competency needed to be successful using this approach.

Third, after passing the Final Knowledge Assessment, learners/candidate trainers are provided with practice and feedback in training skills in one of the following ways:

- Attend a group-based practice session and then co-train a skills course (as described below). Depending on program needs and resources available, as well as on the complexity of the competencies being taught, candidate trainers may have the opportunity to apply and practice what they have learned through ModCAL and receive feedback by an experienced trainer before proceeding to mentored co-training.

- Immediately prepare for and co-train a clinical skills course with an experienced trainer. This individual is qualified to mentor candidate trainers in applying their training skills with actual course participants, in both classroom and clinical settings. This practicum provides the candidate trainers an opportunity to develop and achieve true competency, as they will be practicing their training skills with actual skills course participants.
Throughout this third phase, the learners/candidate trainers and Training Skills Course facilitator work together to continue to develop and assess the learners’ progress.

Fourth, the candidate trainers are formally assessed in the Jhpiego training skill set (core competencies). Those who demonstrate competency are qualified by Jhpiego.

Exhibit F-1. Main Components of Training Skills Course Using a Blended Learning Approach

As the graphic shows, use of ModCAL enables learners to complete the knowledge update and final knowledge assessment before attending a group-based practice session, if applicable. Without this blended learning approach, these activities would be incorporated into the group-based session (as suggested by the dotted-line triangle)—potentially increasing the session time by about 40%. The optional nature of the group-based session is represented by the dotted-line parameter of its box, whereas the possibility of advancing from ModCAL directly to mentored-co-training is indicated by the dotted-line arc connecting the two components.

HOW THIS MANUAL IS ORGANIZED

Although the manual is organized to reflect the way the Training Skills Course may be taught, it is also intended to provide learners with a valuable reference as they facilitate clinical skills courses independently.

- **Section One: Training Skills Foundations and Principles.** In this section, the basic concepts, theories and central skills that underlie and inform Jhpiego’s training approach are presented and explained. Emphases are: competency, as the true goal of training; facilitation, as a set of techniques and process that apply in all training sessions and learning activities; the principles of competency development for knowledge, skills and attitudes; and the principles of competency assessment, as an ongoing process both to develop and evaluate competency, as well as to determine final qualification.

- **Section Two: Training Skills in Practice—Conducting a Clinical Skills Course.** This section focuses on the day-to-day interaction between the clinical skills course trainer and course participants, from the very beginning of the course up to qualification. It provides practical guidance for facilitators and learners in applying the principles covered in Section One, through:
  - Outlining and describing a typical course from beginning to end;
- Providing guidance specific to the classroom setting; and
- Providing guidance specific to the clinical setting.

**Section Three: Planning, Managing and Following Up a Clinical Skills Course.** How well the logistical aspects of conducting a clinical skills course are managed has a significant impact on training success. This section provides practical guidance on:

- Planning and preparing for a clinical skills course;
- Addressing problems that may arise during a clinical skills course; and
- Completing post-course requirements, which may include follow-up and continuing support of newly qualified providers.
SECTION ONE:
TRAINING SKILLS FOUNDATIONS AND PRINCIPLES
COMPETENCY-BASED TRAINING

Beyond Knowledge to “Know-How”
What if you taught people to drive by having them read about it in a book? Or taught a pilot to fly from listening to a lecture? Providing health services requires a high level of responsibility—as well as complex “competencies” that include psychomotor/hand, clinical decision-making and communication skills, along with the knowledge and attitudes required to apply those skills appropriately in the provision of high-quality services.

Many health care services are much more complex than driving a car, or flying a plane, and the right approaches must be used to develop the competencies needed to provide them. Through this course, you will develop training skills to ensure that learners develop desired competencies before applying them on the job with real clients. The participatory, “hands-on” training techniques that you will use are best reflected in the following saying, based on an ancient proverb by Confucius:

“What I hear, I forget; what I see, I remember; what I do, I understand.”

INTRODUCTION
The goal of clinical training is to help health professionals achieve competency in providing safe, high-quality, beginning-level health services to clients through improved work performance. Competence is the ability to perform successfully a specific task, procedure or activity—such as inserting an intrauterine contraceptive device (IUD), providing voluntary counseling and testing (VCT) for HIV, or diagnosing and managing eclampsia/pre-eclampsia. Training deals primarily with continually developing and assessing learners’ progress toward achieving competence, while transferring the knowledge, attitudes and skills needed to carry out such health services.

Mastery learning, which is central to Jhpiego’s approach to training, assumes that all learners can become competent in the knowledge, skills and attitudes being taught, provided that sufficient time is allowed and appropriate training methods are used. The goal of mastery learning is for 100% of those trained to achieve competence—to be able to demonstrate the ability to perform the desired task/procedure/activity in a clinical setting. While some learners are able to do so quickly, others may require additional time or alternative learning methods. Individuals learn at different speeds and learn in different ways, through written, spoken or visual means. Mastery learning takes these differences into account, using a variety of teaching and training methods. It is also consistent with current, evidence-based learning principles and competency-based training (CBT).

This chapter introduces and explains some important principles of CBT, which is applied both when training candidate clinical trainers in training skills (through the Training Skills Course) and when training skilled health care providers and other health workers (through various clinical skills courses). Before clinical trainers can have a full understanding of competency-based training, they must have an understanding of what competence/competency is.
WHAT IS COMPETENCE/COMPETENCY?

There are different definitions for the term “competency,” “competence” and “competent.” Trainers may say, “We will train the learners to competency in inserting IUDs,” or “Through this activity, learners will build competence in performing male circumcision,” or “You will become competent in providing postpartum family planning counseling before you become proficient,” or “The learner has become competent in antiretroviral (ARV) management.”

“Competence” is the ability to perform a specific task, procedure or activity safely and effectively. A trainer may say, “You have developed a level of competence in certain skills that allows you to practice them without direct supervision.” The term “competency” defines the level of competence: “He has demonstrated competency in the desired skills and is ready to practice independently.” The term “competency” also is used to define a set of related tasks and activities required to perform a job successfully. They may say, for example, “She is able to perform the competencies required for her job.”

Competency Domains

All competencies consist of a blend of knowledge, skills and attitudes—which are known as the three competency domains. Review the following example—for a training course designed to produce competency in “initiating and managing ARV therapy”—to gain a better understanding of each domain.

- **Knowledge**—Learners are provided information needed to analyze situations, make clinical decisions and solve problems—the foundation for skills development. For the ARV course, some knowledge-related objectives might include: List the indications for beginning ARV therapy; list common side effects of ARV drugs; describe how to conduct a targeted history and physical exam.

- **Skills**—Learners are provided with opportunities to practice and receive feedback in psychomotor (hand), communication and clinical decision-making skills. For the ARV course, some skills-related objectives might include: Conduct a targeted physical examination; diagnose common adverse effects of ARV drugs; identify clients appropriate for ARV therapy initiation; provide patient education (an important communication skill!).

- **Attitudes**—Learners have the chance to observe the trainer model desired behaviors and reflect on their own ways of interacting with clients so that they can develop the attitudes and professional demeanor needed to provide high-quality services. For the ARV course, attitudinal objectives might be: Demonstrate awareness of personal biases when counseling ARV clients (do not let personal opinions have an impact on care provided); treat clients initiating ARV treatment with kindness and respect; show support and empathy for clients struggling with complicated ARV drug regimens.

Addressing each of these domains (knowledge, skills and attitudes) is essential in the development of any competency required of a health care provider. Integrating the knowledge, types of skills and attitudes required for the desired competencies will enable the trainer to prepare providers who are able to deliver safe, high-quality, beginning-level services in the workplace (Exhibit 1-1).
Exhibit 1-1. Key Aspects of Competency

Relationship between Competency and Workplace Success
CBT focuses on the development of competency—the knowledge, skills and attitudes needed for a provider to perform a particular procedure, task or activity successfully under ideal circumstances. But many other factors are required for the provider to succeed in the actual workplace. Trainers can help ensure “transfer of learning” by addressing these “job performance factors”: (1) clear job expectations; (2) feedback on performance; (3) tools/equipment/supplies and (4) infrastructure needed to do one’s job; (5) some type of incentive; and (6) organizational support. Training alone will not produce the desired result if these factors, as further explained below, are not addressed.

- **Motivation**: While improving knowledge, skills and attitudes through training is an often-selected intervention, motivation is also essential to ensure transfer of newly acquired competencies to the workplace. All of the job performance factors have a direct impact on motivation, and motivation can play an even greater role than training in improving worker performance.

**The Power of Motivation**
Seven national hospitals in Malawi used “training performance standards” (further described on page 5) to improve infection prevention practices among workers, formally recognizing achievement of the standards to further motivate the facilities. From 2002 to 2004, the seven sites improved an average of 60% in achievement of the standards.
Chapter 1

- **Capability**: The focus of training is preparing providers who are competent in the delivery of high-quality services. But, again, training alone is not the complete solution. To ensure their capability to apply their new competencies on the job, they will need clear job expectations, necessary tools/environment and organizational support. For example, even if providers are competent in providing manual vacuum aspiration for incomplete abortion, if their facility does not support the practice or if the necessary equipment is not available or is malfunctioning, the providers may not be “capable” of performing this service.

- **Opportunity**: Even if providers are competent in a specific service, if they are not given the opportunity to provide it—because they lack the organizational support needed or their job descriptions do not include the service—they will lose the related skills, as well as the chance to become proficient in them.

---

**Competency-Based Training—A Key Tool in Life-Long Learning, Life-Long Success**

The education of health care providers is a continuum, which starts with entry into an academic program and ends with retirement. Pre-service education and training are relatively short interventions in comparison to the potential length of one’s career, so health care providers should develop life-long learning skills to ensure that they continue to develop professionally. This includes deciding both what needs to be learned and how to learn it.

CBT has a place in this life-long process. Pre-service education should prepare individuals who are competent in providing high-quality services from the moment they begin working. But ongoing, in-service training for practicing providers should also be available—to reinforce or update existing competencies; to gain new knowledge, skills and attitudes to meet emerging needs; and for continued professional development throughout their professional careers. This is because what it means to be “competent” in a given service may change as new information becomes available or new problems emerge.

**COMPETENCY-BASED TRAINING**

**What Is Competency-Based Training?**

Competency-based training (CBT) is distinctly different from traditional educational processes. It is “learning by doing,” rather than learning by simply acquiring new information, and focuses on developing the specific set of competencies needed for quality job performance. Practical application of new knowledge, skills and attitudes on the job is emphasized. CBT requires the clinical trainer to “facilitate learning” as a mentor/coach, rather than function solely as an instructor or lecturer. While CBT has traditionally been used for in-service training (for providers already in the workforce), this approach is equally applicable to the pre-service setting (for students in educational institutions).

Competency-based training supports countries in producing an adequate number of trainers to train other providers in specific clinical competencies (e.g., newborn resuscitation, male circumcision, postpartum family planning services)—based on country and program needs.
Core Components of CBT

Performance Standards and Skills Standardization

The goal of CBT is to develop specific competencies in learners—the right mix of knowledge, skills and attitudes they need to do their jobs according to specific performance standards. Performance standards describe expected behaviors and actions on the job.3 In CBT, the desired competencies and expected results of training are clearly stated at the beginning of training. Training is designed to address gaps between worker performance and the desired performance standards.

An important part of CBT is the process of skills standardization. Each clinical skill or activity to be taught in order to meet the performance standards must first be broken down into its essential steps. Each step is then analyzed to determine the most efficient and safe way to learn and perform it. Once a procedure—such as how to screen for and treat cervical cancer using the single visit approach—has been standardized, competency-based skill development and assessment instruments (e.g., checklists) can be designed. These instruments make learning and assessment easier and more objective.

Appropriate Learning and Assessment Methods

Key to effective training is using the most appropriate learning and assessment activities to develop various competencies. Exhibit 1-2 lists appropriate activities based on each competency domain. A typical clinical skills learning package may include a few or many of such activities.

Exhibit 1-2. Learning Activities and Assessment Tools for Each Competency Domain

<table>
<thead>
<tr>
<th>COMPETENCY USE</th>
<th>KNOWLEDGE</th>
<th>SKILL</th>
<th>ATTITUDE</th>
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<td>Activities for Learning</td>
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<td>Illustrated Lecture</td>
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<td>Case Study or Role Play</td>
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<td>Clinical Drill-Coaching</td>
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<td>Self-Assessment</td>
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As shown:

- There is a range of options for building knowledge—whether updating existing knowledge or providing new information. More than just transferring facts, trainers need to help learners apply and analyze the new information in order to make good clinical decisions. Therefore, competency development and

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3 Some countries may not have explicit, written performance standards; in such cases, there are usually service delivery guidelines or other documents that can be adapted for this purpose. Performance standards for clinical trainers are included in the Learner’s Guide.
assessment activities focus on learners’ ability to apply and analyze the information.

- Different types of **skills** are taught, including psychomotor (sometimes called “hand” or “procedural” skills), clinical decision-making and communication skills. Depending on the course goal, a different skill type may be emphasized. For example, preparation of a competent surgeon requires a strong emphasis on psychomotor and clinical decision-making skills, while preparation of a counselor requires a focus on communication skills. In any case, while the trainer may use somewhat different techniques for different types of skills, all skills require demonstration and practice with feedback for development. Therefore, learning activities for skills focus on observing and assessing the learner’s ability to demonstrate or perform the desired competencies.

- **Attitudes** can be addressed in several ways: behavior modeling is particularly useful, as are role plays and observation with feedback. Self-reflection, or journaling, is another means for learners to work on attitude development. Attitudes are more difficult to assess objectively than knowledge and skills; therefore, observing behaviors demonstrated—during practice in a simulated or clinical setting—is essential. Observation with an assessment tool that clearly outlines expected behavior (e.g., checklist or performance standards) makes the assessment more objective.

Throughout all learning activities, the behavior modeling that occurs during informal contact between the learners and the trainer is essential for attitudinal development.

Development of new competencies is an ongoing process facilitated through demonstrations conducted by the trainer, ample practice for the learners (in simulations and clinical settings) and continual coaching, as described below. Competence in the new skill or desired competencies is assessed both: (1) continually throughout the course, through a variety of means; and (2) at certain critical points in the course, with specific tools.

**Coaching**

**Situation 1-1:** You are conducting a clinical skills course. During the last day of the course one of the service providers approaches you and indicates an interest in becoming a trainer just like you. He is aware that another clinical skills course is being taught in two weeks and asks if he can co-train with you to become a clinical trainer. How do you answer him?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

An essential component of CBT and one of the most important of the trainer’s roles is coaching. Coaching refers to a general philosophy or approach to training, as well as a specific activity carried out during a training session in order to help a learner learn something new. Coaching uses **questioning, providing positive feedback and active listening** to help learners develop specific competencies—while encouraging a positive learning climate. Unfortunately, the teaching model with which most health professionals are familiar is one in which the classroom instructor lectures a group of students who anxiously take notes so that they can pass a written examination.
Clinical skills are best developed through coaching. In the role of coach, the clinical trainer first explains the skill and then demonstrates it using an anatomic model or other training aid, such as a videotape or role play. Once the skill has been demonstrated and discussed, the trainer/coach observes and interacts with the learner as she/he practices the skill—to monitor progress, provide feedback and, if needed, assist in solving any problems. In the role of coach, the clinical trainer guides the learner through the learning stages while building the learner’s confidence that she/he can do it!

**The Courage to Coach**

Coaching has been used successfully for technical training in industry for many years. It has a proven track record and can be very rewarding for both trainers and learners. Yet, it may feel very different from the training/teaching styles you have experienced. Coaching asks you to step away from the comfortable, traditional role of the all-knowing teacher. Even when you have the answers, you may need to keep them to yourself—allowing the learners to solve problems for themselves and become more independent.

**EDUCATIONAL PRINCIPLES CENTRAL TO COMPETENCY-BASED TRAINING**

Competency-based training is supported by well-established educational principles, as described below.

**Adult Learning**

- **Situation 1-2:** You have been selected to attend an intrauterine contraceptive device (IUD) clinical skills course and you are both excited and nervous about it. When you arrive at the classroom, a number of the other learners are already there and you do not know any of them. As you take a seat, the trainer arrives and begins describing her clinical background. After about 20 minutes of listening to her talk, you are very apprehensive and wonder if you made a mistake in attending the course. Why are you feeling so nervous about this course? What would you suggest that the trainer do differently to relieve your uneasiness?

Write your responses on a piece of paper and then compare your responses with the ones found in Appendix A.

Effective clinical training is based upon **adult learning principles**. Adult learners:

- Have **high expectations** for themselves and their trainer.
- Are most productive when they are **ready to learn** and need a **positive learning environment** that encourages learning.
- Are highly **motivated** if they believe learning is **relevant**; they need to be aware of what they need to learn, why it is important and how it relates to their work.
- Desire **variety** in learning methods and techniques used, and to **participate** and be **actively involved** in the learning and assessment process.
- Appreciate when learning **builds on** what they already know or have experienced, while recognizing them as individuals with **unique backgrounds**.
- Require ample **opportunity for practicing** skills—as well as **repetition** to become competent and, ultimately, proficient in a skill.
Must maintain their **self-esteem**. Although immediate, ongoing feedback is essential to learning, it must be positive, constructive and nonjudgmental—the learners must feel confident they can succeed.

Have **personal needs and concerns** that must be considered. Because they have adult responsibilities, learners may require the trainer’s flexibility in certain situations.

**Humanistic Training**

**Situation 1-3:** During the opening session of a clinical skills course, one of the physicians asks why she needs to learn the skill on an anatomic model. She has always learned skills by watching a skilled clinician and then trying the procedure herself. What is your response?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

The use of humane (humanistic) techniques contributes to more effective clinical training. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids—such as simulations (e.g., role plays) and use of audiovisual aids (e.g., slide sets, videotapes). The effective use of models shortens training time and allows learners to practice skills and make mistakes without harming clients.

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

- The clinical trainer should **demonstrate** the required skills and client interactions several times using an anatomic model (and actual instruments), simulation or other appropriate aid.
- While being supervised, the learner should **practice** the required skills and client interactions using the same model/simulation/aid in a simulated setting that is as close as possible to the real situation (i.e., providing services to clients in an actual clinic).

The more realistic the setting in which learning takes place, the more effective the training.

The number of procedures learners need to observe, assist with and perform using models will vary depending on their backgrounds. Only when the skill is demonstrated correctly in simulation can learners advance to practice with clients. The safety of clients is a critical principle of CBT and should be a priority in any clinical skills course—as in every health care facility.
Competency-Based Training: More Effective, More Humane

In a study conducted in Thailand in 1991, the traditional IUD training method (a six-week course) was compared with a two-week course using the CBT approach. The results clearly demonstrate the benefits/advantages of CBT.

- **CBT approach**: When learners were allowed to learn and practice repeatedly with pelvic models, 70% of the 150 learners were judged to be competent after just two insertions with clients, and 100% by six.
- **Traditional approach**: By contrast, of the 150 learners taught without the use of pelvic models, 50% obtained competency only after an average of 6.5 insertions, and 10% never achieved competency (i.e., were not qualified) even after 15 attempts.

**Using such humanistic techniques, competency-based training helps to ensure that learners and providers can deliver services safely before they practice or work with actual clients.**

### Cognitive Apprenticeship

Another important learning theory supporting competency-based training is called “cognitive apprenticeship,” the goal of which is to make the complex skills of a “master” (one who is truly proficient in a skill) easy for a learner to observe and learn. In the cognitive apprenticeship process:

- The master (or trainer) demonstrates skills and models behaviors for the apprentice (or learner);
- The master explains his/her decisions and thought processes while he/she works;
- The apprentice practices alongside the master, getting continual mentoring/coaching; and
- Over time, as the apprentice becomes more skilled, she/he performs more and more independently.

This process is applied during competency-based training. Side-by-side with a mentor/coach, learners have the opportunity to practice skills in a work-like setting similar to their own, while **learning to “think” like the proficient provider who is their trainer—not just mimic the trainer’s actions.** As a result, evidence shows, individuals learning in this manner with an experienced mentor/coach learn more quickly, achieve a higher level of learning and retain learning longer.

### Playing Master?

When you hear the word “apprenticeship,” what do you think of? Learning from a master? A master and apprentice spending time working side-by-side? The apprentice slowly becoming more independent? All of these are correct. The concept of apprenticeship is very old, and so much a part of how people have learned over the years. And yet the thought of playing the role of “master” (or apprentice) may feel strange to you. It is a big responsibility.

The important thing to keep in mind is that **behavior modeling** is an essential part of the training process. “How” you talk to learners and relate with others says more than “what” you say. Think about this: everything you do demonstrates behaviors—as well as attitudes—for learners, and many learners will adopt them, whether or not they are appropriate or effective.

**Mentoring** learners through the skills development process is another key component that competency-based training and cognitive apprenticeship have in common. And **coaching** is an essential tool in mentoring: using questioning, positive feedback and active listening to help develop the problem-solving skills essential to the cognitive component of true competency.
CHAPTER SUMMARY

- Competence is the ability to perform a specific task, procedure or activity successfully.

- Competencies consist of three different domains: knowledge, skills (psychomotor, clinical decision-making and communication skills), and attitudes.

- Competency-based training focuses on a learner’s competent performance of a specific procedure, task or activity, not only on the knowledge she/he has acquired.

- In order for a competent provider to be successful on the job, she/he needs a supportive, enabling work environment—training alone is not the answer.

- Competency-based training is targeted to needs and performance gaps, uses appropriate teaching and learning activities, and incorporates a coaching style of teaching.

- Competency-based training is an evidence-based approach—supported by adult learning principles, humanistic training and cognitive apprenticeship theories.
CHAPTER TWO

FACILITATION OF TRAINING

Creating an Environment Where Learning Is Easy (or Easier)

The environment within which learning occurs has a tremendous impact on the quality of the learning experience. A positive learning environment maximizes the effectiveness of training, thereby helping learners to achieve the course objectives. Because the clinical trainer sets the tone for the course, how she/he delivers information is the key to establishing and maintaining a positive learning environment during training—how something is said is as important as what is said. The effective trainer creates an atmosphere of capability, one that supports the learners’ sense that they cannot only build competence in the new knowledge, skills and attitudes being taught, but that they can ultimately master them and apply them in their work to provide improved services to the communities they serve. Learners need to feel that they can achieve, and the trainer helps to build that feeling by creating and maintaining a positive learning environment—largely through effective facilitation.

INTRODUCTION

Learning is a partnership between the facilitator and learners; the development and achievement of competency is a responsibility—and reward—that they share. In simplest terms, to facilitate is to make things easy or easier. So in the role of facilitator, the trainer aims to make learning easy/easier for the learner. She does so not through oversimplifying information or by bringing course content down to a lower level than is useful; she does so by enhancing the capability of learners through building a positive learning environment and using a variety of facilitation methods/techniques that are consistent with current, evidence-based learning principles and competency-based training. Unlike the traditional teacher, the facilitator does not see him/herself as the source of all there is to learn in a course.

This chapter introduces and explains some of the main methods/techniques used by the facilitator, which is a fundamental role of Jhpiego’s trainers of trainers (through the Training Skills Course) and of skilled health care providers and other health workers (through various clinical skills courses). Jhpiego’s trainers are as much facilitators and coaches as they are instructors/teachers, working as hard to see that their learners/students are successful as to “set the stage” for such success.

CREATING A POSITIVE LEARNING ENVIRONMENT

Creating a positive learning environment—or atmosphere of capability—is one of the major goals of facilitation, and a cornerstone of effective clinical skills courses. To help learners feel that achievement is within reach, and to achieve, the effective facilitator:

- Is clear and explicit about what is to be achieved: lets learners know what they need to learn during the course, and the skills in which they are expected to achieve competency.
Chapter 2

- **Builds logically and gradually from simpler concepts and tasks to more complex ones**: starts with what is “normal” in managing labor and childbirth, for example, before moving on to complicated cases.

- **Provides encouragement as well as positive, specific and constructive feedback**—reinforcing the correct way of doing something and suggesting specific ways to improve.

- **Treats learners as individuals, with individual learning approaches.**
  - Provides opportunities for them to learn the way they learn best (reading, practicing, working with others, etc.)
  - Builds on their unique areas of expertise and work experiences during discussions and group/small group activities

- **Creates an atmosphere of honesty and openness.**
  - Models such behaviors and attitudes him/herself
  - Encourages learners to admit when a concept is difficult or unclear
  - Admits when she/he doesn’t know something, while assuring learners that she/he will find the answer and get back to them (the trainer is not the source of all knowledge!)

- **Encourages discussion.**
  - Guides discussions to identify barriers to learning and solutions for overcoming those barriers
  - Enables learners to learn from each other’s related experiences and areas of expertise

- **Requests—and responds to—feedback from learners.**
  - Is not afraid to elicit the opinion of learners
  - Makes changes based on learner feedback, as appropriate

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**BASIC FACILITATION SKILLS**

**Situation 2-1**: You are attending an emergency obstetrical skills course. One of the trainers is giving a presentation on the etiology of pre-eclampsia. Since you are hoping to become a trainer someday, you pay close attention to how the presentation is being delivered. You see that the trainer is looking very closely at a set of notes, is talking loudly enough at a constant volume level, is moving around in the left side of the room and is asking many questions to those learners on the right side of the room. What are some effective presentation skills this trainer is using? What suggestions for improvement would you offer this trainer?

Write your responses on a piece of paper and then compare your responses with the ones found in Appendix A.

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During a training course or session, the trainer must be comfortable facilitating a variety of learning activities (e.g., presentation, case study, role play, skills demonstration, skills practice, etc.) to develop knowledge, skills and attitudes in the learners. To be an effective facilitator, she/he uses a range of techniques—including those that follow (which draw on basic presentation skills)—to involve learners, maintain interest and stay on track:
Follow a plan, which includes the session objectives, introduction, body, activity, audiovisual reminders, summary and evaluation. And prepare and use trainer’s notes (further discussed later) to enhance the execution of that plan.

Communicate in a way that is easy to understand. Many learners will be unfamiliar with the terms, jargon and acronyms of a new subject. The clinical trainer should use familiar words and expressions, explain new language and attempt to relate to the learners during the presentation.

Maintain eye contact with learners. Use eye contact to “read” faces. This is an excellent technique for establishing rapport and getting nonverbal feedback on how well learners understand the content.

Project your voice so that those in the back of the room can hear clearly (particularly important in presentations). Vary volume, voice pitch, tone and inflection to maintain learners’ attention. Avoid using a monotone voice, which is guaranteed to put learners to sleep!

Avoid the use of slang or use repetitive words, phrases or gestures that may become distracting with extended use. Examples:

- Repeatedly saying things like: “OK, now...,” “Is that clear?” or “Do you see what I’m saying?”
- Keeping hands in pockets
- Pacing
- Rocking on heels

Display enthusiasm about the topic and its importance. Smile, move with energy and interact with learners. The trainer’s enthusiasm and excitement are contagious, directly affecting the morale and motivation of the learners.

Move around the room and maintain eye contact (particularly important in presentations). Moving around the room helps to ensure that the trainer is close to each learner at some time during the session. Eye contact encourages learners to remain active participants.

Use appropriate audiovisual aids (particularly important in presentations and demonstrations), as further discussed below.

Be sure to ask both simple and more challenging questions.

Provide positive feedback to learners, even during activities that are less “hands-on” such as presentations and discussions. Examples:

- “Thanks for sharing that story. It really helps illustrate the point.”
- “Anne Marie has made an excellent comparison!”

Use learners’ names as often as possible. This will foster a positive learning climate and help keep the learners focused on the presenter. Examples:

- During questioning (e.g., “Miriam, why do you disagree with Jane?”)
- When providing positive feedback (e.g., “Very good point, Ilka!”)
- When referring to comments previously made by learners (e.g., “As Tadesse mentioned earlier, …”)

Training Skills for Health Care Providers
Display a **positive use of humor** related to the topic. **Examples:**
- Cartoons or quotes/sayings on a flip chart
- Photos/cartoons for which learners are asked to create captions
- Humorous stories and anecdotes

**Provide smooth transitions between topics/activities.** Within a given presentation or training session, a number of separate yet related topics or activities may be addressed or included. When shifts between topics or activities are abrupt, learners may become confused and lose sight of how everything fits together in the bigger picture. The clinical trainer must ensure that the transition from one topic/activity to the next is smooth through a variety of devices. **Examples:**
- A brief summary
- A series of questions
- Relating content to practice or an exercise (case study, role play, etc.) before moving on to the next topic/activity

**Be an effective role model.** The clinical trainer should be a positive role model in dress, appearance, manner and enthusiasm for the training course.

**Begin and finish at the scheduled times.** Keeping on time sets a precedent, allowing you to expect/request that learners do so as well. If need be, learners can refer to reference materials to read up on topics you have had to reduce or omit because of time constraints.

**Transferring Knowledge, Skills…and Attitudes**

*Remember: You are modeling behavior the entire time that you are presenting to or interacting with learners. This means that the attitude with which you regard the topic being presented or discussed (e.g., through your tone of voice, facial expressions and gestures, how much time you spend on it) will influence learners’ attitudes toward it as well. Therefore, you should be mindful, for example, of what you emphasize or de-emphasize. When you spend a lot of time on something, learners will tend to regard it as important, just as they may dismiss something that you spend little time on as unimportant.*

**Use your time and other resources wisely.** If it is important, then spend time on it. If not, or the content is already well-understood, do not bore the group by discussing/repeating unneeded information. Your time is better spent on topics that assessment shows are not so well-understood. Learners will benefit more as well.

These skills apply throughout the training course/sessions and can enhance the impact of any learning activity.
USE OF AUDIOVISUAL AIDS

Audiovisual aids help trainers communicate information clearly and maintain learner interest, making them among the most useful of teaching tools. Writing on a board or using diagrams in a presentation, for example, reinforces or supplements course content—allowing learners to absorb more information more easily. Audiovisual aids are useful not only for presentations, but also for demonstrations, introductions or summaries of training sessions, and any learning activity. Examples of audiovisual aids:

- Paper handouts
- Writing boards
- Flip charts
- Computer graphics/slide presentations
- Videos

**Bringing Content to Life**

Think about the last presentation you attended. What visual aids did the presenter use? Were they effective? Did they hold your interest and help emphasize important points? What types of visual aids do you use in your teaching? Visual aids can be a powerful complement to any learning activity—helping to bring course content to life, while:

- Highlighting important points, key steps or tasks; or
- Providing supplemental information that can be used for reference during and beyond the course.

Although there are some specific uses and tips for each type of visual aid, some basic rules apply in every situation.

- **Prepare and/or carefully review aids beforehand,** if possible and appropriate, particularly if they are complicated (e.g., detailed graphics, instructions for complex activities).
- Make sure aids are **easy to read** (not overcrowded with text or design elements).
- Use them to **emphasize** important information (further emphasis can be achieved with underlining, boldface, etc.).
- Always **check any equipment** needed ahead of time.
- Make sure aids are **legible/visible** from anywhere in the room.
- Always **face and focus on the learners**, not the aid itself. And use text provided as a prompt, not a script to be read aloud.
UNDERSTANDING GROUP DYNAMICS

Situation 2-2: You are a new clinical trainer and you want the learners to approve of you. The first day of the clinical skills course, two learners from the same province arrive late and join the group after the introductions and review of the day’s agenda. For the next two days, they continue arriving late each morning, as well as after tea and lunch breaks. By the third day, other learners are joining the pair in arriving late. You are growing concerned and are wondering what you should do. What are your options in dealing with the individuals? What are your options in dealing with the “time issue” in the group?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Why is it important for the clinical trainer to understand group dynamics? For the training group to move toward its learning goals, it needs three important elements: structure, direction and leadership. With these elements in place, a healthy group process can develop. Without these elements, the group may begin to disintegrate, and undesirable group behavior that will hinder learning may emerge. Understanding what to look for will help the trainer maintain good group dynamics or determine when intervention is required—such as if the group begins to develop any unhealthy patterns (e.g., arriving late, ridiculing other learners, talking during a presentation). The trainer can also intervene in the group in order to reinforce positive, healthy group behavior.

What the Group Does (Content) and How It Does It (Process)

In monitoring group development, the trainer attends to the content of the course, as well as the process of the group. In Exhibit 2-1, the content of the course—what the group does—is depicted by the part of the tree that is above the soil: the trunk and branches. The process or interaction of the group is depicted by the root system of the tree and the soil that surrounds and supports the roots.

- In a training course, the content is determined before the course begins, described in the course objectives and further refined during each session. For an individual training session, the content or “tree” includes: the course schedule; the day’s agenda; instructions, materials and methods; and learning goals for each topic and activity. The challenge for the clinical trainer is to make sure that all required course content is covered and that the course objectives are met.

- When the individuals in the course are working together as a group, their interaction is known as group process. Since the root system is below the surface, it is more difficult to see and understand. However, managing group process is as important for the trainer as ensuring that the course objectives are met.
Characteristics of a Healthy Group

Whichever training approach is used, typically, some component of it will involve a group—a group learning or practicing together, assessing one another, supporting each other as they apply their new skills in the workplace. Establishing a positive learning climate depends in large part on the individual learners coming together to form a healthy, mutually supportive group. A collection of individuals becomes such a group when:

- They share a common purpose,
- The members think of themselves as a group and they share a common experience in attending the course,
- Each member’s contributions and questions are valued and respected,
- An open and trusting climate develops, and
- The members pay attention to how they work together.

These are the forces, known as group dynamics, that are present among individuals who come together to form a group. To understand and learn to manage group dynamics, the trainer, without making any judgments, must become acutely aware of what is happening in the training room. Gradually, as shown in Exhibit 2-2, the trainer progresses through several steps: observation, increased awareness and discussion with any co-trainers, before developing options to support the group and help it achieve its goals.
Exhibit 2-2. Steps in Understanding Group Dynamics

Step #1: Observe how learners interact, who is quiet, who speaks too much, who needs additional time and support, and who needs less. Observe for any tension or stress that needs to be addressed before it becomes a problem.

Step #2: Become increasingly aware of what is happening in the classroom or clinical setting. This includes paying attention to individual, small group and large group behaviors. Journaling is a good way to increase your awareness and skills in improving how groups work together.

Step #3: Share your observations with your co-trainers to identify any patterns of behavior among the group members.

Step #4: Independently, or with co-trainers, consider options to support the group. This may involve focusing on certain individuals or the group as a whole.

While monitoring the development of the group and making choices to guide it, the trainer must also realize that the group functions at several levels—as individuals, as members of small groups and, collectively, as the larger group. And at each level, the dynamics are different. A trainer may find that she/he is most comfortable observing and understanding the behaviors at one of these levels—individual, small group or larger group. The new trainer must be aware of this, and strive to become adept in working at each level in order to manage group dynamics effectively.

Respect and Be Respected

As a trainer, you are continuously modeling the behaviors and attitudes you want your learners to demonstrate in the classroom and adopt as trainers. Respect is key among these attitudes. Examine your attitudes about training—do you feel that you are there to help the group learn, or that they should listen to you because you are in charge? Whatever are your true, underlying feelings regarding your role, these will be communicated to the learners through facial expressions, tone of voice and other subtle cues. Seek feedback/counsel from other trainers if you find it difficult to continually maintain a respectful attitude toward the group.

THE FACILITATION PROCESS

In addition to creating a positive learning environment, largely through applying basic facilitation skills introduced in this chapter (and further discussed in Section II), the trainer should become proficient in the “facilitation process”—a sort of template that applies to the course as a whole and any and all training sessions and learning activities that she/he conducts. In brief, this process involves introducing,
conducting and summarizing sessions/activities in a way that engages and enables learners to get the most out of each. This process is summarized below and expanded upon in Exhibit 2-3, page 21.

**Introducing Training Sessions/Learning Activities**

In the context of the facilitation process, the experienced trainer understands that the first few minutes of any activity are critical. Effectively introducing training sessions or learning activities is, therefore, an important component in the process. Learners may have their minds on other matters, be unclear regarding what the upcoming activity is about or have little interest in the topic.

The introduction should:

- Review the learning objectives/goals of the activity
- Capture the interest of the entire group and prepare learners for the information/task that follows
- Make learners aware of the clinical trainer’s expectations, including detailed instructions if applicable
- Help maintain a positive learning environment

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**Connecting to the Big Picture**

Every learning activity has an objective (or objectives) and expected learning outcomes. An effective introduction gains learners' attention, sets the expectations and fosters a learning climate. The purpose of the introduction is to make sure the learners know the learning objectives, enabling them to get the maximum benefit from the learning activity. ALL learning activities should be introduced in order to put them in the context of the overall goals and objectives of the course. This helps keep the course, and every segment within it, connected to the bigger picture—addressing the health problems the learners’ communities are facing through provision of high-quality services.

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**Conducting Training Sessions/Learning Activities**

**Situation 2-3:** You are conducting a clinical skills course. During a break, one of the learners approaches you and asks you why you ask so many questions during your classroom and clinical sessions. How would you respond to this question?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Once the trainer has provided an effective introduction, and the learners are interested and know what to expect or do, she/he can begin conducting the session/learning activity. During many learning activities, the trainer shifts into the “coaching” role, which involves effective use of questioning, as well as feedback and active listening. Use of audiovisual aids, anatomic models and other interactive techniques is also important, as learners and trainers work together to develop and assess learner competency.

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4 Although coaching is most often discussed in the context of skills practice, coaching techniques are equally applicable and helpful in many other types of learning activities, including those aimed at building knowledge and considering/reshaping attitudes.
Effective facilitation of an activity should:

- Engage the learners on many levels (visually, cognitively, physically, etc.)
- Balance focusing on a specific topic or task with flexibility, allowing room for creativity and exploration
- Be a two-way process, where both the facilitator and learners have a role to play
- Help maintain a positive learning environment

**Summarizing the Training Session/Learning Activity**

<table>
<thead>
<tr>
<th>Situation 2-4: You are attending a clinical training skills course and are planning a classroom presentation. You know you need a summary at the end of your presentation, so you make a note to ask if there are any questions. Answering the questions will serve as your summary. Is this an appropriate summary technique? Why or why not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write your response on a piece of paper and then compare your response with the one found in Appendix A.</td>
</tr>
</tbody>
</table>

After the trainer has facilitated a session/activity, she/he should provide a brief summary. An effective summary—the final, critical component in the facilitation process—should:

- Be brief
- Reinforce key content and draw together the main points
- Involve/engage the learners (e.g., through questioning, games)
- Transition to the next topic or activity
- Highlight overall relevance (e.g., to what they’ll be doing in the workplace)
Exhibit 2-3. Facilitation Process Guidelines and Tips*

**STEP 1: INTRODUCE THE LEARNING ACTIVITY**

In introducing the learning activities indicated in the course outline, the clinical trainer should always provide certain key information to ensure that learners know what to expect, know what to do and understand the overall relevance of what will follow. The trainer can also select from a number of optional techniques to provide variety and keep learners interested and engaged.

For every introduction, you should do the following, further discussed below:

- **Provide essential information**
- **State the objective of the activity**
- **Provide clear instructions**
- **Indicate a time limit, if applicable**
- **Underscore the relevance of the activity/put it into context**
- **Generate interest and enthusiasm**

1.1. Include the following elements as part of every introduction:

- **State the objective of the activity.** Introducing the topic by a simple statement of the related learning objective keeps the learners aware of what is expected of them. This should be a part of every introduction. Example:
  
  "This afternoon we will learn how to use the training arm model for contraceptive implants. Our objective is to insert contraceptive implants in the training arm using the standard insertion technique. Any questions before we begin?"

- **Provide clear instructions.** Letting learners know exactly what their role is during the activity, regardless of whether they are active participants or observers, is essential. What do they need to do during the activity and/or share afterward? If instructions are lengthy or detailed, they should be provided in written form as well (on handouts, a flip chart, white board, etc.). Example:
  
  "While Leonora and I do the role play, follow along with the VCT job aid. Pay special attention to how Leonora, in the role of the counselor, makes use of the patient education materials. Write down one thing you think she does well and one thing she should do differently (a specific suggestion). Be prepared to share your thoughts with the group."

- **Indicate a time limit, if applicable.** If a time limit will be imposed on learners’ part of the activity, make this clear up front. Break it down into increments if appropriate. Example:
  
  "You have a total 15 minutes to work on this case study in small groups. Spend about 10 minutes reading and discussing it. In the last 5 minutes, assist your group reporter in preparing your responses to share with the larger group."

1.2. Underscore the relevance of the activity or place it into a meaningful context:

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

- **Relate the topic to real-life experiences.** Example:
  
  "Our next topic is pre-operative counseling for a man considering male circumcision. Have you ever had a client who was very nervous and anxious? What did she say or do? How did it affect you? Ivan, tell us how you would feel if you were the client."

(continued on next page)
Chapter 2

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

1.3. You may also choose from these techniques to generate interest and enthusiasm about the topic that is the focus of the activity:

- **Ask a series of questions about the topic.** The effective clinical trainer will recognize when learners have prior knowledge concerning the course content and encourage their contributions. The trainer can ask a few key questions, allow learners to respond, discuss answers and comments, and then move into the body of the activity. **Examples:**
  
  “Andre, what is an example of an important infection prevention practice?”

  “Silvia, the next topic is client assessment for postpartum family planning. What are some of the questions we should ask the client?”

  “This is a slide showing the floor plan of an antenatal clinic. Jose, what do you see that may have an effect on client flow?”

- **Share a personal experience.** There are times when the clinical trainer can share a personal experience in order to create interest, emphasize a point or make the topic more job-related. **Example:**
  
  “This morning we will practice diagnosing pre-eclampsia through the use of case studies and role plays. Before we begin, I would like to share with you my first experience caring for a woman with pre-eclampsia. The client was....”

- **Bring in an expert.** Speakers with a specific area of expertise often add credibility to a presentation. **Example:**
  
  “This session will review infection prevention practices. To begin our discussion I would like to introduce Sister Ade Wachura, Infection Prevention Specialist for the hospital. Ade will share with us the hospital’s recommended infection prevention practices for surgical contraceptive methods. Please join me in welcoming....”

- **Show a videotape (or use another audiovisual aid) or conduct a mini-activity.** Appropriate audiovisuals, small group activities or demonstrations generally build tremendous interest in a topic. **Examples:**
  
  “Now that we have defined active management of the third stage of labor and understand its importance, we’ll view a computer animation of the procedure. Afterwards, we’ll practice the steps ourselves.”

  “Our next topic is the three essential criteria for the lactational amenorrhea method of contraception. Please read the case study on page three of your course handbook and answer the questions on page four. We will discuss your responses when everyone has finished.”

  “This afternoon, we will be practicing the male circumcision procedure on an anatomic model. Let me give you a quick peek at the model itself, and a mini-demonstration of the procedure. We will go through the procedure in more detail later.”

Clinical trainers should keep a file of topic-related cartoons, signs, slogans and similar items. When appropriate, these can generate interest and a few smiles at the same time.

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**STEP 2: CONDUCT THE LEARNING ACTIVITY**

In conducting the learning activities indicated in the course outline, the clinical trainer will employ techniques that are appropriate to each type of activity. For example, effectively facilitating small group work on a case study requires some different techniques from those required for delivering an interactive presentation or conducting a discussion or clinical skills practice session.

Techniques that are specific to particular learning activities in the classroom or clinical setting are discussed in Chapter 6 and Chapter 7, respectively. Techniques that come into play, at some point, in most learning activities are those involved in "coaching," which are as follows and discussed in more detail in Chapter 3.

- Questioning
- Feedback
- Active listening

### 2.1. Key Coaching Technique One: Questioning

Three main principles of effective questioning are to:

- Use a variety of questioning techniques, such as follows, and avoid a pattern.
- Respond appropriately to learners’ correct, incorrect or lack of responses.
- Be prepared to respond to learners’ questions, as well.

### 2.2. Key Coaching Technique Two: Providing Feedback

Clear and specific feedback is useful for developing knowledge, all types of skills and attitudes—and fundamental for learning and performance. No matter what the situation, the basic rules for providing effective feedback are:

- Be timely;
- Be specific and constructive; and
- Speak for yourself.

### 2.3. Key Coaching Technique Three: Active Listening

Active listening enables a clinical trainer—in the role of coach—to stimulate open and frank exploration of ideas and feelings and establish trust and rapport with learners. It also helps the clinical trainer clarify learner comments and enables the learner to be heard and understood. In active listening, the trainer accepts what is being said without making any value judgments, clarifies the ideas or feelings being expressed and reflects these back to learners. The following are examples of active listening techniques:

- Stop talking and listen to the speaker.
- Restate the speaker’s exact words.
- Paraphrase in your own words what the speaker said.
- “Reflect back” the underlying feelings/emotions of the speaker.

These coaching techniques are expanded upon in Exhibit 3-2 (page 31).

**STEP 3: SUMMARIZE THE LEARNING ACTIVITY**

Summarizing activities helps to ensure that learners understand the material as it is being presented and the overall significance of activities, while reinforcing key information and transitioning to what's next. Many summary techniques are available to the clinical trainer, including the following:

### 3.1. Ask the learners for questions to clarify their understanding of the instructional content

This may result in a lively discussion focusing on those points that seem to be the most troublesome.

### 3.2. Ask the learners questions that focus on major points of the presentation

(continued on next page)
3.3. Administer a practice exercise or quiz that gives learners an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for discussion by asking for correct answers and explaining why each answer is correct.

3.4. Use a game to review main points provides some variety, when time permits. One popular game is to divide learners into two teams, give each team time to develop “review questions” and then allow each team to ask questions of the other. The clinical trainer serves as moderator by judging the acceptability of questions, clarifying answers and keeping a record of team scores. This game can be highly motivational and can serve as an excellent summary at the same time.

* Although these guidelines apply in a general sense to training sessions (and even the course as a whole) as well, they are geared more toward learning activities in terms of level of detail, content, etc. The trainer will be facilitating many learning activities, and it is within these individual learning activities that competency development and assessment truly occur.

**TRAINER AS COACH**

The trainer will assume the role of coach during simulations and other learning activities in the classroom, as well as when learners practice with actual clients in the clinical setting. Helping a learner, through coaching—to analyze and apply new information, develop a new clinical skill or address a certain attitude—is one of the most important roles of a clinical trainer. In this role, the clinical trainer is able to guide the learner through the learning stages, *while* enhancing and maintaining and the learners’ confidence and self-esteem that are critical to independence.

The characteristics of an *effective clinical coach* are basically the same as those of an *effective clinical trainer*—and those of a football coach. A football coach is an expert in the game of football, as well as in the strategies and techniques involved in beating the opposing team. The coach knows, however, that players will benefit most, not by being lectured on “winning moves,” but by trying them out on the field—with each other during practice—before they play actual games against other teams. During practice, the coach observes the players and makes specific suggestions for improvement, while keeping their motivation up and making them feel like the “winners” they can be on game day.

An effective coach/clinical trainer:

- Is proficient in the skills to be taught
- Encourages learners in learning new skills
- Promotes open (two-way) communication
- Provides immediate feedback, when appropriate:
  - Informs learners whether they are meeting the objectives
  - Does not allow a clinical task or skill to be performed incorrectly
  - Gives positive feedback as often as possible
  - Avoids negative feedback and instead offers specific suggestions for improvement
- Recognizes that clinical training can be stressful and knows how to *regulate learner as well as trainer stress*:
  - Uses appropriate humor


- Observes learners and watches for signs of stress
- Provides regular breaks during training sessions
- Varies the training routine
- Focuses on learner success instead of failure

Learners learn new skills most easily when they are highly motivated to learn and are not overwhelmed by feelings of anxiety and fear. If the learning environment is pleasant, supportive and enhances self-esteem, the learner is more likely to learn and use the skills.

<table>
<thead>
<tr>
<th>The Effective Coach...</th>
<th>The Ineffective Coach...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focuses on the practical</td>
<td>Focuses on the theoretical</td>
</tr>
<tr>
<td>Encourages working together (collegial relationship)</td>
<td>Maintains a distance (status is above the learners)</td>
</tr>
<tr>
<td>Works to reduce stress</td>
<td>Often creates stress</td>
</tr>
<tr>
<td>Fosters two-way communication</td>
<td>Uses one-way communication</td>
</tr>
<tr>
<td>Is a facilitator of learning</td>
<td>Acts as the authority or the only source of knowledge</td>
</tr>
</tbody>
</table>

Key coaching techniques are fully explored in Exhibit 3-2 (page 31).

**CHAPTER SUMMARY**

- The environment in which learners learn has a critical impact on the quality of their learning experience. It is the clinical trainer’s responsibility to create a positive learning climate that supports learners’ progress toward achieving competency.

- To create and maintain an environment that is conducive to learning, the trainer must be well-prepared and well-organized, as well as understand the principles of adult learning, be able to build and maintain energy and enthusiasm, manage learner and trainer stress, and—most important—use a full range of effective facilitation skills.

- Healthy group dynamics are essential to a positive learning environment, helping individuals move together toward their learning goals. The trainer must have effective strategies for building, maintaining and—as needed—improving group dynamics.

- The trainer makes training sessions/learning activities more stimulating and, ultimately, more effective by adhering to a basic facilitation process: providing interesting and informative introductions; effectively using questioning, audiovisuals and feedback techniques; and wrapping up with concise and interactive summaries.

- In the classroom and clinical setting, the trainer often assumes the role of coach to make learning a truly interactive experience and to shift more of the responsibility for learning to the learners themselves.

**Sample**: See Sample B-1. Facilitation Skills: Self-Assessment Guide in Appendix B.
CHAPTER THREE

COMPETENCY DEVELOPMENT

The Power of Feedback in Competency Development
Practice does not make perfect without feedback. Feedback is how you help learners improve and achieve competency. As part of coaching, feedback is essential throughout learning; it is particularly important during and after practice and assessment. Specific, constructive feedback provides a “blueprint” for how learners can improve.

INTRODUCTION
Clinical training places the learner with an experienced trainer in simulated and then real clinical settings, where the learner can observe and then practice the skills required to achieve desired competencies. The trainer helps learners develop competence through:

- Providing some means of transfer of knowledge;
- Assisting learners in developing types of skills by providing demonstration and opportunities for practice;
- Incorporating behavior modeling and attitude development in all learning activities and trainer–learner interactions; and
- Assessing learner competence on a continuous basis to help them learn.

As a trainer, your main role is to assist learners in developing the knowledge, skills and attitudes that they need to become competent. The trainer will be most effective, the learners most successful, if the trainer assumes the role of coach—rather than instructor—during training. Although coaching becomes especially critical in the clinical setting, it is an important component of facilitating classroom-based learning activities as well. All of this is true in both pre-service (educational) and in-service (training) settings.

Assessment is useful both during developing and evaluating competence. Throughout the learning process, the trainer continually assesses the learners and provides them with feedback to help them learn and become more confident and competent. This kind of assessment, known as formative assessment, is further described in Chapter 4. This chapter focuses on introducing and explaining some important principles of developing competency in learners.

DEVELOPING KNOWLEDGE, SKILLS AND ATTITUDES NECESSARY FOR COMPETENCY
Throughout training, you will facilitate activities, use questions and provide feedback to help learners master the desired competencies. Here are some tips for helping learners develop knowledge, skills and attitudes.
Building Knowledge
As a coach, you can help learners move from recall of new information to the ability to analyze and apply that knowledge in clinical situations, by using the following techniques.

- **Present material in a logical way.** Begin with simple information, concepts and tasks and move to more complicated content. For example, review basic physiology of postpartum hemorrhage before reviewing how to diagnose and manage the condition.

- **Use a variety of learning activities.** This helps keep learners engaged, and different methods are more useful for some things than others. For example, a quiz is a great way to reinforce important information, whereas a case study or clinical simulation may be more useful for helping learners analyze and apply information.

- **Use audiovisual aids** as appropriate to help illustrate your points and keep learners interested.

- **Use questions to continually assess** learners’ understanding. Trainers should use questions to decide which areas are understood, and which need additional attention. Written assessments—such as quizzes or questionnaires—or other exercises can be used to assess learner comprehension before moving into skills practice.

- **Use questions and feedback** to reinforce correct information and assist learners in analyzing and applying new knowledge. For example, a learner may recall the relationship between tuberculosis and HIV infection, but the use of questioning and feedback will help the learner analyze and apply this information during clinical practice.

Questions and feedback can be provided through one-on-one interactions; group discussions; written or computer-based formats; use of case studies; and a variety of other means.

Developing Skills
There are three phases in the transfer and development of all types of skills. In training, the goal is for learners to achieve competence. Here’s a summary of each phase of the process, and what you do to facilitate it.

**Coaching to Competency**
As a trainer, you have a range of training techniques and tools to assist you in developing the competency of your learners. Most critical is your ability to coach. Use coaching to help close the gap between desired and actual performance. Because it is not authoritative, it helps learners to become more confident and independent.

**Phases of Skill Development**
**Acquisition:** During skill acquisition, or learning, the trainer demonstrates or otherwise “breaks down the skill” into manageable pieces. Family planning counseling; determining whether a client needs to initiate, stop or revise a medical therapy; and management of postpartum hemorrhage—are all skills that can be
broken down into steps. Once learners have observed the demonstration, they are provided the opportunity to acquire the skills themselves, through practicing the skill and receiving feedback.

**Competency:** Skill competency, the goal of training, means that the learner is competent in the skill—that is, she/he can perform the skill accurately and with some degree of confidence. An assessment tool (e.g., checklist) is used—by trainers and learners—to develop and assess competency first in simulations in the classroom and then in the clinical setting.

**Proficiency:** Proficient health care providers perform efficiently, confidently and often without being conscious of the decisions they are making or of the individual steps involved in a clinical process or procedure. This level of skill develops only with repeated practice in the workplace.

The trainer can help learners move from skills acquisition to competence by applying the following principles.

1. **Structure training so that learners advance from simple to complex skills.** Once learners master simple skills, they will feel more comfortable with complex skills. For example, learners should master history taking and physical examination before moving on to more complex skills, such as diagnosing and treating illnesses.

2. **Follow a whole-part-whole strategy during demonstration and practice.** In demonstration, first demonstrate the complete skill, and then break it down into individual steps. In practice, learners can practice “parts” of a whole competency and integrate them later. For example, learners in an ARV management training will not be able to initiate treatment, conduct a return visit, manage complications or side effects, or switch regimes all with one patient. Instead, they will have to practice those skills in “parts” and later integrate them.

3. **Allow learners to practice with supervision before practicing alone.** Learners will perform better and master skills faster with the guidance of a trainer rather than on their own. The trainer should allow the learner to move gradually toward independence, recording his/her increasing level of competence in the process.

**Skills Development Methodology**

No matter what type of skill the trainer is demonstrating—whether a psychomotor or hand skill, a clinical decision-making skill or a communication skill—the coaching methodology for skill development includes these steps or phases:

- **Demonstration** of the clinical skill by the trainer, using models, simulations and an assessment tool (usually a checklist) to outline critical steps. For clinical decision-making, a “demonstration” of the skill entails explaining to learners the rationale for each decision made. In this way, learners are “walked through” the thought process of a provider who is proficient in clinical decision-making.

- **Practice** of the skill by the learner (using the same checklist) with feedback from the trainer, first in simulation and then with clients; and
Assessment of the learner’s skill competency by the trainer in simulation and then with clients (using the same checklist).

The coaching process helps learners develop skills successfully. In Exhibit 3-1, note how the roles shift during the process.

**Exhibit 3-1. Coaching in Clinical Training**

<table>
<thead>
<tr>
<th>ROLES</th>
<th>LEVEL OF PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skill Acquisition</td>
</tr>
<tr>
<td><strong>Clinical Trainer</strong></td>
<td>Demonstrates skill/activity</td>
</tr>
<tr>
<td><strong>Learner</strong></td>
<td>Observes the demonstration</td>
</tr>
</tbody>
</table>

Throughout the coaching process, the trainer uses the three key coaching techniques—of questioning, providing feedback and active listening—to develop, as well as assess, learner competency. These techniques are fully explored in Exhibit 3-2.

**Sample:** See Sample B-2. Clinical Demonstration Skills: Self-Assessment Guide in Appendix B.

**Shaping Attitudes**

Facts can help address attitudes. For example, providing evidence that HIV cannot be transmitted through casual social contact may help providers be less fearful and treat HIV-positive clients better. Addressing attitudes requires continual behavior modeling on the part of the trainer—as well as opportunities for learners to reflect on and self-assess their own underlying feelings and beliefs. A trainer can model the appropriate attitudes and values through the use of “value clarification” exercises to help learners assess their attitudes and feelings. Activities that are especially useful for exploring and addressing attitudes are large and small group discussions, role plays and anything involving thought-provoking scenarios in which the “right” answer is not clear.

**What about Attitudes?**

During a course, you may encounter attitudes and opinions that you do not agree with. It’s very important not to judge learners for their attitudes—to keep a positive learning climate and professional behavior. Provide as many opportunities as possible for learners to self-assess and respond to different situations to help in attitude development. You may not be able to change some learners’ attitudes during a short training course. You can, however, increase learners’ awareness of their attitudes and begin the process of self-reflection and self-assessment.
Although coaching is often thought of in the context of skills practice, the facilitator can and should use these techniques throughout the course to increase the effectiveness of almost any learning activity. Likewise, many of the “key coaching techniques” are basic facilitation skills.

**ONE: EFFECTIVE USE OF QUESTIONING**

Questions can be used at any time to introduce a topic, stimulate discussion and assess learner understanding.

1.1. Use a variety of questioning techniques, such as follows, and to avoid a pattern.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some learners may dominate while others may not participate. *Example:*
  
  “Someone, please tell me, why do we...?”

- **Target the question to a specific learner by using that individual’s name before asking the question.** The learner is aware that a question is coming, can concentrate on the question and respond accordingly. The disadvantage is that once a specific learner is targeted, other learners may not concentrate on the question. *Example:*

  “Jose, please tell us, what would happen if we...?”

- **State the question, pause and then direct the question to a specific learner.** All learners must listen to the question in the event that they are asked to respond. The primary disadvantage is that the learner receiving the question may be caught off guard and ask the clinical trainer to repeat the question. *Example:*

  “Notice the instrument we are we using today. Rosminah, what is it called?”

- **Use learners’ names, in general, during questioning.** This is a powerful motivator and also helps to keep all learners involved. *Examples:*

  “Sharuk, you seem to be puzzled by my response. Can you tell me what you are thinking?”

  “Oghislayne, you appear to be considering all of this. Why do you think Mrs. B (in the case study) is so opposed to returning to the health center to have her baby? What do you think she is afraid of?”

1.2. Respond appropriately to learners’ correct, incorrect or lack of responses.

- **When a learner provides a correct answer:**

  - Provide positive reinforcement for responses to keep the learners interested in the presentation. Positive reinforcement may take the form of praise, displaying a learner’s work, using a learner as an assistant or using positive facial expressions, nods or other nonverbal actions. *Examples:*

    “I couldn’t have said it better, Alain!”

    “I like the way you stated that, Aimee.”

    “You’re exactly right and make a good point too, Jose.”

  - Repeat a learner’s correct response. This provides positive reinforcement to the learner and allows the rest of the group to hear the response. *Example:*

    “Juan is correct. The Copper T 380A IUD is now approved for use for up to 10 years.”

- **When a learner’s response is partially correct,** reward the correct portion and then improve the incorrect portion or redirect a related question to that learner or to another learner. *Examples:*

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

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

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• **When a learner’s answer is incorrect**, make a noncritical response and then restate the question to guide the learner to the correct response. *Examples:*

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

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

• **When a learner makes no attempt to respond**, restate the question to guide the learner to the correct response (as above) or redirect the question to another learner. After receiving the desired response, be sure to draw the original learner back into the discussion. *Example:*

  “Jose, can you think of any other reasons for partograph use, adding to those that Enrique has listed?”

1.3. Be prepared to respond to learners’ questions, as well.

When learners ask questions of the trainer, she/he has three options: answer the question, respond with another question or defer the question but offer a rationale for doing so. The clinical trainer must draw on personal experience and ready knowledge to determine which option is appropriate in each situation.

• **When you can answer a learner’s question**, it is never inappropriate to do so. However, when the question is based on the current topic, it represents a valuable opportunity for learning. If appropriate, try answering by asking the learner another question. *Example:*

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

• **When you are unable to answer a question**, acknowledge it (admit to not knowing the answer) but explain that you will look into it and get back to the course participants as soon as possible. After the session, research the answer and share it during the next session or as soon as an evidence-based explanation can be found. *Example:*

  “That’s a good question, Renata, but one that I’m afraid I can’t answer right now. I will look into it, however, and get back to you.”

• **When learners ask questions that will guide the discussion away from the topic**, you must decide whether or not answering the question and allowing the ensuing discussion will be valuable.

• **When learners will benefit, and time permits**, you may wish to follow the new line of discussion but in a limited manner. *Example:*

  “That’s an excellent question, Alex. In fact, our discussion next hour will focus on care of the HIV-positive client who is co-infected with TB. To answer your question briefly, ...”

• **If you do not think learners will benefit**, you must move the discussion back to the topic, offering a rationale to help keep the discussion going and protect learner self-esteem/confidence. *Example:*

  “Gabriel, that is certainly a valid concern, but I’m afraid it lies beyond the scope of this particular course. Can we talk about it during break?”

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Chapter 3

TWO: EFFECTIVE USE OF FEEDBACK
During any learning activity (not just skills coaching), feedback is perhaps the most important component of effective facilitation.

Effective Feedback: One Size Does Not Fit All
You may deliver feedback differently depending on the type of learning activity.

- If using either paper-based or computer-facilitated exercises to reinforce knowledge, you may provide written feedback.

- In group settings, you provide feedback on answers provided and learner contributions to discussions. During discussions and presentations, feedback will be short such as “Good answer, Willie” or “Thanks for sharing that story, Debora,” whereas during skills practice, feedback will be one-to-one and more detailed.

- In the clinic, you generally do not provide feedback in front of clients. It is often provided later—between clients, during breaks or in the post-clinic meeting.

No matter what the situation, here are some basic rules for providing effective feedback:

2.1. Be timely. Whenever possible, give feedback immediately after an answer to a question or a practice session.

2.2. Be specific and constructive. This is challenging for trainers. Feedback is only as useful as it is specific. Describe exactly what was well done and why and what could be done better—providing specific tips or guidance on how to improve. Use reference manuals or learning aids (like algorithms, performance standards, checklists or learning guides) to help keep your feedback specific and constructive. Example: A trainer is providing feedback after observing an education session about infant feeding for an HIV-positive mother.

- Here’s an example of vague feedback: “You did a good job educating the client.”

- Compare that to this more specific, useful feedback: “You did an excellent job summarizing the mother’s concerns and addressing them. You also used questions to ensure the mother’s understanding of key points. Nice work.”

- Being specific is even more important when providing corrective feedback: “You did a very good job of explaining safe alternatives to breastfeeding in clear and understandable terms, but I thought your definition of exclusive breastfeeding was quite technical. Could you try simplifying that part, perhaps by breaking it down a bit?”

2.3. Speak for yourself. “Own” your feedback. Even if training with others, use the singular “I,” not “we,” when providing feedback. And start your comment with “I,” rather than “you,” especially when providing corrective feedback. Example:

Rather than saying, “You didn’t monitor the mother well after that delivery,” the effective trainer might say, “I noticed that you didn’t monitor the mother until 30 minutes after delivery of the placenta.” In the second example, the trainer has “owned” his/her feedback, as well as provided specific feedback on performance.

2.4. Model receiving feedback for the learners. Demonstrate good behaviors related to receiving feedback. Ask for feedback about an activity, accept it and thank the learners for it. Don’t be afraid to ask for suggestions about how to improve and then demonstrate changes as a result of the feedback.

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THREE: EFFECTIVE USE OF ACTIVE LISTENING

Active listening is a powerful communication tool that can be used any time to shape learning and reinforce correct information, good practices and positive attitudes in a supportive way. It can also “draw the learner out” to explore and expand further on their thought processes, beliefs and feelings. When actively listening, it is appropriate to:

3.1. **Maintain a nonjudgmental tone**, even when you disagree: “You seem to have a negative perception of the doctor’s actions in this situation. Can you tell me what you are thinking or feeling?”

3.2. **Refrain from questions that have only one correct answer**: for example: “You say that the client in Case Study B is ‘resisting’ the midwife’s advice. Why do you think that is?”

3.3. **Ask open, “non-leading” questions**: for example: “Can you tell me why you gave patient education materials to everyone in the woman’s family?”

3.4. **When asking “probing” questions, avoid** making it sound like you are “cross-examining” or doubting the learner; for example: “That’s an interesting choice you made there. Can you share your reasons with us?” or “The client still seems upset. What are some other things you might try to reassure her?”

3.5. **Ask for clarification, when needed**: for example: “I’m not sure I fully understand what you are saying—can you explain more?” or “I’m confused as to what your reasoning is—can you try putting it another way?”

3.6. **Identify with the learner’s emotions** and state the implications of those feelings; for example: “It sounds like you were concerned that the woman’s family might not support her decision. That must have made it difficult to counsel her with them present.”

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

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**Sample**: See Sample B-3. Coaching for Clinical Skills: Self-Assessment Guide in Appendix B.

DEVELOPING DIFFERENT TYPES OF SKILLS

Knowledge, skills and attitudes are often discussed separately for training purposes, when in actuality, they often overlap. A trainer coaching a learner in providing postpartum family planning to an HIV-positive client must be vigilant in assessing how the learner’s knowledge of and attitudes toward HIV affect the communication and clinical decision-making skills needed to competently provide this service. The common types of skills typically addressed in training include psychomotor, clinical decision-making and communication skills. While the basic process for teaching skills is the same, here are some tips for teaching each type of skill.

**Psychomotor Skills**

- **Characteristics**: Psychomotor, or “hand,” skills require repetition, are generally done in a specific, step-by-step order and involve use of some type of model.

- **Examples**: IUD insertion, active management of third stage of labor, male circumcision.

- **Demonstration**: During demonstration, be sure that everyone has an adequate view of fine hand skills. Use of video or other means to show steps over and over again is helpful. Video is also useful for demonstrating procedures that are rarely
performed (e.g., bimanual compression of the uterus during a postpartum hemorrhage, repair of a severe obstetrical laceration) and tasks that are difficult to see (e.g., vaginal repair, internal surgery).

- **Practice and Feedback**: Step-by-step assessment tools, such as checklists or detailed performance standards, are essential to outline steps for correct completion of tasks involved in a skill. Feedback in the classroom is focused on the procedure itself, ways to improve performance, and tips for working with clients (based on learners’ “interactions” with models). It is essential to assess each learner for progress toward competency with models and appropriate simulations before they begin clinical work with clients.

**Communication Skills**

- **Characteristics**: Communication skills are not as simple to teach as psychomotor skills. Much communication is non-verbal, and teaching good communication skills requires attention to body language, facial expressions and cultural norms.

- **Examples**: Counseling a pregnant HIV-positive woman about postpartum family planning; providing correct information about breastfeeding to a woman and her mother-in-law, who has been giving the woman misinformation; discussing a care plan for your TB/HIV co-infected client with a coworker who disagrees with your approach.

- **Demonstration**: Role plays, especially when well-structured and used in combination with assessment tools that outline key points (e.g., checklists or counseling or education protocols), are very useful for demonstrating communication skills. Use demonstration as an opportunity for learners to observe non-verbal communication. Behavior modeling good communication skills during training is an excellent way to help teach this important skill.

- **Practice and Feedback**: Practice good communication skills in role plays or while practicing with anatomic models. Feedback should focus not only on what is said, but on how it is said. Again, in order for feedback to be useful, it must be specific. For example, rather than saying “You communicated well with that client,” you might say, “You did a great job paraphrasing and redirecting the client during that counseling session.”

**Clinical Decision-Making Skills**

- **Characteristics**: Clinical decision-making is a process used to make decisions about a client’s condition, diagnosis and treatment. Because clinical decision-making is a cognitive skill, it is more difficult to demonstrate than other skills. And yet the principles remain the same. As trainer your job is to break down the clinical decision-making process into manageable steps. Strong clinical decision-making skills are critical to quality care, and development of them must be a training priority, beginning in the classroom and continuing through the clinical training experience.

- **Examples**: Adjusting an HIV-positive client’s medications based on new symptoms; adding to or emphasizing certain messages for family planning counseling based on a couple’s reproductive goals; using a partograph to make an appropriate decision regarding the management of a woman’s labor.
Demonstration: Although you may be able to demonstrate how to perform certain aspects or steps of a clinical decision-making process—such as history taking or physical exam—you will need to “explain” instead of “show” other steps (again, because these other steps are actually thought processes). Either way, the key is to share with learners the reasoning and judgment used to make decisions. Clinical simulations, case studies, role plays and questioning can all be used to demonstrate, examine and discuss how decisions are made.

Practice and Feedback: As learners observe and practice clinical decision-making through the above-listed activities, you can help them by providing continual feedback. Practical experience with clients, followed by review of clinical decisions made and their outcomes, is essential. Increase the complexity and variety of cases as decision-making skills become stronger. The more practice and feedback learners get in a variety of settings, the better.

Lifting the Curtain on Clinical Decision-Making

Proficient trainers, with expertise in their area of practice, make appropriate decisions without much effort. It is not that these experts are not thinking, but rather that their decision-making has become so integrated with practice that they are not aware of them. Experienced physicians or midwives may have difficulty explaining the steps and decisions involved in their work with clients.

And yet there are reasons and judgments underlying all that these clinicians do and every decision they make. Learners need to have the rationale and thinking behind decisions and actions explained to them. Strengthening learners’ clinical decision-making skills helps them to problem-solve and provide quality care in new situations.

EMPHASIZING CLINICAL DECISION-MAKING

Because clinical decision-making is a crucial skill for all clinicians to learn, it should be continually emphasized throughout the course. Specifically:

- Clinical-decision making must be introduced early in the curriculum and reinforced throughout, receiving continual emphasis. Knowledge and experience are the key components of successful decision-making. Once learners have a basic understanding of the decision-making process, it is important that they be given as many opportunities as possible to reflect upon what they know and how this affects the decisions they make. Being aware of this thinking process is critical to good decisions on a consistent basis.

- Employ the four-step clinical decision-making process as an organizing principle in approaching a wide variety of clinical situations. Learners will be clear about exactly what decisions were involved in the management of clients they discuss or care for if aspects of this process (Exhibit 3-3)—assessment (Step 1), diagnosis (Step 2), intervention (Step 3) and evaluation (Step 4)—are identified and explored.
Exhibit 3-3. Steps in the Clinical Decision-Making Process

- **Explain the reasoning and judgment** behind your decisions. Otherwise, learners may think that they are merely supposed to memorize opinions rather than understand the underlying strategy, values and probabilities, as described earlier, that went into forming that opinion or decision. Hearing the reasoning behind your conclusions helps them learn the process for developing sound conclusions themselves.

- **Ask for the reasoning and judgment** behind their decisions. Learners must be given an opportunity to discuss their thoughts with senior colleagues and use logical reasoning to refine their process of choosing a working diagnosis. Frequent use of the simple question “why?” can help facilitate this effort.

- **Create a safe and supportive learning environment where learners are given an active role** in the outcomes of the simulated and clinical work. By providing learners with an increasing sense of responsibility, trainers can increase learners’ commitment to active decision-making and empower them to risk making their own decisions.

As you facilitate the learning activities and assessments described in Section Two (when appropriate), identify—and encourage learners to try to identify—“where they are” in the clinical decision-making process. And depending on where they are, employ a range of strategies (Exhibit 3-4) to bring learners into, and help them navigate through, the clinical decision-making process.
### Exhibit 3-4. Teaching Main Steps in Clinical Decision-Making Process

<table>
<thead>
<tr>
<th>STEPS*</th>
<th>EXPLANATIONS</th>
<th>STRATEGIES</th>
<th>EXAMPLE QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1: Assessment</strong>&lt;br&gt; In assessment, you: (1) gather information, targeting your history taking, physical exam and diagnostic tests based on the client’s complaints; and (2) use this information to draft a list of differential diagnoses (all the possible causes of the symptoms).&lt;br&gt;• Show learners how to use the knowledge they have acquired to recognize patterns in the data that they collect about clients.&lt;br&gt;• Help learners categorize the information obtained and mentally “file it away” for use in future situations.&lt;br&gt;• Highlight important cases that demonstrate critical principles of client assessment.&lt;br&gt;• Assist learners in choosing when and where to limit the amount of data collected, and justify that decision.&lt;br&gt;• After the decision-making process is completed, help learners identify which of the information collected was most relevant to the final diagnosis. This may help learners develop a shortcut in the diagnostic process.&lt;br&gt;• What are we learning about this client?&lt;br&gt;• What do we already know?&lt;br&gt;• What else do we need to know, if anything?&lt;br&gt;• How will we find that information?&lt;br&gt;• Do we know enough to act?</td>
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<tr>
<td><strong>Step 2: Diagnosis</strong>&lt;br&gt; During this step, based on your list of differential diagnoses, you gather additional information to rule out diagnoses and select a most probable diagnosis. This is called a “working diagnosis,” and it is used until disproved. A diagnosis that is proved, either through a procedure or otherwise, is called the “final diagnosis.”&lt;br&gt;• Assist learners to build associations between clinical features and diagnoses. Help learners to interpret the patient’s initial complaint in terms of possible diagnoses, develop as complete a differential diagnosis as possible and avoid deciding prematurely on a working diagnosis.&lt;br&gt;• Early in the process, encourage learners to develop broad differential diagnoses and use clinical data to support or not support the diagnoses they chose to place on their lists.&lt;br&gt;• In choosing among the possible diagnoses, help learners to interpret the collected data. Help learners see the strength of each piece of data, not only in relation to a specific client but with regard to the types and amount of disease in their client population.&lt;br&gt;• Present hypothetical situations that will challenge learners’ thinking and clarify their reasoning process. Ask “what if” questions such as, “What if the client with postpartum hemorrhage is already in shock when you see her? How would that change your diagnosis and intervention?” This will help expand the learners’ “experience” even though no actual client is involved.&lt;br&gt;• Given these symptoms, what are some possible diagnoses?&lt;br&gt;• Given these symptoms, which diagnosis is potentially most dangerous to this client?&lt;br&gt;• Given these symptoms, which seems more likely, less likely?&lt;br&gt;• Should we step back and include something more in our assessment?&lt;br&gt;• Have we come to a conclusion that makes sense? Why or why not?</td>
<td></td>
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<tr>
<td>STEPS*</td>
<td>EXPLANATIONS</td>
<td>STRATEGIES</td>
<td>EXAMPLE QUESTIONS</td>
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| Step 3: Intervention | Based on your diagnosis, you select appropriate intervention and develop a plan of care. Documentation of the plan is essential to ensure that the health care team implements it correctly, as well as to have a record of care provided. | • **Share with learners your personal experiences** with various treatment options in order to suggest additional data that should be considered in choosing the best option.  
• Help learners **compile and analyze the probability figures** discussed earlier that are needed to evaluate the various treatment options.  
• Ask learners to **anticipate clinical findings, responses to different treatments and clinical developments** as another way to expand their experience. This can be accomplished by asking questions such as, “If the patient’s blood pressure were to suddenly drop to unsafe levels, how would you evaluate her response to our interventions? What are the next interventions to be tried? How do you anticipate her condition will change, based upon those interventions?” Alternatively, have learners research less commonly used treatments, for example, in the library and literature.  
• Assist them in **identifying the full range of outcomes of a treatment** and to consider their personal priorities and values and the level of risk, discomfort or inconvenience they would be willing to accept if they were the client. This helps learners see how their perceptions of risk, discomfort or inconvenience may differ from those of the client, as well as how to involve the client in the decision. | • What have we decided, based on the “diagnosis,” that we should do for the client?  
• How are we doing it?  
• Are we doing it correctly? |
| Step 4: Evaluation | Evaluation of the effectiveness of care should be an ongoing process. It may involve gathering new information, reconsidering the diagnosis and modifying the care plan if it proves ineffective in addressing the client’s needs. Continual evaluation of interventions, whether effective or not, adds to the learners’ experience and will strengthen future decision-making. | • Guide learners in **applying evaluation criteria to the treatment outcome** and make an accurate assessment of its efficacy.  
• Assist learners in **deciding whether the treatment has been effective** in addressing the symptom or the illness.  
• Ask learners **whether another treatment option should be considered**. Help them to choose an alternative, decide on additional information to be gathered and perhaps even modify the diagnosis based on the outcome of treatment. | • Is what we are doing “working,” having the desired effect?  
• Is it helping? If not, why not?  
• What could we do differently? |

* Not every clinical decision involves all four of the following steps to the extent represented here (and, in fact, within each of these steps, providers will make countless other decisions that will have a direct impact on the client). All clinical decisions, however, share the same overall goal and underlying process—to provide appropriate, evidence-based care informed by sound clinical reason and judgment.
CHAPTER SUMMARY

- Helping learners develop the desired knowledge, skills and attitudes required for competency is a three-part process, including: (1) introducing/demonstrating desired competencies; (2) providing opportunities for practice and feedback in simulated (e.g., classroom, skills development lab) and real (e.g., clinic, hospital, laboratory) environments; and (3) assessing learners’ ongoing progress and providing feedback.

- Using the basic facilitation process in a variety of different learning activities, the trainer is able to develop learner competency in each of the three competency domains—knowledge, skills, and attitudes.

- As a coach, you can help learners move from basic understanding of new information to the ability to analyze and apply that knowledge in clinical situations.

- There are three phases in the transfer and development of all types of skills: acquisition, competency, and proficiency. In training, the goal is to develop competency in learners.

- The process of developing learner competence in their knowledge and skills also helps them to explore, develop and integrate the professional values and ethics that are needed for appropriate attitudes—which are essential for the provision of quality health services.

- Throughout the learning process, the trainer uses the three key coaching techniques—of questioning, providing feedback and active listening—to develop, as well as assess, learner competency.

- Although the basic process for teaching skills is the same, the approach varies depending on the type of skill being taught. For example, in an IUD training, the trainer might:
  - Explain questions asked during screening and decisions to be made regarding method appropriateness—in teaching clinical decision-making skills.
  - Demonstrate counseling and provide opportunities for practice and feedback, first in simulation and later with clients—in teaching communication skills.
  - Demonstrate IUD insertion and provide practice and feedback, first in simulation with an anatomic model and later with clients—in teaching psychomotor skills.

- Clinical-decision making should be introduced early as a skill that is fundamental to competency in all other skills. There are opportunities to strengthen clinical decision-making skills—to explore the rationale behind the choices a provider makes—in virtually any learning activity.
CHAPTER FOUR

COMPETENCY ASSESSMENT AND QUALIFICATION

A Fresh Look at Assessment

Whatever form it takes—a written test, a role play, observed practice with actual clients, even an educational game—assessment can sometimes cause anxiety for learners and trainers alike. Learners hope to do well; trainers hope for this as well, to reassure them that their teaching methods have been effective. Throughout training, reinforce the following themes with learners:

- Life-long learning is important for all health care providers;
- Continuous assessment is an essential component of that process; and
- Assessment is about learning and evaluation—providing learners with opportunities to practice and receive feedback, and trainers a chance to review and refine their strategies.

Assessment is a shared responsibility among trainers and learners, as well as a shared benefit!

INTRODUCTION

An essential component of any training course is assessing learner competency. Assessment must be meaningful—linked to the competencies being taught and the related learning objectives—and constructive, used for building as well as evaluating competency. And it must provide an accurate, reliable measure of learner progress.

Like every aspect of effective training, assessment is a shared responsibility among learners and trainers. Both are responsible for developing and assessing the competencies that enable learners to provide safe, beginning-level services independently, given the appropriate enabling environment.

This chapter introduces and explains the basics of assessment and qualification of learners. It also discusses how to use the results of assessment to meet learners’ needs.

PRINCIPLES OF ASSESSMENT

As a general guide, effective assessment requires:

- Clear definition of learning objectives
- Use of a variety of appropriate assessment procedures or methods to meet those objectives
- Consistency among the learning objectives, assessment tasks and assessment methods
- An adequate sample of learners’ performance
- Procedures that are fair to everyone
- Clear criteria for judging successful performance
- Feedback to learners that emphasizes strengths of performance and areas to be improved
- Support of a comprehensive grading and reporting system
When assessing learners’ progress and determining whether a learner has mastered the content and can perform the desired competencies, trainers and the assessment methods they use should adhere to few key principles, as described below.

1. **Assessment methods should be competency-based—that is, directly related to the competencies they are intended to measure.** You would not expect a person to pilot a plane successfully simply after reading a book about flying. Likewise, when assessing this person’s ability to fly, you would not select a written exam as your primary means of assessment. For certain clinical skills, lives are also at stake and strict criteria should be used in assessment; assessment methods should “fit” the competencies they are measuring.

2. **The results of assessment should be used both formatively (to help develop learner competence) and summatively (to help evaluate and make decisions about learner competence).**
   - In formative assessment, the focus is on giving feedback to learners, helping them to improve their performance and prepare for later assessments. **Formative assessment has been described as “assessment FOR learning.”**
   - In summative assessment, the results are recorded and used to determine whether the learner should move on to a next phase in the course (such as from working with models to working with actual clients) and, ultimately, pass the course. **Summative assessment is sometimes described as an “assessment OF learning” and is used to formally assess and document learner progress at specific times.**
   - A good overall assessment strategy in a course involves frequent formative assessment of key knowledge, skills and attitudes before the learners complete periodic summative assessments. With both types of assessment, trainers should give clear feedback to learners about what they have done well and what they need to improve.

3. **Assessment should be continuous and conducted in a positive manner that builds learner confidence.** Formative assessment can be a powerful tool for change because the focus is on the process of learning, rather than on the results of a test. **Trainers are encouraged to seek out a variety of creative approaches to formative assessment.**

4. **Assessment must meaningfully determine whether learners have achieved the learning objectives.** Therefore, summative assessment tools are carefully developed and validated by a group of subject matter experts. (Read more about this process in Exhibit 4-1.) Again, definitive, objective verification that a pilot has the knowledge, skills and attitudes she/he needs to safely fly a plane is needed before that first independent flight. **Therefore, trainers should not modify tools designed specifically for formal, summative assessment (e.g., final knowledge assessments and skills checklists).** If they feel that changes are needed, to ensure the validity of the assessment tools, they should contact the authors or sponsoring organization/office of the clinical skills training package they are using.

5. **Assessment tools can be used for formative and summative assessment.** Assuming that the tools used to develop and evaluate learning are based on up-to-date, evidence-based information, using many of the same tools (e.g.,
knowledge assessments, checklists, training performance standards) throughout a course makes sense for several reasons:

- When beginning training, the trainer can use these tools to set a baseline and goals for training outcomes. Learners can use these tools to assess their skill level and identify their learning needs in the context of clear expectations.
- During training, learners and trainers can use these tools to assess learner progress and provide feedback based on objective criteria and guidelines/standards.
- At the end of training, trainers can use some of these same assessment tools to determine whether the learner has mastered the desired competencies.

Exhibit 4-1. The Creation and Validation of Summative Assessment Tools

Every Jhpiego learning resource package includes a variety of assessment tools: some that are specifically designed for formative assessment, such as role plays and case studies, and others for summative assessment (which can also be used formatively), which include the skills checklists and final knowledge assessments.

Tools designed specifically for formative assessment can be used effectively in a variety of ways, especially as trainers become more experienced. These tools are often modified, in fact, to better meet program needs. Summative assessment tools should not be modified, however, even when they are used formatively. This is because these tools have been created and validated by a panel of Jhpiego subject matter experts to ensure that they accurately measure the knowledge, skills and attitudes related to the desired training competency. This group of experts works together—through the development and review process—to:

- Link the tools directly to the learning objectives. This helps to ensure the validity of your assessments.
- Eliminate nonessential steps/tasks from the checklists, add anything that is missing and ensure that all tools are clearly worded and easy to use. This helps to ensure the effectiveness and efficiency of your assessments.
- Ensure the accuracy of the assessments, that the information presented reflects the most up-to-date, evidence-based practices and national standards of care.
- Develop recommended procedures for administering and scoring the assessments so that they produce consistent results (i.e., the same learner should receive the same score on the same test, even if administered or graded by different trainers). This helps to ensure the reliability of your assessments.
- Determine an appropriate “pass score” for the final knowledge assessment, helping—along with all of the above—to standardize criteria for qualification.
- Make assessments objective by ensuring that the personal opinion of the trainer administering and scoring the assessment does not affect the results.
- Ensure that methods are feasible—that is, that you and other trainers can implement them given the time and resources available.

Trainers who experience difficulties using the skills checklists and final knowledge assessments included in a learning resource package, or have suggestions for changes, should discuss and work together with the authors or sponsoring organization/office.

6. A variety of assessment tools should be used. Certain assessment tools are better suited than others for assessing each of the three “competency domains”—knowledge, skills and attitudes. For example:
- Knowledge is readily assessed through questions, oral quizzes, educational games, case studies and written examinations or exercises, among other methods/tools.

- Skills assessment usually requires demonstration, observation and documentation, using methods/tools such as skills checklists, algorithms, clinical simulations and role plays.

- Attitudes can be assessed through the use of role plays, self-reflection journals, self-assessment methods or other means.

A typical learning resource package includes the tools needed for assessment in each of the competency domains, as well as specific guidance on criteria for qualification. As Exhibit 4-2 shows, a wide range of methods/tools can be used for the formative assessment of knowledge, skills and attitudes, whereas only validated tools should be used for summative assessment.

**Exhibit 4-2. Formative and Summative Assessment Tools and Their Use**

<table>
<thead>
<tr>
<th>ASSESSMENT METHODS/TOOLS</th>
<th>USE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated objective written examinations (e.g., Final Knowledge Assessment)</td>
<td>Summative assessment of knowledge</td>
<td>These are formal assessments using multiple-choice, true-false or matching questions</td>
</tr>
<tr>
<td>Case studies</td>
<td>Formative assessment of knowledge</td>
<td>These involve real-life clinical scenarios and patient management problems: Information about the case is provided and several objective questions (e.g., multiple-choice, short-answer) are asked; learners work independently or in groups on the series of questions and often share their answers orally.</td>
</tr>
<tr>
<td>Drills, quizzes and practice tests</td>
<td>Formative assessment of knowledge</td>
<td>Drills are verbal question-and-answer periods during a classroom or practical session. Quizzes and practice tests are short versions of written examinations that are designed to help prepare learners for a summative assessment.</td>
</tr>
<tr>
<td>Written exercises</td>
<td>Formative assessment of knowledge</td>
<td>Written exercises involve asking learners to read and then answer questions to check their understanding of the reading. They can also involve asking learners to read a case study, or view a video, slides or photographs and then respond to related questions in writing rather than orally. Written exercises can be a great way to assess the development of clinical decision-making skills.</td>
</tr>
<tr>
<td>Project reports</td>
<td>Formative assessment of knowledge</td>
<td>The learner completes a project (e.g., reads a chapter or article, interviews a patient) and then writes a report about it.</td>
</tr>
<tr>
<td>Essay examinations</td>
<td>Formative assessment of knowledge</td>
<td>An essay question can be written on any subject and is a common type of written examination. Essay questions are easy to write and can test the learners’ ability to organize and express ideas.</td>
</tr>
<tr>
<td>ASSESSMENT METHODS/TOOLS(^a)</td>
<td>USE(^b)</td>
<td>DEFINITION</td>
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<tr>
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<tr>
<td>Oral examination</td>
<td>Formative assessment of knowledge</td>
<td>Examiners interview one or more learners about what they know about specific topics or what they would do in specific situations. This may take place in a classroom setting or when working with patients. Oral exams have poor reliability unless well-structured with standardized questions and case studies. Trainers tend to consider these examinations valid, but learners often do not.</td>
</tr>
<tr>
<td>Games</td>
<td>Formative assessment of knowledge</td>
<td>Although these activities include an element of fun, they are often designed to provide or reinforce key information.</td>
</tr>
<tr>
<td>Validated skills checklists</td>
<td>Summative assessment(^c) of skills and attitudes</td>
<td>Focusing only on the essential steps or tasks involved in a specific competency, checklists contain sufficient detail to permit: (1) the learner to understand exactly what is involved in a specific skill or activity; and (2) the clinical trainer to effectively and objectively evaluate and record the learner’s overall performance of the skill.</td>
</tr>
<tr>
<td>Role plays</td>
<td>Formative assessment of skills and attitudes</td>
<td>These are simulations of activities that involve clinical decision-making and communication skills, in which learners often take turns playing the roles of provider and client.</td>
</tr>
<tr>
<td>Portfolio</td>
<td>Formative assessment of skills and attitudes</td>
<td>This is a collection of “work products” assembled by the learner. Elements usually included are a brief description of the problem encountered, care or management of the problem and lessons learned; it may also contain personal reflection, accounts of challenging experiences and other items deemed significant by the learner.</td>
</tr>
<tr>
<td>Case logs</td>
<td>Formative assessment of skills and attitudes</td>
<td>This document, maintained by the learner, contains a list of skills that she/he should be able to complete by the end of the course, as well as a running record of which have been directly observed and judged successfully completed.</td>
</tr>
<tr>
<td>Medical record review</td>
<td>Formative assessment of skills and attitudes</td>
<td>Drawing from a sampling of the medical records completed by the learner in the clinical setting, the trainer is able to evaluate decisions made, care provided, etc.</td>
</tr>
<tr>
<td>Clinical rounds</td>
<td>Formative assessment of skills and attitudes</td>
<td>While making rounds in the patient ward, the trainer asks the learners questions.</td>
</tr>
</tbody>
</table>

\(^a\) This is not intended to be an exhaustive list of the assessment methods/tools that a training course may incorporate, nor are the designations universal (i.e., terminology tends to vary among different courses, programs and organizations).

\(^b\) Although the tools are divided up according to the competency domain(s) to which they are best suited, there is a lot of overlap; for example, review of a learner’s portfolio will reveal information about what he/she knows (knowledge), what he/she can do (skills) and he/she feels (attitudes).

\(^c\) Summative assessment tools can and are used formatively. For example, the checklist is used summatively to determine whether learners are ready to practice their skills with actual clients and, later, to decide whether they can be qualified, but checklists are used formatively throughout training, as learners practice their skills on anatomic models in the classroom as well as in the clinical setting.
FORMATIVE ASSESSMENT

Formative assessment is described as “assessment for learning.” In formative assessment the focus is on evaluating the learners’ progress and development and providing targeted feedback and suggestions for improvement. It can also reveal important information to the trainer about the effectiveness of training. For example:

- A pre-course assessment or completion of individualized learning plans is conducted before training begins, providing a baseline measure of learners’ existing knowledge, skills and attitudes and learning needs.
- A trainer conducts a skills assessment (using a checklist, Exhibit 4-3) while a learner practices, and coaches the learner through steps where she/he is having difficulty.
- In observing learners role play HIV counseling, the trainer notes that the majority are missing several of the same critical points; she/he adds case studies to the next morning’s schedule that will reinforce these key points, eliminating another activity that is less important.

Here are some key features of formative assessment, which is essential for learners to develop competency throughout the course.

- **Incorporates a range of formal and informal tools**, such as role plays, case studies, games, quizzes, skills checklists, written assessments, skills demonstrations, discussions and many more. Almost anything that happens in the classroom can be used as a tool for formative assessment.
- **Can be unstructured and flexible.** Trainers may develop new activities and approaches in the field to better meet program needs. Even the tools included in the package can be used in creative new ways.
- **Is non-threatening.** Some of these assessments (e.g., quizzes) may be scored, but they are not “graded” in the sense that they do not have a direct impact on whether a learner advances. Learners can score their own work and are often encouraged to ask questions about the content.
- **Involves direct and immediate feedback.** Whether asking group or individual questions, doing group exercises, games or reviewing homework, direct and immediate feedback should be provided. Formative assessment provides an opportunity to use feedback to help learners master new content.
- **Can provide structured information on learners’ understanding** of a certain topic, perhaps through a quiz or homework assignment. Trainers can use such information to evaluate mastery of content to date and revise training accordingly.
- **Facilitates learning**—helping learners learn by reinforcing important information, giving the trainer an idea of learner progress so that she/he can focus on learning activities and practice that will directly address the learners needs. Skills practice and coaching sessions are a great example of how to use formative assessment to help learners learn.
SUMMATIVE ASSESSMENT

Summative assessment is described as “assessment of learning,” and is conducted periodically during the course to assess and make decisions about learners’ readiness to progress. It is used at the end of the course to determine whether an individual is ready to provide safe, beginning-level services independently (i.e., may be qualified). For example:

- Following a computer- or technology-assisted update on long-acting contraceptive methods, a knowledge assessment identifies learners who are ready for a group-based skills training session and those who should review certain modules and retake the test before moving on.
- A trainer conducts a skills assessment (using a checklist, Exhibit 4-3), while a learner practices inserting an IUD on an anatomic model; based on the checklist, the trainer determines that the learner is ready to practice with actual clients under supervision.

Here are key features of summative assessment, which is essential for determining learner progress and competency at specified points during the course:

- **Can incorporate a range of tools** as well, but all must be validated to ensure that they consistently measure the knowledge, skills and attitudes that they were designed to measure. Whether a written exam, checklist for observable skills or an objective structured clinical examination, summative assessment tools provide a definitive measure of learner progress and ability.

- **Is well-defined and structured.** For example, a learning resource package will include standardized tools to use for summative assessment of knowledge and skills, along with specific guidance on how to use them.

- **Is scored by trainers according to defined procedures** and can have an impact on if/when a learner advances.

- **Involves feedback,** but typically it will not be in “real time” (as it often is in formative assessment), and will identify if remediation is needed (e.g., steps the learner can take in order to repeat the summative assessment, if possible).

- **Provides a summary of learner progress** at certain times during training. Summative assessment tools may summarize previous experiences or formative assessment results, providing a complete picture of learner progress.

- **Is used to make decisions about learner progress or ability** at specified points, such as to determine whether a learner can begin practicing skills with real clients or when she/he can be qualified to provide services independently.
Exhibit 4-3. Using Validated Skills Checklists

Although checklists focus only on the essential steps or tasks involved in a specific competency, they contain sufficient detail to permit: (1) the learner to understand exactly what is involved in a specific skill or activity; and (2) the clinical trainer to effectively and objectively evaluate and record the learner’s overall performance. Using checklists in competency-based clinical training:

- Ensures that learners have mastered the clinical skills and activities, first with models or in role play, and then with clients
- Ensures that all learners will have their skills measured according to the same standard
- Forms the basis for follow-up observations and evaluations

The checklist is first used formatively, to develop learner competency. Following along with the checklist, the trainer and/or peers will observe the learner’s performance on models—providing coaching and feedback as needed. After learners demonstrate competency on models or in role play, they can practice their skills with actual clients under supervision, and the checklist is once again used to assess their performance.

When clinical practice is completed, the checklist—together with the clinical trainer’s review of the learner’s case logs, skill portfolio and any medical records—becomes a tool for summative assessment; it provides objective documentation of the learner’s level of performance. Furthermore, it serves as one part of the process of attesting that the learner is qualified to provide the clinical service (e.g., male circumcision, postpartum family planning, diagnosis and management of pre-eclampsia/eclampsia). Like other tools used in summative assessment (e.g., the post-course knowledge assessment) the competency-based checklists used in skills development are developed and validated by a group of subject matter experts. As such, they should not be modified.

Samples: Refer to your clinical LRP for an example of a skills checklist, and/or see Sample R-1. Checklist for Providing Post-Test PMTCT Counseling (for a woman with a negative result) in the Resources folder on the ModCAL flash drive. It is designed to be used by either a program supervisor or the provider, for self-assessment. Note that it focuses only on the key steps of the process.

QUALIFICATION

Jhpiego is not a certifying body and so does not provide certification; the organization does, however, provide a “statement of qualification.” (Qualification does not imply certification, which can be granted only by an authorized organization or agency.) “Qualification” is the term used to establish that a learner has demonstrated competency in a specific skill or skill set and is, therefore, qualified to provide services. It is a statement made by a training institution(s) that the learner has met the requirements of a specific course—in terms of knowledge, skills and attitudes—and can successfully bring these elements together in practice.

As explained previously, determining whether a learner is qualified should be based on observed and measured performance using competency-based, validated assessments—rather than on completion of a set number of practice cases. The use of the standardized assessment tools contained in each learning package provides an evidence-based justification for qualifying or withholding qualification from an individual who has been trained.
USING ASSESSMENT TO EVALUATE AND GUIDE TRAINING

Assessment is also used to give the trainer information about the effectiveness of the course itself—specifically how it could be revised to better meet learner needs. If many learners perform poorly in the same part of the course, there is a problem that needs to be addressed. Maybe the content is confusing, or the learning methods inappropriate.

Addressing problems depends on an accurate understanding of the problem. When attempting to revise existing course materials or instructions, a few guidelines to remember are as follows:

- Pre-course assessment is not intended to test but rather to assess what the learners already know, individually and as a group, about the course content. Results of this assessment provide a “baseline” but also critical information about the strengths and needs of a particular group, helping the trainer decide which topics might be emphasized or de-emphasized in the course.

- Results of ongoing assessments can reveal areas that need more attention (e.g., gaps in knowledge, missing steps in clinical simulations, poor attitudes toward “clients” during role plays); the trainer can then adjust the learning activities to focus more on those particular competencies.

- End-of-course assessments can provide important information that trainers can use to improve future courses.

CHAPTER SUMMARY

In summary, when trainers think about how to assess learners, they should keep in mind the importance of ongoing formative assessment in helping learners **build competency** in new knowledge, skills and attitudes, followed by periodic formal, summative assessment to evaluate progress toward competency. Here are some other basic principles to keep in mind.

- Assessment tools and methods used must be linked to desired competencies—use of observation for assessing skills and attitudes, use of questionnaires or other appropriate means for assessing knowledge.

- Formative assessment may be less structured, more informal than summative assessment—trainers can be more creative in their approach to this ongoing effort.

- For summative assessment, tools should have been validated by a group of subject matter experts, so any desired changes should be done in close collaboration with the course creators.

- Assessment results are used by trainers to make important decisions:
  - First, the pre-course assessment or individual learning plans help the trainer better understand the learning needs of the group before the course begins.
  - Throughout the course, results of formative assessment help the trainer evaluate how learners are progressing, individually and as a group—identifying areas where they may need more help.
Summative assessment may be used at specific times during the course as a meaningful measure of learners’ level of competency. Based on the results of these assessments, the trainer can determine learners’ readiness for the next phase of training (e.g., practicing skills in a clinical setting under supervision) and, finally, whether the learner is qualified to provide beginning-level services independently in the workplace.
SECTION TWO: TRAINING SKILLS IN PRACTICE—CONDUCTING A CLINICAL SKILLS COURSE
CONDUCTING A CLINICAL SKILLS COURSE—AN OVERVIEW

**Course within a Course**

Learners in a Training Skills Course are undergoing training to teach clinical skills courses that are—in many important ways—similar to the course they are taking. This is because Jhpiego’s training approach underlies both and the goal is basically the same: building learner competency. So although the subject matter is different—training skills in one, specific clinical skills in the other—the facilitation techniques and many of the learning and assessment methods used are basically the same. Trainers should point out, and learners should look for, parallels between the two types of courses. Noting and discussing them as appropriate, and as time allows, can demystify many of the “unknowns” of conducting clinical skills courses. It can also help learners feel more confident as they transition from the mindset of learner to that of trainer.

**INTRODUCTION**

As a qualified trainer, after the Training Skills Course has ended, you will begin to put into practice all that you have learned to teach a variety of clinical skills courses. In this role, you will be expected to draw from the course to:

- Analyze and apply the new knowledge you are gaining now;
- Demonstrate competency in the full range of facilitation skills you are practicing here; and
- Assume the appropriate attitudes, to which you are being exposed, toward your own course participants, their clients and the clinical staff with whom you will work.

The purpose of this chapter is to provide candidate clinical trainers with an overview of the main components of a typical clinical skills course, from beginning to end. The intention is help learners begin to form a cohesive vision of the course and how all of the previously discussed principles are put into practice. This chapter also provides detailed guidance on aspects of the course that are not specific to facilitation in the classroom or facilitation in the clinical setting, such as introductions and wrap-ups.

**MAIN COMPONENTS OF A CLINICAL SKILLS COURSE**

As a quick comparison of the following graphic (Exhibit 5-1) and that on page xii (Exhibit F-1) will show, the Training Skills Course and clinical skills courses may be structured similarly. Of course, there are also important differences. For example, whereas a skills standardization activity generally precedes the Training Skills Course, skills standardization is an important goal of a clinical skills course. Other similarities and differences between the two types of courses are highlighted below, and additional information is provided about each element of the clinical skills course.
Chapter 5

Exhibit 5-1. Main Elements of a Clinical Skills Course

This graphic represents the structure of a traditional clinical skills course, its two main elements being a classroom-based component, followed by a clinic-based component, both of which typically last a day or more. Although the elements shown here will remain the same from course to course, the structure may vary considerably. If a blended learning approach is used, for example, the knowledge update and final knowledge assessment would be completed before the classroom/group-based component begins—through an electronic application (such as ModCAL for Training Skills) or other means that allows self-paced, individualized learning. Another variation is for classroom- and clinic-based sessions to be held on the same day, one in the morning and the other in the afternoon.

- A classroom-based session is a standard component of the clinical skills course, whereas in the Training Skills Course it may be optional (such as when circumstances allow for learners to move directly from successful completion of ModCAL into mentored co-training in a clinical setting). The classroom-based component of a clinical skills course:
  - Sometimes begins with a pre-course knowledge assessment, which assesses participants’ current knowledge about the subject of the course (to help guide training).
  - Continues with a knowledge update (often featuring interactive presentations, educational games, discussions and other activities); followed by a final knowledge assessment, on which participants must receive a passing score before progressing to the skills practice portion of the session.
  - Transitions to skills-development activities using anatomic models, role plays and other simulations, followed by an interim skills assessment, which helps the trainer decide whether the participant has reached a level of skills competency that allows him/her to practice with actual clients in the clinical setting.

- During supervised skills practice in the clinical setting, the trainer focuses on coaching the participants toward competence in the skills being taught, as well as confidence in performing them with actual clients.
At the end of the clinical session, through a formal skills assessment, the trainer determines whether the course participant has reached a level of skills competency that will enable him/her to provide safe, beginning-level services on the job. If the trainer determines that the participant has, the participant receives qualification.

The following guidelines reflect—at the broadest level—how the course as a whole progresses. More in-depth guidance on developing and assessing competency in the classroom and in the clinical setting is provided in Chapter 6 and Chapter 7, respectively.

INTRODUCTIONS

Situation 5-1: You have been waiting to attend this contraceptive implants training course for over a month. Now the day is here and you are sitting in the room with 14 other learners. The two trainers are ready to begin the course. What information are you hoping will be covered during the course overview?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Introducing the Course

An effective introductory course overview provides learners with basic information about the course, while helping them feel comfortable and beginning to engage them in the learning process. The trainer usually includes a variety of activities in the introduction, such as the following:

- Reviewing course goals and learner learning objectives. Example:
  
  “Welcome to the IUD Course. My name is Ilka and I will be one of your trainers. The goal of this course is to prepare service providers to provide high-quality IUD services. Let's take a look at the course objectives.”

- Facilitating learner introductions. Example:
  
  “Let’s take a few minutes and introduce ourselves. I would like you to find another learner to interview. In addition to your partner’s name, ask about where your partner works, what he/she does, why he/she has come to course, etc. Please take about 5 minutes and then we will each introduce our partner to the rest of the group.”

- Examining the clinical skills course materials. Example:
  
  “The reference manual we will be using in this course is IUD Guidelines for Family Planning Service Programs. The manual contains the essential, need-to-know information we will be learning during the course. In addition, you have a copy of the learner’s handbook which contains the course syllabus, schedule and other information we will use during the course.”

- Reviewing the clinical skills course schedule and describe the activities and assessments that will occur during the course. Example:
“Each of you has a copy of the course schedule. Note that the major activities are identified for each day including classroom presentations, clinical demonstrations using the models and practice sessions. You will see that during this course you will have the opportunity to practice active management of third stage of labor on an anatomic model before practicing your skills in a clinical setting with actual clients. Are there any questions about the schedule?”

- Reviewing learner expectations for the course. Examples:
  
  “Each of you came to this course with certain expectations. Now that you are aware of the course goals, objectives and schedule, the trainers would like to know if you have any special expectations. These could be things you want to learn or do during the course in addition to what has been planned.”

  “Please talk with the person next to you. Once you have identified your expectations, please write them on the flip chart in the front of the room. These will be posted on the wall for reference throughout the course.”

- Discussing and generating a list of “group norms”—agreed-upon rules of conduct. Ask the group how various issues should be handled by the group, such as lateness, interruptions, disagreements, side conversations, etc. Generate and review the list before posting them to the wall (Brainstorming [page 70] works well for this.)

- Introducing the individualized learning plan, if you plan to have learners use them in the course, as well as any self-assessment tools you want learners to use (Exhibit 5-2).

- Covering basic logistics, such as the location of bathrooms and other services/facilities.

- Answering any questions learners might have.

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5 If such a tool is not included in your clinical skills LRP, one can easily be created (note also the one used in the Training Skills Course Learner’s Guide). Have learners review the performance standards related to the learning objectives for the course and list five “priority areas” in which they wish to improve. This paper should be signed by the learner and trainer and revisited by both periodically during the course; it may be taken into consideration as part of the qualification process.
Exhibit 5-2. Skills Portfolio for Self-Assessment

Depending on the course focus, learners may greatly benefit from keeping a skills portfolio (also called “journaling”). The portfolio is a collection of “work products” assembled by the learner, usually including brief descriptions of problems encountered (in practicing skills in the classroom or clinical setting), management of the problem and any lessons learned in the process. Portfolios may also contain:

- **Detailed accounts of procedures performed**: The learner can use the portfolio to record both positive events—great leaps forward—as well as setbacks and struggles.
- **Personal reflections**: The learner may record thoughts and feelings about interesting experiences related to the learning goals. For example, a midwife in an emergency obstetrical care training program may record her management of a postpartum hemorrhage, analyze her ability to use the required hand skills, as well as the appropriateness of the clinical decisions that she or he made. She may also use the portfolio to reflect upon her environment, considering whether she had the appropriate equipment, supplies and support needed to be effective.
- **Difficult, complicated or outstanding issues**: The learner may recount ethical dilemmas faced, provide an analysis of challenging cases or adverse events and list questions that have not been answered or resolved.
- **Remarkable learning experiences**, especially those in which the learner has minimal or no supervision, such as home visits, community-based experiences or rotations to distant clinic sites.
- **An evidence-based list of references or other helpful resources**

Through providing an opportunity for reflection, the portfolio provides a means of self-directed formative assessment for the learner. This formative self-assessment is consistent with adult learning practices and the development of life-long learning skills that are needed by health care providers. The portfolio can also be reviewed by the trainer periodically to help the learner target his/her efforts or during the final summative assessment to get a broad perspective of the learner’s development over time.

If the LRP for a given course provides no specific guidance or tools for self-assessment, the trainer should work with program staff to develop an approach to self-assessment/using a skills portfolio that is appropriate to the course.

### Daily Warm-Ups

Each day, warm-ups are a good way to re-engage learners. They can be done any time throughout the day, in fact, to lighten the mood/ease tensions, improve group cohesion—or just for fun, to keep energy levels high. There are many types of warm-up activities available. *Examples:*

- In “Two Truths and a Lie,” each individual shares three details about her/his life, two that are true and one that is not. Next, have the others try to guess which is which.
- In “Three Things You Don’t Know about Me,” each individual writes three things about him/herself on a piece of paper. The papers are folded and placed in a central repository. After each of the others selects a paper, they read them aloud, trying to guess whose they are.

Warm-ups can also be more closely related to course content. For example, have learners share two things they learned or something that especially surprised them from the previous session. Or have them answer a question or respond to a graphic that specifically relates to the upcoming session’s objective. (See the Resources Folder on the ModCAL for Training Skills flash drive for sample Warm-Ups, as well as sample Icebreakers and Introductions.)
CONDUCTING THE CLASSROOM-BASED PORTION OF THE COURSE

As shown in the figure on page 52, clinical skills courses are group-based courses that have both classroom- and clinical setting-based components. The first part of this chapter focuses on the classroom portion of the course. But what is a classroom? In considering this question, you may envision a simple room, the teacher stationed at the front, you and your classmates seated in rows facing forward. The truth is that a classroom can be many things: it is wherever learners learn. It can be a group-based session in a training area; a group or individual working in a skills lab; or someone working independently, with or without feedback, using a computer or other device as an aid. What is important is what happens in the “classroom”:

- Knowledge is…presented, discussed, clarified, absorbed, assessed and reinforced;
- Skills are…described, demonstrated, practiced, simulated, assessed and further developed;
- Attitudes are…explored, clarified, considered, evaluated and—when needed—revised; and
- Learners learn!

Establishing a Positive Learning Environment Right from the Start

One practical way to help build learners’ sense of being capable from the very beginning is to remove any distractions and limitations that may interfere with their learning. For example:

- Make sure the room is as comfortable as possible;
- Address cell phone use, explaining what is and is not permissible;
- Note potentially “difficult” individuals and begin “managing” them immediately to ensure that others are not interrupted or distracted from the topic at hand;
- Schedule timely breaks, letting the group know when to expect them;
- Assure the group that sufficient practice time has been scheduled, helping to reduce any anxiety; and
- Make yourself available for their questions and concerns.

Many things may pose potential distractions, but you are there for the learners—to help keep them on track. Take reasonable actions to protect them from these distractions and stimulate their interest, so that you can focus on what’s really important: continually assessing your learners’ understanding and guiding them toward competency.

Developing and Assessing Competency in the Classroom

As described in Chapter 2, trainers should apply the same basic facilitation process—of introducing, conducting and summarizing—in each learning activity that they facilitate. And they should use a variety of learning activities. Learning activities that are commonly used in the classroom-based portion of a clinical skills course include:
Interactive presentations

Small group activities:
- Case studies
- Educational games and exercises
- Brainstorming
- Role plays
- Clinical simulations

Discussions

Skills demonstration and practice sessions (in simulation)

In the earliest phase of the course, the trainer will focus on facilitation of certain learning activities (e.g., interactive presentations, case studies, educational games, group discussions) to assist learners in acquiring or reinforcing, analyzing and applying new knowledge. The coaching process—of questioning, providing positive feedback and active listening—is central to the facilitation process and as relevant to the successful transfer of knowledge as it is to the development of skills and attitudes.

After the final knowledge assessment, the course focuses more on skills development and assessment. The trainer conducts skills demonstration and practice sessions in simulation (e.g., with anatomic models, role plays) to provide learners with a clear picture of the skills to be learned. The trainer is able to assess and build the learner’s level of competence in practicing these skills through the use of two key methods/tools—direct observation (integrated with coaching techniques) and structured feedback reports. This is the most valid way to assess learners’ skills and can be conducted by the trainer or the learner’s peers (and, later, by clinical staff).

With the appropriate guides, direct observation can also be used to assess learners’ demonstrated attitudes, as well as communication and clinical decision-making skills—through a variety of simulations (e.g., taking a history, diagnosing illnesses based on patient information, even clinical decision-making). Additional information on using checklists is provided on page 48, Exhibit 4-3.

By the end of this phase in training, learners’ performance will be formally evaluated through an interim skills assessment using the same validated skills checklist(s) used in practice/formative assessment. This will enable the trainer to determine whether they have the level of skills competence needed to practice their skills in with actual clients in a clinical setting. (Remember: Actual competency can be achieved only with actual clients in a clinical setting.)

More in-depth guidance on “Developing and Assessing Competency in the Classroom” is provided in Chapter 6.
CONDUCTING THE CLINIC-BASED PORTION OF THE COURSE

Clinical practice represents a precious learning opportunity for learners. It is the time when they synthesize the knowledge, skills and attitudes that they have learned and practiced in the classroom, and apply them with actual clients under supervision in a clinical setting. Anatomic models, no matter how realistic, are no substitute for the reality of providing care for a living, feeling and reacting human being. The clinic is where:

- Course participants gain independence and confidence in working with actual clients, which is critical to applying new skills on the job.
- The trainer transitions into an expanded role:
  - Supervising learners throughout the above-described process
  - Maximizing learners’ opportunities for practice with actual clients, while protecting the safety and rights of the clients
  - Working with clinical staff to ensure that clinical practice goes smoothly

Preparing Learners for Clinical Practice

Clinical practice can be a challenging, but particularly rewarding, experience for both trainers and learners. It is also essential for ensuring that learners will be able to provide safe, beginning-level services when they return to the workplace. In the interest of ensuring a smooth transition to clinical practice:

- Review course goals and learning objectives in the context of the clinical setting. Example:
  
  “Let’s take a look again at the course goals and objectives and discuss how practicing in the clinic will contribute to each.”

- Reviewing learners’ expectations for the clinic-based portion of the course. Examples:
  
  “What do you hope to gain from working with actual clients? What are some challenges you might encounter? What will you do if you feel you cannot do something you are asked to do?”

  “Please work with the person next to you to list three main differences and similarities between the classroom and clinical setting. After five minutes, be prepared to share your list with the rest of the group.”

- Let learners know which activities they can do independently and which require supervision. For example, if a learner is already competent in counseling patients with HIV/TB co-infection, she/he can practice that portion of services independently. She/he must wait until the trainer is present, however, when practicing history-taking and physical examination to diagnose HIV/TB co-infection.

- Discuss activities learners can do when there are no appropriate patients at the clinical practice site. There may be times when learners will not have any planned activities with patients. In addition to continuing to work on learning activities with which they are already familiar (e.g., case studies, role plays, skills practice in simulation), introduce alternative activities for learning such as
interviewing patients about patient satisfaction, observing existing infection prevention practices on the inpatient wards, reviewing charts and learning about how care is documented.

- Discuss how the individualized learning plan and skills portfolio might continue to serve the learners in the clinical setting, and introduce them to the concept of keeping a case log (Exhibit 7-1, page 92).

- Cover basic logistics, such as how you will get to the facility, how the sessions will be structured, etc.

- Answer any questions learners might have.

**Developing and Assessing Competency in the Clinic**

As in the classroom, trainers should apply the same basic facilitation process—of introducing, conducting and summarizing—in each learning activity that they facilitate. Learning activities that are commonly used in the clinic-based portion of a clinical skills course include:

- Skills demonstration and practice sessions (in simulation and with actual clients)
- Medical record reviews
- Clinical rounds
- Role plays, clinical simulations, etc., when client opportunities are not available

The trainer and learners build on what they have learned in the classroom: they use the same validated skills checklist(s) to guide the same basic process of skills demonstration and practice—although with modifications to ensure that the activity is safe and comfortable for clients.

By the end of this phase in training, learners’ performance will be formally evaluated through a final skills assessment using the same validated skills checklist(s) used in practice/formative assessment. Results of this assessment will be considered by the trainer, along with other work products, in determining whether the learner should receive qualification to provide beginning-level services to actual clients on the job.

More in-depth guidance on “Developing and Assessing Competency in the Clinic” is provided in Chapter 7.

**WRAP-UPS**

An effective daily or course wrap-up should provide learners with an increasing sense of accomplishment and confidence that they can return to their workplaces and apply what they are learned (as well as information on what to do if they encounter difficulties, discussed further in Chapter 9).

Wrap-ups should also provide opportunity to provide feedback about the course. Learner evaluations are an integral part of the clinical training process. Evaluation can determine whether the training has met its goals (i.e., whether learners’ knowledge, attitudes and skills improved) and identify aspects of the course that should be strengthened. Evaluation of the course is not only an end-of-course activity
performed by learners filling out a form. It is integral part of the learning experience (as described in Chapter 10), conducted both formally and informally, and may occur several times during the course (such as at the end of the day). And it may provide not only learners, but also clinic staff and others, many opportunities to weigh in on how the course is going and to effect change when needed.

**Daily Reactions**
Trainers should continually monitor the training. Daily monitoring encourages learners to think and talk about what they learned during the day and to make suggestions to the entire group about how to improve the course. Trainers often monitor their course using a daily evaluation form. Such monitoring can also be conducted as a learner-led exercise at the end of each training day. A useful technique is to have learners:

- Write on a piece of paper the two or three most important ideas or concepts that they learned during the day, and questions that are still unanswered, as well as suggestions for course improvement.
- Share with the group one or two items from both categories on their lists.
- Begin the next training day by making sure that unanswered questions and any other issues are addressed before moving on.

**End-of-Course Reactions**

**Situation 5-2:** You and a co-trainer are conducting a clinical skills course. The day before the course ends your co-trainer asks you about allowing the learners an opportunity to provide written feedback about the course. You remember that this is mentioned in the course schedule, but you both have been so busy that you forgot to prepare for this. What kinds of questions should you include in the end-of-course written evaluation?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

At the end of the course, it is especially important to ensure that all the essential elements are completed, and that the proper course documentation is in place. The trainer should use the learner’s course evaluation to obtain feedback on the course and his/her performance as a trainer. Trainers should also do self-evaluations after a course is completed and request feedback from co-trainers and others about how the course went—as part of their continuous learning as a trainer.

**Written course evaluations**, which are typically included in a learning resource package, allow trainers to identify the:

- Extent to which the course met learners’ expectations
- Aspects of the course that learners found the most or least helpful
- Relevance of the course content to the learners’ work
- Appropriateness and effectiveness of the training methods used
- Extent to which administrative aspects of the course were satisfactory (e.g., the training environment, accommodations, food, travel arrangements)
The clinical trainer should schedule sufficient time for learners to complete the evaluations. Evaluations should not be distributed late on the last day of training when learners are tired and may be preparing to depart. Consider distributing them at the end of the day, prior to the final day of training or before lunch on the last day.

**Samples:** Refer to your clinical LRP for an example of an evaluation, and/or see Samples R-2 and R-3, course and trainer evaluations, in the Resources folder on the ModCAL flash drive.

**Informal discussions** can accompany the formal written evaluation so that the clinical trainer can better understand the learners’ reactions. If learners’ expectations were recorded on a flip chart during the training introduction, they can provide a great framework for this informal discussion. For example, learners can be asked, individually or in small groups, to discuss questions such as:

- “What were your expectations for the course? To what degree were they met?”
- “Based on the stated course objectives, did you learn what you expected to learn?”
- “How can the training team best meet any unmet expectations following the training?”
- “What suggestions do you have for the training team that will help to improve future courses?”

Answers to these questions can then be summarized by a group reporter (during the session) and shared with the clinical trainer(s) either orally or in writing. Alternatively, the clinical trainer can select several aspects of the course (e.g., course content, training methods, administrative arrangements) and ask learners to write their reactions to each anonymously. Learners’ comments can be posted under their respective category headings on flip chart sheets or on a writing board. The trainer or a learner can then lead a general discussion with the learners about the comments.

**CHAPTER SUMMARY**

- Although there are obvious, significant differences between the Training Skills Course and clinical skills courses, there are also similarities—in structure, approach and overall goal: building learner competency. Noting these similarities can be illuminating to learners and eliminate some of the “unknowns” of becoming a trainer.

- The structure of a clinical skills course may vary, but it will always include a classroom-based component and clinic-based components, as well as:
  - A variety of learning activities aimed at developing the knowledge, skills and attitudes required for the desired competencies; and
  - Ongoing formative assessment with periodic summative assessments, including: a final knowledge assessment (to determine learner readiness for skills practice in simulation); an interim skills assessment (to determine learner readiness for skills practice with actual clients); and a final assessment (to determine whether the learner should receive qualification).
Properly introducing the course, as well as each day’s activities, engages and prepares learners for what will come next.

During the classroom-based component of the course, it is important to:
- Establish a positive learning environment; and
- Facilitate a variety of activities to develop and assess learners’ competency, with a focus on supporting them in: analyzing and applying new knowledge, developing skills (in simulation) and considering/reshaping attitudes.

Conducting the clinic-based component of the course includes:
- Preparing learners for clinical practice; and
- Facilitating a variety of activities to develop and assess learners’ competency, with a focus on supporting them in gaining independence and confidence in practicing skills with actual clients.

Properly wrapping up the course, as well as each day’s activities, helps to reinforce key content and ensure that the objectives have been met.
CHAPTER SIX

FACILITATING IN THE CLASSROOM

Clinical Decision-Making Starts in the Classroom

Although you are assisting your learners in developing a range of competencies within a skill or skill set, never lose sight of the ultimate objective, which is to strengthen learners’ mental capacity to apply what they have learned in unique and unanticipated ways, to problem-solve and provide quality care in situations wholly different from those they’ve encountered in textbooks, past experiences and even within the current course.

This capacity is at the heart of clinical decision-making. Even though certain learning activities and forms of assessment are more geared toward developing/assessing clinical decision-making skills than others, one or more of the clinical decision-making “steps” generally come in to play during any activity. The trick is to recognize, and help learners recognize, that this is the case—that clinical decision-making is not a discrete activity, but truly a skill that encompasses and informs everything you do as a provider. Therefore: exploring the thinking behind decisions made—through questioning, providing feedback and active listening—is every bit as important in the classroom as in the clinical setting.

INTRODUCTION

The classroom is the place where competency development begins. In the classroom, the trainer uses a variety of learning activities to transfer knowledge, skills and attitudes to learners—in order to develop the desired competencies. Activities include:

- Delivering interactive presentations;
- Facilitating a variety of group/small group activities (case studies, role plays, clinical simulations, brainstorming, educational games, discussions), using a variety of approaches; and
- Facilitating skills demonstration and practice sessions in simulation.

And throughout it all, the trainer looks for opportunities to connect individual activities to the high-level, cognitive skill of clinical decision-making. This skill will become increasingly important as the course proceeds and as the learners gains more independence in working with actual clients; moreover, it is absolutely essential to providing high-quality care on the job.

This chapter provides additional guidance on how to facilitate a range of activities aimed at developing and assessing competency in the classroom. As you read through and apply this information with learners, continually consider/highlight aspects of the clinical decision-making process—to demystify it and make it more comfortable/familiar for learners.
TIPS FOR FACILITATING LEARNING ACTIVITIES

Apply the basic facilitation skills and the facilitation process (as discussed in Section One)—of introducing, conducting and summarizing—for each learning activity discussed. The following tips focus on guidance that is specific or especially critical to a given activity.

Interactive Presentations

Situation 6-1: You are a learner who is attending a clinical training skills course in order to learn how to be a clinical trainer. One of the other learners is making a presentation and you have been asked to observe the introduction carefully. The learner begins the introduction by asking several questions. After about 10 minutes of discussion related to the questions, the learner shares the objectives and moves into the presentation. What aspects of the introduction went well? What suggestions would you offer for improving this introduction?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Situation 6-2: You are observing a colleague as she conducts her first clinical skills course. She asks many questions and interacts with the learners, but she has a tendency to stand behind a table and read information from the reference manual. What would you advise her to do to prevent reading from the reference manual?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

An effective presentation can be one of the most rewarding aspects of the training and learning experience. The goal of a presentation is to help a variety of learners, each with a unique learning style, gain new knowledge and integrate that knowledge with their clinical experience and practice. The trainer who is able to keep learners engaged with an exciting, dynamic delivery—using a variety of learning techniques—is more likely to be successful in helping learners progress from basic understanding of concepts to applying them to practice.

In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to interactive presentations.

During the presentation (as part of conducting)—
Never forget that your focus is the learner. Make eye contact with all of the learners, not just a few of them. Scan the room frequently to ensure that everyone is paying attention.

To keep things interesting, enhance learning and maintain energy, as well as assess learner understanding:

- Build in group/small activities, such as discussions, case studies or short games.
- Make ample use of coaching techniques. Asking questions and providing feedback frequently make presentations less “one-way,” more interactive.
- Move around the room. Keeping moving helps to ensure that you are not consistently blocking the view of any learners. Moving toward learners also serves
to reinforce certain learner behaviors (e.g., asking/answering questions) and discourage others (e.g., having side conversations).

**Use audiovisual aids, but remember not to pay more attention to them than the group!**

- Always face the group. If showing a computer slide presentation, for example, position your monitor so that you can see the information without turning your back on the learners (to face the projection screen).
- Use aids as a reminder of content, rather than an exact script to be followed—reading them word-for-word during the presentation will not only keep you focused on the materials, but will also bore the learners.

**Sample:** See Sample B-4. Guide/Job Aid for Using Visual Aids in Appendix B. And Appendix C provides additional information on effective use of audiovisual aids.

- Spend no more than 45 minutes on a given presentation. Learners will begin to lose attention after that amount of time, no matter how important the topic.

**Group/Small Group Activities**

**Situation 6-3:** You are conducting a clinical skills course for IUD service providers. During the session on counseling, you suddenly decide this would be a good time for an activity. You ask the learners to divide into small groups and practice counseling each other. As you move around the room you find that most of the learners in the small groups are just talking and that they are not sure what they are supposed to do. You ask yourself, what went wrong?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Group/small group learning activities can be used during classroom and clinical sessions to help learners build knowledge, skills and appropriate attitudes. In this section, you will learn about five useful group learning activities: case studies, role plays, clinical simulations, brainstorming, educational games and exercises, and discussions. Group learning methods often overlap. For example, a clinical simulation might include a role play or a case study. Furthermore, some group learning activities, such as case studies, also can be used for individual learning.

**Note:** If your class has more than 10 learners, you may choose to divide learners into smaller groups for many of these activities. While they are working, circulate among the groups to ensure that everyone is participating and to keep them on track.

Building on the basic facilitation process (as all activities do), tips for facilitating group/small group activities are as follows:

**Before dividing the learners into small groups,** clearly describe the activity to all learners, specifying exactly what individuals in the group are supposed to do. Explain how they should record their findings, decisions, recommendations, etc. (e.g., a recorder should keep notes or write decisions on flip chart paper) and
suggest how each group’s discussion should be reported back (as described below) to the larger group.

- **While the groups are at work**, move among the learners to monitor the progress of each group, remind learners of the task and time limit, if needed, and offer suggestions to groups that are having difficulties or straying from the main task.

- **After the groups have completed** their activity, bring them together to report back to the larger group and discuss the activity. This may involve:
  - Oral reports
  - Responses to questions
  - Role plays (developed by learners in small groups and presented to the large group)
  - Recommendations

- **Always summarize the group activity** by stressing the main points and relating them to the learning objectives.

**Case Studies**

Case studies present realistic scenarios/situations that focus on a specific issue, topic or problem, which may be related to the diagnosis or treatment of patients, interpersonal skills, or any of a wide range of managerial or organizational problems. Learners typically read, study and react to the case study individually or in small groups. In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to case studies.

**During the case study** (as part of conducting)—

After learners have read the case study, either individually or in small groups, give them the opportunity to react to it. Typical reaction exercises include:

- Have learners analyze the situation presented in the case study and **determine the cause(s) of the problem**. *Examples:*
  - “Why do you think the client finds it difficult to adhere to the lactational amenorrhea method?”
  - “We agree that the client was not treated well by the provider. Why do you think this is?”

- Have them **offer possible solutions** for the situation being presented. *Examples:*
  - “How could the woman’s partner’s fears have been addressed?”
  - “What patient-management mistakes were made and how could they be corrected?”

- Ask learners to **respond to case study questions** (typically included). *Examples:*
  - “Do you feel the client was properly counseled? If not, why not?”
  - “Did you agree with the diagnosis and care provided? If not, why not?”

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**Sample:** Refer to your clinical LRP for an example of a case study.
Role Plays
In a role play, learners play out different roles or parts—such as of a patient and a provider—in a simulated situation. Role plays promote learning through behavior modeling, observation, feedback, analysis and conceptualization. They are also often useful for exploring, discussing and influencing the behaviors and attitudes of learners, as well as for helping learners develop skills such as history-taking, physical examination and counseling. In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to role plays.

Before the role play (as part of your introduction)—

- Brief the learners on their roles. Although a role play is typically brief and to the point, it usually provides learners with questions or activities to help them to focus on the main concept(s) being explored. Review these together.
- Explain what the other learners (those not playing a role) should be looking for during the role play and how to document and share their feedback afterward. For example: Should they observe for verbal communication skills? Nonverbal communication? The use of questioning? (See Exhibit 6-1 on “structured observation.”)

During the role play (as part of conducting)—

- Try not to intervene as facilitator while the role play is being performed (even if you are playing a part), except to help the activity stay on track and to handle unexpected situations that might arise (confusion, arguments, etc.).
- Providing feedback after the role play is performed is as important as the role play itself—essential to the effectiveness of this teaching method. It is important to ensure that all learners have an opportunity to receive feedback from you, their peers and other trainers.
- To help organize the feedback session, follow the structured observation guidance you gave learners prior to the role play.

Exhibit 6-1. Structured Observation Guidelines for Learners

When we know what we are looking for, we are more likely to find it. “Structured observation” is an important tool in facilitating certain learning activities in the classroom (e.g., clinical simulations, role plays) and in preparing learners for clinical practice (such as when visiting the facility where clinical practice will occur). This tool is especially well-suited to homing in on provider attitudes to be reflected upon and discussed later. As with every learning activity, ensure that objectives are clear before the observation begins. This is what makes the observation “structured.”

Explain to learners:
- What they are observing for (e.g., essential steps in a focused antenatal exam)
- What tools they should use to record their observations (A clinical skills checklist can be used to guide observations. Alternatively, a simple notebook or structured evaluation tool, developed by the trainer, can help learners organize their thoughts during the observation.)
- What will be discussed later during the post-observation debrief (i.e., how will observations be shared?)
**Clinical Simulations**

A clinical simulation presents the learner with a carefully planned, simulated patient management situation. Clinical simulations are an excellent method for developing clinical decision-making skills and can take a variety of forms (Exhibit 6-2). Through this activity, learners interact with persons and things in the environment, apply previously/newly acquired knowledge and skills in responding to a problem and then receive feedback about those responses **without having to be concerned about real-life consequences**. Clinical simulations are often conducted with a small group of learners—one learner may be the primary responder while other learners provide feedback, or all learners in the group may be involved in the exercise. In addition to using basic facilitation skills and adhering to the basic facilitation process, adhere to the following guidelines.

**Note:** Before any clinical simulation, set up the area as realistically as possible. Ensure that anatomic models, equipment or supplies or other props that will be needed are in place.

**Exhibit 6-2. Different Types of Clinical Simulations**

- **Case study simulations** involve the presentation of a real case (from past experience) by one group of learners to another. Through a sequence of question-and-answer sessions, more of the case is revealed and decisions made are evaluated and discussed.

- **Live simulated-patient scenarios** involve the use of persons trained to act the role of the patient. They are given a very specific script to follow while interacting with the learner. The interaction may be videotaped or observed so that feedback can be provided to the learner.

- **Mediated simulations** use audio or visual media to present the problem, represent an interpersonal situation or help in the analysis of a problem or situation. For example, a video of people interacting may be shown, or audiotapes of heart sounds may be played, to provide information for the learner to use in the simulation.

- **Structured role play simulations** allow the learner to take on the role of an individual involved in a clinical situation. The main purpose is to give the learner new insights into behaviors and feelings of other people.

- **Simulations using anatomic models** (physical simulators) that closely resemble the human body (or parts of it) are often used for developing psychomotor skills. A physical simulator may be used along with a role play in a clinical simulation that requires learners also to demonstrate technical skills.

- **Written simulations** are pencil-and-paper presentations of actual problems or cases about which the learner must make decisions as if performing in the real-life situation. After making each decision, the learner receives feedback on the effects of that decision, and incorporates it into the next decision. These simulations may be used in assessing learners’ knowledge.

*Additional guidance provided below*

**Sample:** Refer to your clinical LRP for an example of a clinical simulation, and/or see Sample R-4. Clinical Simulation: Management of Vaginal Bleeding during Early Pregnancy in the Resources folder on the ModCAL flash drive.
**Case Study Simulation**

**Before the case study simulation** (as part of your introduction)—

- Ask two or three learners (Group A) to prepare a case for presentation from their clinical experience. Tell them to be prepared for all clinical and theoretical aspects of the case. Important aspects of a case may include the patient’s:
  - Presenting illness/symptoms
  - History
  - Physical examination findings
  - Laboratory values

**During the case study simulation** (as part of conducting)—

- When it is time to present, have Group A share the patient’s presenting complaint. Stop them after the allotted time.

- Ask other learners (Group B) what they think the problem or diagnosis could be, and tell them to explain their answers. Ask others from Group B to respond to this information. Group A members can ask questions to prompt Group B to think through possible problems and provide additional data as needed. The facilitator can also ask probing questions or provide additional information needed to prompt the participants.

- Allow Group A to present additional relevant data. Stop them after the allotted time.

- Ask Group B learners if they have changed their views or what their next steps would be, and why.

- Continue this process of allowing information to be revealed gradually, and asking and responding to Group B learners’ answers. Guide the discussion by providing essential information when needed, asking related questions to help learners make decisions and giving them feedback on their proposed diagnoses and interventions.

*Note:* This type of clinical simulation is more effective with senior-level learners who have had more experience with managing patients. Also, remind learners to protect the confidentiality of the actual patients they are discussing during this activity.

**Structured Role Play Simulation**

Because conducting a structured “role play” scenario in a simulated practice setting requires learners to demonstrate a skill or “act out” a patient situation, it may involve more than some other activities in terms of giving instruction. These scenarios may include responding to a clinical problem or an emergency situation.

**Before the role play simulation** (as part of your introduction)—

- Clarify the objectives of the activity, whether to develop decision-making skills, practice handling an emergency or manage a sick patient.
Discuss how the learner or learners should perform the clinical skills. Should they talk it through or demonstrate the skill?

If you are using a clinical simulation to help learners develop life-saving skills, give learners clear instructions about their individual roles during the clinical simulation. Who will act as the physician? Who will act as the nurse? Who will run for supplies? Who will be responsible for documenting interventions?

If you are using a tool such as an algorithm or recording form, find out whether the learners are familiar with it; if necessary, explain it to them and describe how you will use it as a teaching tool.

Define your role during the activity. Will you only ask questions or will you also provide information, along with feedback, at key points?

Simulations Using Anatomic Models

During the simulation using anatomic models (as part of conducting)—

Present the initial information about the patient or the situation. Begin by providing relatively little information.

Have a learner respond to that information and identify what other information is needed. You respond with additional information and ask that learner or other learners what their next steps might be. You may ask the learner to demonstrate on the model the actions she or he would then choose to take. Respond by asking the learner such questions as, “Why would you choose that intervention?” or “Are you sure you want to do that?” in order to understand their rationale for the intervention.

Continue to provide pieces of information and ask questions of the learners. “What would you do next?” “What information would you need now?” “Why did you make that decision?”

Provide the learner or learners with feedback on their responses. Ask questions to check their understanding and help them continue to develop their cognitive skills.

How to Work with Models

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

When clinical trainers use models in clinical training, it is important that:

- Sufficient models are available (usually one model for two or, at most, three learners).
- The model is positioned as if it were a client. This enables the learner to perform the skill/activity as it will be performed with clients.
- Conditions, such as instruments used to perform the procedure and recommended infection prevention practices, duplicate the real situation as much as possible.
- The model is treated gently and with the same respect given an actual client.

Brainstorming Sessions

Brainstorming stimulates thought and creativity and is often used as the basis of a group discussion or an introduction to an activity/topic. In brainstorming, learners rapidly generate a list of ideas, thoughts or possible solutions that focus on a specific topic or problem for a certain period of time—without stopping to discuss or
evaluate items on the list until after that time is up. The key to successful brainstorming—to keeping it creative/dynamic, fun and useful—is to separate the generation of the list from the evaluation of the list. In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to brainstorming.

Note: Plan for brainstorming by determining the objectives of the activity and making sure that there is a way to record responses and suggestions (e.g., flip charts, writing boards).

Before the brainstorming session (as part of your introduction)—

- Explain the ground rules before beginning the session. There are three basic rules: (1) all ideas/thoughts/suggestions are accepted (added to the list); (2) all discussion of the ideas/thoughts/suggestions is delayed until after the list is generated; and (3) no criticism of ideas/thoughts/suggestions is allowed.
- Clearly state the objective of the brainstorming session to keep it focused; this may be in the form of a question to be answered or a problem to be solved.
  
  Example:
  “During the next few minutes, we will be brainstorming and will follow our usual rules. Our topic today is ‘Benefits of Family Planning.’ I would like your full participation. Maria will write your ideas on the board so that we can discuss them later.”

Sample Brainstorming Topics

- What behaviors or communication skills do you want your health care provider to have?
- What are the functions of a medical record?
- What are the essential parts of a complete history and physical?
- What are issues to consider when counseling adolescents about family planning and reproductive health?
- What are some concerns a man who is about to undergo circumcision might have?
- What are potential complications that may occur during childbirth?

During the brainstorming session (as part of conducting)—

- Maintain a written record on a flip chart or writing board of the ideas and suggestions. This will prevent repetition, keep learners focused on the topic and be useful when it is time to discuss each item.
- Provide opportunities for anonymous brainstorming by giving the learners cards on which they can write their comments or questions. Post the cards and use them for a later discussion. This technique allows learners to share thoughts or questions they might not be comfortable revealing.
- Involve all of the learners and provide positive feedback in order to encourage more input. Avoid allowing a few learners to monopolize the session, and encourage those not offering suggestions to do so.
- Review written ideas and suggestions periodically to stimulate additional ideas.
Conclude brainstorming by reviewing, discussing and evaluating the ideas. It may also be useful to guide learners in summarizing items on the list or looking for patterns or themes and organize items into groups/categories.

**Educational Games and Exercises**

Educational games and exercises are a great way to check learners’ understanding of key points, generate discussion and foster changes in attitude—energizing the group at the same time. Unlike warm-ups and ice-breakers, whose sole purpose is to energize and foster cohesion in the group, this type of activity should be directly tied to course objectives and may add excitement through an element of playfulness or competition. Games/exercises can be developed for large groups, small groups or even individuals working on their own. Examples of games/exercises that may be readily adapted to specific learning objectives include: races and other competitions, debates, word puzzles, matching games, simulation/role play-related games and board games. In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to educational games/exercises.

**Before the educational game/exercise** (as part of your introduction)—

- Make sure “ground rules”/expectations, instructions and the point of the activity (i.e., that it is not all about having fun) are perfectly clear.
- Announce the availability of small prizes (e.g., candy, colored pens), if available and appropriate, for “winners/winning team”—to add to the fun and encourage full participation.

**During the educational game/exercise** (as part of conducting)—

- Try not to intervene while the game/exercise is under way, except to help the activity stay on track and to handle unexpected situations that might arise (confusion, arguments, etc.).

**Samples:** Refer to your clinical LRP for an example of an educational game or exercise, and/or see Sample R-5. Game Used in Male Circumcision Course in the Resources folder on the ModCAL flash drive.

**Group Discussion**

A group discussion is an opportunity for learners to share their ideas, thoughts, questions and answers in a group setting with a facilitator. A discussion that relates to the topic and stays focused on the learning objectives can be a very effective teaching method. Guide the learners as the discussion develops and keep it focused on the topic at hand. In addition to group discussion that focuses on the learning objectives, there are two other types of discussions that may be used in a learning situation:

- **General discussion** that addresses learners’ questions about a learning topic. For example, a learner asks about a situation she observed in the clinic. You decide that this is an important question and therefore devote five minutes to a general discussion.
Panel discussion in which a moderator conducts a question-and-answer session among panel members (e.g., clinicians, patients, recent graduates from the same training) and learners.

In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to group discussion.

Note: Plan for discussion by determining the objectives of the activity, considering what learners already know about the topic (too much and the discussion may be pointless, too little and it may be hard to keep going), making sure that there is a way to record responses and suggestions (e.g., flip charts, writing boards).

Before the group discussion (as part of your introduction)—

- Have a very clear idea in mind of what the group will discuss and what you hope to gain through the discussion. State the topic/objective as part of the introduction (you may even want to write it on a flip chart or board). Example: “To conclude this presentation on counseling the sexually active adolescent, let’s take a few minutes to discuss the importance of confidentiality.”

- Make the time limit very clear, as discussions may be difficult to end once they gain momentum.

During the group discussion (as part of conducting)—

- Continually shift the conversation to the learners, ensuring that everyone has a chance to share their thoughts. Actively engage quieter learners by asking them specific questions, while keeping others from dominating. Examples:
  - “Abdul, would you share your thoughts on...?”
  - “Srijana, I can see that you have been thinking about these comments. Can you give us your thoughts?”
  - “Another interesting point, Dr. Olondo. Marion, do you agree?”
  - “Juan, you have contributed a great deal to our discussion. Let’s see if someone else would like to offer....”

- Allow the group to direct/lead the discussion, if appropriate, but act as a referee, interceding only when necessary to ensure that the discussion stays on the topic at hand. Example:
  - “It is obvious that Alain and Ilka are taking opposite sides in this discussion. Alain, let me see if I can clarify your position. You seem to feel that....”
  - “Monica, would you clarify for us how your point relates to the topic?”
  - “Let’s stop for a moment and review the purpose of our discussion.”

A poorly directed discussion may move away from the subject and never accomplish the learning objectives. If the trainer does not keep the objective firmly in mind and maintain control over the direction of the discussion, a few learners may dominate the activity while others lose interest.
• **Summarize the key points of the discussion periodically**, providing feedback on learners’ comments when appropriate. *Examples:*

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

  “Actually, Nsungu, confidentiality is essential for counseling and testing for HIV. Can anyone tell me why?”

• **Acknowledge the contributions of each learner and provide positive reinforcement.** Point out differences or similarities among the ideas presented by different people. Encourage interaction. *Examples:*

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

  “So, Oscar, you would support Maria’s statement about the practice, but hold a different opinion about…”

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

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**Striking a Balance in Discussions**

At its best, group discussion can be a very powerful learning experience—an exciting opportunity for learners to explore ideas, learn the perspectives of others and consider, even question, their own attitudes and beliefs. At its worst, it can become counterproductive, leaving learners confused. Your role as the discussion facilitator is to strike a balance—*keeping the discussion focused and on track*, ensuring that all learners have an opportunity to participate and *intervening when the discussion moves away from the learning objectives*. By facilitating, rather than leading, the discussion, you encourage learners to view examination of their thoughts, opinions and experiences as an important part of the learning process.

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**TIPS FOR CONDUCTING SKILLS DEMONSTRATION AND PRACTICE SESSIONS (IN SIMULATION)**

**Situation 6-4:** A new clinical trainer conducts a clinical skills course. During her first demonstration of how to perform male circumcision, she discusses each step in the procedure and then asks for questions. When there are no questions, she instructs the learners to work in small groups to practice the skill on an anatomic model. While checking on their progress, the trainer notices that most of the learners are having difficulties. What should the trainer have done to prevent these problems from occurring?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

**Skills demonstration** is absolutely critical to the skills development process, in both simulated and real environments, and is especially important when a skill is relatively complex, for example, the skill of performing a vasectomy. Clinical skills such as taking a history, performing a physical examination, providing a specific treatment or conducting a surgical procedure often can be clearly demonstrated by showing a video or “acting out” the skill with a simulated patient or anatomic model. Other methods are needed, however, to demonstrate communication and clinical decision-making skills. These methods include role plays, case studies and various clinical simulations.
The most important step in teaching and learning skills is **skills practice**. Practice is the performance by learners of the skill in the presence of a teacher, tutor or clinical instructor. After you introduce, demonstrate and discuss a skill, observe and interact with learners as they practice it. Monitor learners’ progress and coach them—through questioning, feedback and active listening—as they overcome challenges and move toward competency. **Feedback is especially critical here**, ensuring that learners gain experience with a skill and improve their proficiency where needed. Initial skills practice sessions should be relatively easy and short, so that learners experience success and positive/constructive feedback right away. As learners build competence, you can introduce more difficult skills.

In addition to using basic facilitation skills and adhering to the basic facilitation process, here are some tips that are especially relevant to skills development and practice.

**Skills Demonstration**

**Before the skills demonstration** (as part of your introduction)—

- Introduce and provide an overview of the skill:
  - What the skill is,
  - Why the skill is important,
  - When it should be used,
  - The objectives of the demonstration, and
  - Highlight important steps involved in performing the skill.

- Assess to what degree learners understand the information provided by asking them questions. **Examples:**
  
  "Why is this skill important?"
  "When should you use this skill?" "What are the main steps in performing the skill?"

- Be sure to ask if anyone has any questions before proceeding.

**During the skills demonstration** (as part of conducting)—

- Make sure everyone is able to see what you are doing/the demonstration. Move people around if needed.

- When applicable, provide competency-based learning tools (e.g., checklists) to help learners follow the steps as you demonstrate the skill.

- Demonstrate the skill in as realistic a manner as possible, using a variety of methods, props and as much as possible of the equipment, supplies, materials, etc., that would actually be used.

- Use audiovisual aids, anatomic models or other appropriate tools/methods (e.g., role plays, simulated patients) to enhance and increase the effectiveness of the demonstration.
Particularly for complicated skills, during the demonstrations the learners should refer to a competency-based learning tool such as a checklist, decision tree, flowchart, algorithm, poster or chart. This helps familiarize them with the use of a learning tool, and reinforces the standard way of performing the skill.

- Whenever possible, use the “whole-part-whole” approach to demonstrate a skill (or a procedure that involves a number of skills or tasks):
  - Demonstrate the whole procedure from beginning to end to introduce learners to the entire procedure;
  - Isolate or break down the procedure or activity into parts (e.g., pre-operative counseling, getting the patient ready, performing the procedure, etc.) and allow practice of the individual parts of the procedure; and
  - Demonstrate the whole procedure again and then allow learners to practice it from beginning to end.

- Continually interact with the learners. It is not enough to perform the skill correctly and visibly. You must emphasize the important points, as well as—
  - Explain to learners what is being done—especially any steps that are difficult or hard to see. Take enough time so that they can observe and understand each step.
  - Ask questions of learners to keep them involved, such as: “What should I do next?” or “What would happen if...?” Encourage questions and suggestions. Again, a handout or other learning tool (e.g., checklist) will help learners learn the necessary points.

- Always demonstrate the skill correctly. Obviously, you must never demonstrate incorrect methods. Remind the learners to follow along with the competency-based learning tool if one is available. Correctly perform the steps of the skill in the proper sequence and according to the performance standards. This includes demonstrating “nonclinical” steps such as delegation of tasks to staff, pre- and postoperative counseling, communication with the patient, and decision-making about diagnosis and treatment.

- Use equipment and materials correctly and make sure that learners see clearly how they are used. You should also make sure that the necessary equipment will be available to the learners when they are working in the field.

Starting with demonstrations that do not involve real patients enables you to take time, stop and discuss key points, and repeat difficult steps without endangering the health or comfort of a patient.

**After the skills demonstration** (as part of summarizing)—

- Briefly review and discuss the competency-based learning tool (if available), in relation to the demonstration. This is an excellent time to ask learners questions to assess their understanding of the skill.

- Encourage learners to ask questions as well.
Skills Practice Session

Before the skills practice session (as part of your introduction)—

- Review the skill with the learners, including the steps that will be emphasized during the session. Ask if they have any questions before they begin.
- Explain how audiovisuals, tools/methods (e.g., role plays, case studies) and other materials (e.g., equipment, anatomic models) will be used.
- If competency-based learning tools are available (e.g., checklists), ask learners to refer to them during the practice session—if they are either practicing or observing others practicing.
- Discuss the roles of the teacher/trainer (and other tutors or instructors), learners and others during the session—specifying who will practice, who will help (if applicable) and who will observe and give feedback.
- If the group of learners is large and the number of teachers/trainers (and other tutors or instructors) is limited, there are several options you can choose from, including:
  - Dividing the learners into small groups, and having them do a staggered rotation through the practice area.
  - Identifying other persons, such as tutors or more senior learners, who could observe the learners during practice and give feedback.
  - Asking learners to work in pairs or groups of three and taking turns practicing, observing and giving feedback to each other. In this option, the teachers/trainers (and other tutors or instructors) should move from group to group to observe learners as they practice.

Note: To the extent possible, practice should be set up to resemble real-life situations that candidate clinical trainers will face in their future careers. This means having available anything that will contribute to the realism of the simulation, such as the actual supplies, equipment and job aids that would be used in the clinical setting. Practice sessions in the clinical setting (e.g., clinic, hospital, laboratory) require additional preparation and coordination, which are described in detail in Chapter 8.

During the skills practice session (as part of conducting)—

During the practice and feedback session, a great deal of two-way communication should occur to reinforce the development of skills within a positive learning climate.

- If competency-based learning tools are available (e.g., checklists), follow along while watching the learners practice.
- Encourage learners to explain what they are doing and why they are doing it.
- Continually interact with them. It is not enough to observe quietly. Here is where coaching really comes into play!
  - Ask questions of learners to keep them thinking about what they are doing, what comes next, etc. Again, a handout or other learning tool (e.g., checklist) will help learners learn the necessary points.
Chapter 6

- Provide feedback, noting and praising correct practice, offering specific suggestions to address errors or improve techniques.
- Actively listen to their explanations of what they are doing and their reasons why, to their answers to your questions, and to their responses to your feedback.

The Power of Feedback

Practice must be combined with feedback to be most effective. Feedback is your way of giving crucial information to learners about the quality of their performance—they need it to grow more competent, confident and ultimately independent in their practice. Like coaching, feedback is essential throughout learning; it is particularly important during and after practice sessions and after learners have had their skills assessed. If given correctly, feedback is positive enough to function as reinforcement and encouragement for learners, and specific enough that it provides a sort of “blueprint” for how they can improve.

After the skills practice session (as part of summarizing)—

- Ask learners how they felt about their own performance. Begin by asking them what they believed they did well and what they would like to improve, or what they would do differently next time. Refer to a competency-based learning tool, if one is available, for a quick review of the steps, and ask learners where they experienced difficulty.
- Then discuss the strengths of their performance and offer specific suggestions for improvement. Determine if they need additional practice and, if so, arrange for additional independent or facilitated practice sessions.
- Finally, try to come to agreement with the learners on what will be the focus of the next practice session.

Note: If practice sessions occurred in small groups, each group should report to the larger group the main results of their practice, such as the types of skills practiced, the main difficulties encountered and the main achievements.

Bringing It All Together

What happens in the coaching process before, during and after a skills demonstration and practice and session is summarized in Exhibit 6-3.
Exhibit 6-3. Using the Coaching Process for Demonstration and Practice

<table>
<thead>
<tr>
<th></th>
<th>DEMONSTRATION</th>
<th>PRACTICE SESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before</strong></td>
<td><strong>Clinical trainer:</strong></td>
<td><strong>Clinical trainer:</strong></td>
</tr>
<tr>
<td></td>
<td>• Provides an overview of the skill/activity</td>
<td>• Reviews any earlier practice sessions</td>
</tr>
<tr>
<td></td>
<td>• Uses audiovisual and other training aids</td>
<td>• Reviews any critical steps</td>
</tr>
<tr>
<td></td>
<td>• Reviews the assessment tool</td>
<td>• Answers questions about the skill/activity</td>
</tr>
<tr>
<td></td>
<td>• Asks for questions</td>
<td></td>
</tr>
<tr>
<td><strong>During</strong></td>
<td><strong>Clinical trainer:</strong></td>
<td><strong>Learner:</strong></td>
</tr>
<tr>
<td></td>
<td>• Demonstrates each step of the skill/activity</td>
<td>• Performs the procedure while trainer observes</td>
</tr>
<tr>
<td></td>
<td>• Uses audiovisual and other training aids</td>
<td>the assessment tool</td>
</tr>
<tr>
<td></td>
<td>• Asks questions as appropriate</td>
<td>• Asks questions as needed while coach provides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>positive feedback, asks questions and offers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>suggestions</td>
</tr>
<tr>
<td></td>
<td><strong>Learner:</strong></td>
<td><strong>Clinical trainer:</strong></td>
</tr>
<tr>
<td></td>
<td>• Observes using the learning guide</td>
<td>• Trainer observes and evaluates learner</td>
</tr>
<tr>
<td></td>
<td><strong>Both:</strong></td>
<td>performance on models using the checklist</td>
</tr>
<tr>
<td></td>
<td>• Two-way interaction takes place</td>
<td></td>
</tr>
<tr>
<td><strong>After</strong></td>
<td><strong>Both:</strong></td>
<td><strong>Learner:</strong></td>
</tr>
<tr>
<td></td>
<td>• Discuss the skill/activity</td>
<td>• Shares feelings about positive aspects of the</td>
</tr>
<tr>
<td></td>
<td>• Review the assessment tool for critical steps</td>
<td>practice session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Offers suggestions for self-improvement</td>
</tr>
<tr>
<td></td>
<td><strong>Trainer:</strong></td>
<td><strong>Clinical trainer:</strong></td>
</tr>
<tr>
<td></td>
<td>• Answers any questions</td>
<td>• Provides positive feedback</td>
</tr>
<tr>
<td></td>
<td><strong>Learner:</strong></td>
<td>• Offers suggestions for improvement</td>
</tr>
<tr>
<td></td>
<td>• Is ready to practice</td>
<td><strong>Both:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review any problematic or critical steps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Set goals for additional practice if needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Clinical trainer:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Determines if learner is competent to</td>
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<tr>
<td></td>
<td></td>
<td>move from models to clients</td>
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</tbody>
</table>

**TIPS FOR CONDUCTING ASSESSMENTS IN THE CLASSROOM**

**Formative Assessment in Practice**

As a learner progresses through the course, the trainer performs formative assessment in the classroom and the clinical setting. Again, this type of assessment helps learners develop the desired competencies—primarily through feedback—and also prepares them for summative assessments, those critical “decision points” during the course when knowledge, skills and attitudes are formally evaluated. (This section provides detailed information on issues or practices unique to formative assessment, while the details of how to conduct many of the activities mentioned are covered in Chapter 6 and Chapter 7.)

**Building Knowledge**

To help learners acquire new knowledge, the trainer presents information using a variety of techniques to help them retain and understand it. Through the use of tools/methods—such as oral quizzes, written tests and exercises (Exhibit 6-4), case studies, games and questioning techniques—and by providing learners ample feedback, the trainer is able to highlight key points, reinforce correct information and correct misinformation—as well as to assess learners’ level of knowledge. **By the end of this phase of training, learners will take a validated, objective written examination**
(summative assessment) (see “Final Knowledge Assessment,” page 81), which will enable the trainer to determine whether they have in fact acquired the knowledge necessary to move on to the skills portion of the course.

Exhibit 6-4. Using Written Tests in Formative Assessment*

Subjective written tests (e.g., short-answer questions, essay questions, written assignments), which are often used for formative assessment, may be more difficult to score than objective tests, such as the validated objective written examination used in summative assessment. Use of an answer key (perhaps outlining main points a “correct” answer should cover) is recommended, and may be provided, for ease of scoring. Blind testing/scoring is also recommended to eliminate any biases.

Either way, however, because the purpose of formative assessment is to provide feedback to learners to help them improve their performance, it is not necessary to assign a numerical score to the assessment. The results of formative assessments may be reported to learners on a scale such as poor, fair, good or excellent. The crucial aspect of formative assessment is to explain to the learners why they answered questions wrong or received a given rating, and how they can improve the results when reassessed on the same topic in the future.

Following are some ways to help learners learn from knowledge assessments:

- Ensure that they understand which course learning objective corresponds with any incorrect responses, so that they know where to focus their energies.
- Instruct learners to review the materials related to the questions they missed.
- Give learners an opportunity to ask you questions about any test items on which they scored poorly or that they did not understand.
- Discuss answers as a group (protecting anonymity), asking learners the reasons why different answers are correct or incorrect.

(Additional guidance for conducting written tests is provided on pages 81–82.)

Note: If many learners had trouble with the same questions, either the teaching methods or materials may not have adequately addressed the corresponding learning objective(s), or the questions (in formative assessment tools only) may need to be rewritten. Adapting the teaching methods/materials to better address the problem areas might also be considered. These issues are further discussed in “Using Assessment to Evaluate and Guide Training” (page 49).

* Written tests and exercises are highlighted here but may in fact be used in any phase during the course.

Building Skills in a Simulated Setting

In this phase of the course, the trainer conducts clinical demonstrations to provide learners with a clear picture of the skills to be learned. The trainer is able to assess and build the learners level of competence in practicing these skills through the use of two key methods/tools—direct observation of skills practice sessions and structured feedback reports. By the end of this phase of training, learners’ performance will be formally evaluated according to the validated skills checklist (summative assessment), which will enable the trainer to determine whether they have the level of skills competence needed to practice their skills in with actual clients in a clinical setting.

Remember: Actual competency can be achieved only with actual patients in a clinical setting.
Final Knowledge Assessment
After learners have undergone the knowledge acquisition phase of training, they will take a validated objective written examination, which will enable the trainer to determine whether they have in fact acquired the knowledge necessary to move on to the skills portion of the course. Guidelines for conducting this examination, many of which are applicable for any written test, are provided below.

Before the final knowledge assessment (as part of your introduction)—
Trainers should make necessary preparations before administering a written test.

- Make certain that the testing area is ready (e.g., sufficient space, at desks or tables, for learners to complete the assessment, as well as adequate lighting, ventilation and comfortable temperature).
- Select an appropriate knowledge assessment tool, depending on the purpose of the assessment.
- Make sure that there are adequate supplies for the test.
- Make arrangements to ensure that learners being tested will not be interrupted.
- Review the test procedures.
- Rehearse by reading the instructions, as you will be sharing them with the learners immediately before administering the test.
- Try to anticipate any questions that might be asked before the test begins.

During the final knowledge assessment (as part of conducting)—
The trainer should try to create a relaxed atmosphere from the beginning. Too much learner anxiety can have a negative effect on learners’ ability to demonstrate what they know. The following guidelines can help the trainer further support learners in taking any written test.

- Give clear instructions to the learners. To perform to the best of their abilities, learners must know the purpose and basic parameters of the assessment. This means that they must be aware of the time limit (if there is one), the manner in which they are to select and record answers, and the scoring system that will be used. Often, as is the case with summative knowledge assessments, all of the instructions will be provided. In any case, the trainer should review them with the learners and answer any questions they may have before they begin taking the test.

- Give learners enough time to respond. Some people are able to perform well on tests when faced with the pressures of a time limit; many others do not. Therefore, untimed written examinations are generally recommended. The trainer can make special provisions for learners who may need more time, such as allowing others who have finished “early” to leave the room for a break (to be called back in when everyone is done). Alternately, if there are two trainers, two rooms can be set up for test taking, one for those who anticipate finishing early and another for those who do not. The important thing is to equate the “ability to finish early” or “needing more time” with differences in individual learning and test-taking styles, rather than with differences in intelligence. If a time limit must be imposed (for logistical reasons), make sure that it is reasonable for each learner; state the time limit clearly in the beginning; and let people know when
they are half-way through and when there are five minutes left. Jhpiego summative assessments provide guidelines for length of time to complete—usually approximately one minute per question.

- **Manage the testing environment** to maximize learners’ ability to focus on the examination. The most neglected of all test administration issues has been the physical condition of the testing area, which has been proven to adversely affect the test performances of many students. To ensure a test-friendly environment:
  - Minimize noise to ensure that learners can hear the oral instructions and will not be distracted while taking the test.
  - Again, monitor lighting, ventilation and temperature. These factors, if not maintained at adequate levels, can also affect learners’ concentration.
  - During the testing process, refrain from any special coaching on the subject matter in an attempt to reduce anxiety and frustration.
  - Remain in the room during the examination and move around the room, as needed, to monitor the learners and respond to any questions.

**After the final knowledge assessment**—
- Score according to the guidelines provided.
- Discuss scores with learners, making specific suggestions for study (as well as arrangements) for those who must retake the test before advancing.

**Interim (Summative) Skills Assessment**
After learners have undergone the phase of training focused on skills acquisition and development in simulated settings, they will undergo a formal skills assessment using a validated skills checklist, which will enable the trainer to determine whether they are ready to practice their skills with actual clients in a clinical setting. Guidelines for conducting this skills assessment (most of which are applicable for formative skills assessments as well) follow:

**Before the skills assessment** (as part of your introduction)—
- **Discuss previous practice sessions with the learner.** Ask if the learner has any questions about the skill and is ready to be assessed.
- **Review the assessment tool.** Briefly review the checklist, recording form or rating scale with the learner. Whether the learner is being assessed with a model, a simulated patient or an actual patient, provide an opportunity for reviewing the essential steps.

**During the skills assessment** (as part of conducting)—
- **Observe and assess** the learner’s performance.
- **Stand to the side,** or somewhere else where you can see without intruding, and let the learner perform the skill.
- **Do not interfere or interrupt** the learner unless the learner is about to make a mistake that would endanger or hurt a patient.
■ **Provide only essential feedback** while the learner is performing the skill.

**After the skills assessment**—

■ **Review the skill with the learner.** Ask the learner to share feelings about what she or he did well during the session and what could be improved.

■ **Provide positive feedback and offer suggestions for improvement.** Tell the learner what she or he did well and then offer specific tips or instructions on how to improve performance.

■ **Determine whether the learner is competent or needs additional practice.** Based on the pre-determined criteria, decide whether the learner is competent in performing the skill or needs additional practice. *(Note: Validated checklists include only critical tasks related to competency and, like validated objective written examinations, are accompanied by complete instructions for scoring.)*

**CHAPTER SUMMARY**

■ The classroom is the place where competency development begins. In the classroom, a variety of learning activities are used to transfer knowledge, skills and attitudes in order to develop the desired competencies. Throughout it all, you’ll use the effective facilitation skills as you assess learner progress and readiness to work with clients.

■ Using a variety of techniques, the trainer can engage learners’ interest while effectively and efficiently transferring information to them through interactive presentations, facilitating their progress from understanding to application and analysis of new knowledge.

■ Group learning activities—such as case studies, role plays, clinical simulations, brainstorming session, educational games and discussions—can be used during classroom and practical sessions to help learners build knowledge, skills and appropriate attitudes. They also energize the group, giving learners a chance to ask questions, interact and explore different perspectives.

■ Helping learners develop the desired knowledge, skills and attitudes required for competency is a three-part process, including: (1) introducing/demonstrating desired competencies; (2) providing opportunities for practice and feedback in simulated (e.g., classroom, skills development lab) and real (e.g., clinic, hospital, laboratory) environments; and (3) assessing learners’ ongoing progress and providing feedback.

■ Specific tools and strategies for formative and summative assessment in the classroom guide the learner toward greater competency, while helping to build the confidence and independence needed to work with actual clients.
CHAPTER SEVEN

FACILITATING IN THE CLINIC

Where Practice Meets Reality
Practicing in simulation (or in a classroom) is necessary preparation for gaining practical experience in the clinical setting—but the “practicing,” as such, continues. Again, true skills competency can only be achieved by practicing with actual clients. This is because part of being competent is being able to provide high-quality services in real-life situations with living, breathing people—despite difficult emotions, unexpected findings and other unanticipated occurrences. So although trainers and learners will continue to use many of the tools and methods they became familiar with in the classroom, building on what they already know, no one knows what will actually happen in the clinical setting … not even the trainer. Ensuring that learners can practice and finally demonstrate the desired competencies in this “uncharted territory” requires careful planning, clear communication, flexibility and a firm commitment to protecting the safety and rights of clients—on the parts of everyone involved: the trainer(s), learners and clinical staff.

INTRODUCTION
Clinical practice represents a precious learning opportunity for learners. It is the time when they synthesize the knowledge, skills and attitudes they have learned and practiced in the classroom, and apply them with actual clients under supervision in a clinical setting. Trainers also face new roles and responsibilities. They and their learners will have to make critical modifications to competency development and assessment approaches to ensure that the clinical practice is as effective and efficient as possible. Most of these modifications are aimed at:

- Protecting the safety and rights of clients
- Ensuring that services at the facility are not impeded by the presence of learners or their activities
- Maximizing valuable learning experiences for candidate clinical trainers by balancing/integrating:
  - Practice with actual clients, as well as doing other clinic-specific activities such as observing facility practices, going on clinical rounds, etc.;
  - Practice in simulation, for skills or components of skills for which no real clinical opportunity presents itself;
  - Continuation of learning activities, either individually or in small groups, when real clinical opportunities are not available (these should be discussed/prepared in advance);
  - Supporting learners in gaining confidence as they move toward greater independence, by having the practice simpler skills with clients before moving on to more complex ones; and
  - Ensuring, through appropriate supervision, that all services provided by learners to clients adhere to performance standards.
Clinical practice can be a challenging, but particularly rewarding, experience for both trainers and learners. It is also essential for ensuring that learners will be able to provide safe, beginning-level services when they return to the workplace. This chapter provides additional guidance on how to facilitate continued competency development and assessment in the clinical setting.

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Safe and efficient provision of services must be the highest priority for everyone working in the clinic, regardless of individual roles and responsibilities, and must not be compromised for the sake of learning.

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SUPERVISING LEARNERS

**Situation 7-1:** You are conducting a course on reversible family planning methods that has now moved into the clinical area. It is the first day in the clinic and the seven learners you are supervising are eager to begin working with clients as quickly as possible. You are going to supervise their interactions with clients and their service provision skills. After a short period of calm, you suddenly have four learners who need you to assist them at the same time: one is going to do basic counseling, another needs to give a Depo-Provera injection, another needs to perform a pelvic examination and the fourth needs to help a client who has returned complaining of nausea, breast tenderness and spotting between periods since beginning combined oral contraceptives two months ago. What do you do?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

In the clinical setting, in addition to coaching learners as they practice with actual clients, the trainer is ultimately responsible for supervising them. In the role of supervisor, the trainer must closely monitor learners’ activities so that:

- Each learner receives appropriate and adequate **opportunities for skill practice**;
- **Learners do not disrupt the efficient provision of services** within the clinic or interfere with staff and their duties; and, most important,
- The care provided by each learner **does not harm clients** or place them in an unsafe situation.

Here are some basic principles the trainer should keep in mind in supervising learners in the clinic:

1. **The trainer should be with learners when they are practicing with clients as appropriate**—such as when the learners are conducting surgical procedure on a client (in which case, one-to-one, constant supervision is required), or during any client contact involving a skill for which a learner’s initial competency has not yet been determined/recorded.

   - What learners can do independently, or without constant supervision, depends in part on the amount of risk involved and the skills in which they are already proficient or have developed a certain level of competence.
   - Once initial competency has been recorded, the trainer must periodically review the learner’s performance to ensure that competency is demonstrated consistently.
Safe and efficient provision of services must be the highest priority for everyone working in the clinic regardless of their roles and responsibilities, and must not be compromised for the sake of learning.

**Knowing When the Time Is Right—Trainer’s Call, Trainer’s Responsibility**

There are few hard and fast rules about when a learner can work with clients without direct supervision from the trainer. Even in counseling, where no obvious or immediate risk is posed to clients, learners in their eagerness to learn a new skill may present certain methods in a persuasive manner while counseling a client (e.g., perhaps if the client chooses an IUD, the learner will have the opportunity to perform IUD insertion). The trainer may need to closely monitor counseling sessions, therefore, to be sure that information on all contraceptive methods is presented in an unbiased manner and that client screening is performed to prevent unnecessary examinations or provision of an unsuitable method. Once the trainer is comfortable with a learner’s level of competence in a skill or task, she/he may be allowed more independence.

Aside from ensuring an appropriate level of competence before allowing the learner to practice certain skills independently, keep the following principles in mind:

- Humanistic teaching does not put learners into situations where they are “in over their heads” and may cause harm.
- With cognitive apprenticeship, learners can learn more, and more quickly, with the direct guidance of the trainer, who must gradually move the learner toward independence.
- A learner’s readiness for eventual independence must be monitored using formative assessment technique.

Whatever you decide with regard to the level of independence an individual learner should have at a given time, this decision will depend on many factors. *This is probably the single most important responsibility of the trainer.*

2. Most trainers have more than one or two learners to supervise. Because the trainer cannot be with all of them at the same time, the following, **other methods of supervision must sometimes be used:**

- Learners must understand what they can do independently and what requires trainer supervision, so that they can keep busy when the trainer is involved with another learner.
- Having additional activities (that require no direct supervision) prepared ensures that learners can remain actively engaged in learning when they are not with clients. They should gradually move toward more independent practice as they gain competence and confidence.
- Clinic staff also can act as supervisors if the trainer is confident of their clinical skills, the consistency of the care they provide with the performance standards, and their ability to provide appropriate feedback.

3. The more learners there are in the clinic, the more the trainer relies upon the staff also to act as trainers. Nevertheless, the **ultimate responsibility for each learner, including that of final assessment of skill competency, is the trainer’s.** For this reason, if multiple clinical sites are used during a course, a trainer must be assigned to each site.
PROTECTING CLIENTS’ RIGHTS

**Situation 7-2:** As the clinical trainer for a male circumcision course, you overhear the learners, who are sitting in the clinic waiting area, discussing the cases they performed that morning. Several clients are still waiting to be seen and the housekeeping staff are tidying up the area. Clients are being mentioned by name and their behavior and cases described in detail, often in uncomplimentary terms. One learner is furious that a client refused to let him perform the procedure because he is “just learning.” How would you intervene in this situation?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

The rights of clients to privacy and confidentiality should be considered at all times during a clinical training course. The following practices will help ensure that clients’ rights are routinely protected during clinical training.

- The right to **bodily privacy** must be respected whenever a client is undergoing a physical examination or procedure.

- The confidentiality of any client information obtained during counseling, history taking, physical examinations or procedures must be strictly observed. Clients should be reassured of this confidentiality.

Confidentiality can be difficult to maintain when specific cases are used in learning exercises. Such discussions should be conducted without reference to the client by name, and should always take place in a private area where other staff and clients cannot overhear what is being said.

- The **client should be informed** about the role of each person involved such as the clinical trainer, other clinicians-in-training, support staff or researchers. In addition, clients have the right to information about their diagnosis, treatment options and plan of care.

- **The client’s permission should be obtained** before having a clinician-in-training observe, assist with or perform any procedures. Understanding the right to refuse care from a learner is important for every client. Furthermore, care should not be rescheduled or denied if the client does not permit a clinician-in-training to be present or provide services. In such cases, the clinical trainer or other staff member should step in and perform the procedure.

- **Safe practices, quality service delivery and clean facilities** are not a privilege but a client’s right, as is now reflected in many clients’ rights statements. To ensure a **humane clinical learning environment** in which this fundamental right is protected:

  - **Early in clinical training, the trainer must be present during all interactions between the learner and client,** and the client should always be made aware of the situation, the learner’s role and the trainer’s role. Later, as competency continues to develop, the learner can be given the opportunity to practice more independently. Throughout clinical training, the trainer must balance the needs of the learner with the complexity of the task for which the learner is being prepared—always putting client safety first. For example, surgical procedures may involve sustained, direct contact between trainer and learner. In contrast, frequent check-ins (in between clients) to
discuss clinical decisions that the learner has reached may be sufficient when teaching an experienced provider to manage ARVs.

Remember, the trainer is ultimately responsible for the safety and comfort of clients and must remain alert to their needs.

- The **trainer must be careful about how coaching and feedback are given** during practice with clients. Corrective feedback in the presence of a client should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the learner.

- **Clients should be chosen carefully** to ensure that they are appropriate for clinical training purposes. For example, learners should not practice with clients who are “difficult” or have complicated needs/conditions until they are competent in performing the procedure under more normal circumstances.

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**Making the Most of Clinical Practice**

In order for learners to demonstrate competency with clients, adequate practice in the clinical setting is essential—and yet there are so many variables and factors that are beyond anyone’s control. Many of the same organizational and management skills you have developed in the classroom carry over or can be adapted to the clinical setting, to make the most out of learners’ time there:

- As always, organize activities so that learners progress from simpler to more complex skills.
- Make sure each day’s objectives are clear to all involved.
- Have a schedule for each clinic day to help ensure learners do not overload a particular unit, for example, and so that staff are aware of what is going to happen, and where and when.
- Take advantage of the caseload when it is available, which means you may need to adjust this course schedule (share changes to schedule with all).

And as for those times of low patient flow or relative inactivity during clinical practice sessions, line up other activities or exercises for the learners to work on. Observing procedures, completing related case studies and doing other small group exercises keep the momentum going and may provide valuable learning experiences.

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**WORKING WITH CLINICAL STAFF IN THE CLINICAL SETTING**

During much of clinical practice, the trainer may be overseeing several clinical staff—as they interact with learners—and providing overall supervision to many learners rather than providing direct guidance to a few. Often this will mean **delegating supervisory responsibilities** to staff, as well as clinical instructors/preceptors. Providing staff with the opportunity to assist in the training can be an enriching experience for the whole facility, as well as improve the skills of staff. Their involvement can also be a great support to the trainer, who is suddenly juggling many additional roles, and can foster an experience of cooperation among them and learners—helping to extend the positive learning environment of the classroom into the clinical setting. There are, however, some important considerations that go along with this arrangement:

- **Staff skills must be standardized** so that staff members are “on the same page” with regard to supervising learners. The more people involved in assessing the
skills of learners, the more critical it is to use a standardized checklist—this helps
to reduce variations in scoring among different observers and increases the
reliability of the assessment. Using the tool correctly will likely require some
training. Moreover, to ensure that the practices of staff do not affect scoring
using the steps outlined in the checklist, a skills standardization activity must be
conducted prior to delegating assessment to clinic staff.

- It is also important to work with staff to ensure that client flow is not
  obstructed and learners do not overwhelm one area. In general, three or four
  learners are the most that a specific area of a clinic can absorb without affecting
  service delivery. If there are more, plan a rotation system that allows ample time
  for all learners in each clinic area, based on your assessment of the individual needs
  of each. This also helps balance the load for staff members who will be working
  with learners. For example, several learners can be assigned to the counseling area,
  several to the screening area, several to the outpatient department and several to
different inpatient wards. They can change work areas every few hours, every day,
  or every few days—whichever seems most appropriate.

- As part of ongoing close collaboration, to ensure that the practice runs as
  smoothly as possible, the trainer should meet with clinical staff and any other
  instructors before each clinical practice session begins. The purpose of this
  meeting is to:
  - Ensure that staff and instructors understand their roles and responsibilities.
  - Review the day’s plan, including overall objectives, rotations, scheduling
    changes, etc.
  - Coordinate any planned learning activities that may require your direct
    assistance.
  - Discuss/resolve any issues that have arisen (e.g., logistical problems).
  - Identify any unique or interesting learning opportunities that might
    presently exist on the unit.
  - Review how client candidates will be identified (i.e., screening out obviously
difficult individuals, those with complicated conditions, those with needs not
  relevant to the training).
  - Ensure that everyone understands which activities learners can do alone
    and which require direct supervision (this will likely be different for
    different learners, especially as the clinical practice proceeds).
  - Review how feedback (if applicable) should be given during and after the
    session (further discussed in “Tips for Providing/Receiving Feedback in the
    Clinical Setting,” pages 94–96).

- Before each clinical training session, the trainer should also visit the different
  areas where learners will be assigned to see if there are any problems or logistical
  issues that should be addressed.

Samples: See Sample B-5. Pre-Service Daily Plan for Clinical Practice and Sample B-6. In-Service Daily Plan for Clinical Practice in Appendix B.
TIPS FOR CONDUCTING THE CLINICAL PRACTICE SESSION

Introducing the Clinical Practice Session
Meet with the learners as a group, if possible on the morning of (or immediately prior to) the clinical practice session. Although this meeting is typically brief, it helps learners have a productive clinical experience. Items to be covered may include:

- Learning objectives for that day or the clinical session
- Learners’ tasks for that day or session, including the work assignments and rotation schedule if applicable
- Use of a case log (Exhibit 7-1)
- Any necessary scheduling changes
- Which activities learners can do alone and which require direct supervision (again, this will likely be different for different learners, especially as the clinical practice proceeds)
- Where learners should go if they have questions or difficulties
- How feedback will be provided during and after the session (further discussed in “Tips for Providing/Receiving Feedback in the Clinical Setting,” pages 94–96)
- Questions related to the session or from previous sessions, if they can be answered quickly; if not, postpone them until the post-session meeting
- The topic for the post-session meeting, so that the learners can prepare cases or look for experiences to share

Conducting the Clinical Practice Session

- **Check in with the staff and instructors periodically** to make sure everything is running smoothly.
- **Ensure that client flow or services are not being impeded:** learners are not overwhelming any one area and/or the “rotation system” is working as planned.
- **Ensure that all learners are occupied** in some sort of learning activity.
- **For learner–client interactions,** the trainer should explain the situation to the client candidate and gain consent before proceeding (Exhibit 7-2).
Exhibit 7-1. Keeping a Case Log

One very useful tool for monitoring learners’ progress over a single or several clinical rotations within one course is a case log (also called a log book or case book). Essentially a list of skills or tasks that learners should be able to perform by the end of the course, a case log provides a standardized tool for learners to use in tracking their skills development throughout a course. (Each course may have a log book, or one case log may be used for several related courses.)

Keeping a case log involves these basic steps:
- When learners feel they are ready, they ask the trainer to observe their performance of a skill.
- The trainer checks off each skill or task in the case log after the learner completes it correctly.
- If the learners do not perform the skill competently, the trainer advises the learner to try again after additional practice—providing verbal and written suggestions for how to improve.

Although keeping a case log requires time because learners must be directly observed, these documents offer several advantages:
- Provide a valuable, ongoing record of the skills that learners are able to perform competently, and allow the learners and trainers to document progress.
- Help learners and trainers identify meaningful experiences during the development of the target skills.
- Encourage the learner to consider things that she/he would do differently next time. For example: After a case in which a learner managed postpartum hemorrhage, she re-examines the partograph, considering whether she might have anticipated the postpartum hemorrhage based on data/risk factors that she recorded during management of the labor.
- Provide an opportunity for learners to reflect on and keep track of their progress.
- Yield a clear report to be considered in the final summative assessment for qualification (though it is important to remember that any specific number of cases does not automatically equal competency).

Keep in mind the following points about using case logs:
- Each course should have its own case log, or a section of a case log, for documenting skills that need to be completed either in simulated practice or during clinical practice.
- The skills contained in the case logs should be based on the related learning objectives.
- The case log does not provide any guidance in the assessment of the skill or task; an accompanying tool such as a checklist, rating scale or recording form can be used to guide assessment.

Samples: See Sample B-7. Case Log for Pre-Service Education/Neonatal Nursing Care and Sample B-8. Case Log from In-Service Training in Appendix B.

Exhibit 7-2. Helping Clients Feel Comfortable with the Learning Experience

Several strategies can be used to increase the chance a client will accept care from a learner:
- Let the client know the exact role of the learner and the importance of practice with real clients.
- Explain that the learner is a skilled provider and has already practiced the new skills on model or in simulations.
- Emphasize that you will be there to supervise during any part of the care in which the learner is not already proficient, and to provide coaching if needed.
- If a client accepts care from the learner, thank him or her for participating.
- If the client refuses care by the learner, assure the client that she/he will be treated with the same respect as those who accept.
- Make clear that the client has the right to opt out at any time, for any reason.
- Make sure to thank those who agree to participate in training. Let them know the importance of their contribution!

A client who participates in the learning process is giving of him/herself for the benefit of others. Trainers and learners should keep this in mind throughout their interactions with this person.
Continue the process of facilitating skills development and assessment, adapting the Skills Practice and Demonstration Session (Chapter 6, pages 74–79) for use with real patients. Learners now have the opportunity to observe demonstrations, practice (while being coached) and demonstrate competency in a real setting. (Have a plan in place for using case logs to track skills or components of skills in which learners have demonstrated competency.)

Provide feedback in a way that will not cause anxiety for the learner or the client. One of the most difficult tasks for the trainer in the role of coach, and one with which even experienced trainers struggle, is providing corrective feedback in the clinical setting. Agree beforehand how the trainer will signal that the learner should stop what he/she is doing immediately.

Corrective feedback will always be an important part of clinical training and you can expect, and should be prepared, to provide it at any point in a learner’s progression toward competency.

As always, maintain a positive learning environment. Learners will be intimidated and nervous at the beginning of clinical practice experiences. Help reduce their anxiety (and thus the client’s) by maintaining a friendly and helpful manner with them. Encourage the clinical instructors and staff also to help put learners at ease so they can ask questions, learn what they need to learn and feel comfortable continuing to practice.

Summarizing the Clinical Practice Session
If possible, meet with the learners at the end of the session. If you cannot meet with them every day, you should still meet with them regularly to assess the progress of their learning in the clinical setting. Conduct these meetings away from the patient care area if possible. Ideally, clinics will have a small room you can use for small group activities or meetings with learners. Below are several actions you can take at the end of the day, or periodically during the rotation, to help further learning:

- Review the learning objectives and assess learners’ progress toward meeting them.
- Encourage learners to present cases seen that day, particularly those that were interesting, unusual or difficult.
- Respond to clinical questions concerning situations and clients in the clinic or information in the reference manual.
- Provide an opportunity for learners to ask questions.
- Ask learners questions about cases or their care plans.
- Tell learners about the logistics of future clinical practice sessions.
These meetings, especially extended sessions, should be conducted away from the client care area if possible. Although every clinic will not have a meeting room, an effort should be made to locate a space that will allow free discussion, small group work and practice on models and that will not interfere with efficient client care or other staff duties.

**Note:** A quick feedback session should be conducted with each learner before the clinical practice session. See below for more guidance.

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**When Competency Seems out of Reach**

Achieving competency is not always possible for all learners during a short training event. Use all available time remaining in the course to provide learners additional practice opportunities and try again to qualify them. As part of this effort, you could also:

- Provide very specific feedback on what the learner needs to practice in order to master the competency.
- Work together with learners and supervisors to create individualized learning plans to be followed after training.

When learners still have **not** mastered content by the end of the course, arrange for practice with supervision in their clinical site and a follow-up visit to reassess. Continued practice and assessment until competency has been reached is essential.

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**TIPS FOR PROVIDING/RECEIVING FEEDBACK IN THE CLINICAL SETTING**

**Situation 7-3:** You are coaching a learner who is inserting an IUD with a client. The client is aware that the “service provider” is learning a new skill and she appears somewhat nervous, but has agreed to have the insertion done by the learner. The learner performs the first steps of the insertion procedure correctly, but has some difficulty applying the tenaculum to the cervix.

- What would you do? How would you interact with her?
- What would you do if the learner, after inserting the speculum, forgot to swab the cervix before continuing with the procedure?
- What would you do if the learner had difficulty using the withdrawal technique for IUD insertion and began pushing the IUD inserter tube to release the IUD in the uterus?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

**Conducting Feedback Sessions**

The feedback sessions before and after practice are often skipped in an effort to save time. These sessions, however, are very important for the continued development of the learner’s skills. Without adequate feedback and coaching, the learner may take longer to achieve competency and end up requiring the “saved” time later. Keep in mind that by this time, the learner has already practiced and been assessed on models/in simulations and may not need extensive feedback on every aspect of the skills she/he is performing. To minimize disruption of services, the pre- and post-practice feedback sessions can take place in just a few minutes in a location away from the client care areas.
The structure of the feedback session is essentially the same regardless of whether the session takes place before or after practice, and whether it is in response to a learner's performance with models or with clients.

First, the learner should identify personal strengths and areas where improvement is needed.

Next, the trainer should provide specific, descriptive feedback that includes suggestions of not only what, but how, to improve.

Finally, the learner and the trainer should agree on the focus of the practice session, including how they will interact while they are with the client. For example, they may agree that if the trainer places a hand on the learner's shoulder, it is a signal to stop and wait for further instructions.

The feedback session before practice should be given before entering the room to work with the client. The feedback session after practice can be delayed until the client's care has been completed and the client is ready to leave the clinic. The trainer should try not to delay it much longer than this (e.g., until the end of the day). Feedback is always more effective when given as soon after the experience as possible. This also allows the learner to apply the feedback with the next client, if appropriate.

Providing Feedback during Learner–Client Interactions

Positive feedback is often easy to give and can be provided in the presence of the client. Trainers often think that hearing feedback, even positive feedback, will disturb the client. Many clients, however, find it comforting to hear the learner being given positive feedback. Keep in mind that:

- Feedback should be restrained and low-key, as overly exuberant praise can be as worrisome to the client as hearing negative comments. Too much praise may cause the client to wonder, “What are they hiding?” “Why is it so surprising that this person is doing a good job?”
- Positive feedback can be conveyed by facial expression and tone of voice rather than words, and still be highly effective.

At the same time, the absence of feedback of any kind can be disturbing to the learner. By this phase of skill development, the learner is expected to do a good job even with the first client, and is accustomed to hearing positive comments. Therefore, in order to maintain the learner's confidence, it is important to give positive feedback.

Corrective feedback is difficult to give under any circumstances, but particularly when a client is present. It is important to keep such feedback even more restrained and low-key. There are a number of techniques that will make it easier.

- Often a look or hand gesture (e.g., a touch on the shoulder) can be as effective as words and less worrisome to the client.
- Do not go into lengthy explanations of why you are making the suggestion/offering an observation—save that for the post-practice feedback session. Simple suggestions to facilitate the procedure can be made in a quiet, direct
Chapter 7

manner. For example, the trainer might say, “Try manipulating the tenaculum with your middle finger and thumb, rather than your first finger and thumb.”

- **To help a learner avoid making a mistake**, the trainer can calmly ask a simple, straightforward question about the procedure itself. If a step in a procedure is about to be missed, for example, asking the learner to name the next step before doing anything further could serve as a reminder and help him/her avoid an error. This is not the time to ask hypothetical questions about potential complications of the error, as this may distract the learner and alarm the client.

- Sometimes, even though they have had extensive practice on models or in a role play, or have completed a task successfully with earlier clients, learners make mistakes that can potentially harm the client. In these instances, the trainer must be prepared to step in and take over the procedure at a moment’s notice. This should be done calmly and with complete control to avoid unnecessarily alarming the client.

- If the learner encounters unexpected difficulty in performing a skill during a client interaction, provide the coaching or help needed in a way that helps maintain learner confidence. Always allow time for adequate de-briefing of learners as soon as possible after a difficult client interaction (e.g., at the post-clinical meeting). Key to corrective coaching are:
  - Reassuring learners that difficult cases cannot always be predicted;
  - Letting learners take the lead in identifying what they are doing well and how they can improve; and
  - Focusing corrective feedback on errors that matter most (could harm or cause discomfort to the client), and avoiding excessive negative feedback.

**Obtaining Feedback from Clinical Staff**

Clinic staff should also be aware of the feedback the trainer would like to receive from them about learners. Trainers should also solicit their feedback on the training as well (logistics, effect on clinical care, suggestions for improvement, etc.). When designing the feedback system (see Exhibit 8-4, page 111), the trainer should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinic staff, who already have a very busy schedule. It is best to keep the system as simple and easy to use as possible.
Structured Feedback Reports

These reports provide a standardized way to give feedback to learners on their performance over the course of a specific time period. Structured feedback reports are typically used in pre-service education, or for courses that require the use of clinical preceptors to help supervise learning in the clinical environment. When you use this method, you are assessing sustained performance rather than just taking “a snapshot” as you would with an isolated assessment or examination. Trainers and clinical instructors (and later, clinical staff) working with or alongside learners can complete these feedback reports. They can cover areas such as overall performance, demonstrated attitudes and essential health care delivery skills. They are particularly useful for assessing characteristics such as professional ethics and attitudes, which are difficult to evaluate using other methods. Most feedback reports include objective rating scales to allow the assessor to provide a quick formative assessment of the learner’s performance.

Standardized feedback reports are useful because they:

- Are easy to use, efficient and consistent
- Provide a formal structure for assessment, particularly formative assessment
- Reinforce essential skills
- Ensure that each learner receives feedback on important, but hard to measure, aspects of service delivery

Trainers should discuss the reports with the learners at various stages throughout the course so that they can give them useful feedback.

Sample: See Sample B-9. Structured Feedback Form (used for pre-service education) in Appendix B.

TIPS FOR CONDUCTING ASSESSMENTS IN THE CLINIC
Building Competence and Confidence with Actual Clients

In the clinical setting, the trainer continues monitoring learners’ progress and coaching them toward competency (remember: actual competency can be achieved only with actual patients!), while also playing a supervisory role and managing/coordinating many logistical aspects of clinical practice. For this reason (depending on the program), qualified clinical staff may share in many of the trainer’s responsibilities—particularly with regard to conducting formative assessment and providing feedback. With the support of the clinical staff (if applicable), the trainer continues to use direct observation (with modifications to protect clients’ rights, etc.) and standardized feedback forms as major methods of formative assessment. Three additional tools may also be incorporated: review of skills portfolios, case logs and medical records (described below). By the end of this phase in training, learners’ performance will be again be formally evaluated according to the validated skills checklist (summative assessment), which will enable the trainer to determine whether they have the level of skills competence needed to practice their skills with actual clients in a clinical setting.

- Skills portfolio review: Learners should understand the importance of documenting or tracking their training experiences, successes and lessons learned. The trainer may review the portfolio with the learner, or have the learner review it him/herself. Either way, reflecting on their learning process helps health care providers continue to grow professionally. Like the individualized learning plan, the skills portfolio is mainly a means of involving the learners in identifying, assessing and working to meet their own needs.
Case log review: During longer courses, the trainer may review the case log at the end of each clinical day to determine what experiences are still needed. This provides an opportunity to provide concrete feedback to learners and also helps the trainer plan for the following clinical practice experience—to ensure that it meets learners’ needs.

Medical record review provides an opportunity to assess the quality of clinical decisions made by learners, as well as their ability to document/record the care that they have delivered. To successfully conduct a record review:

- Have six to eight random medical records available that are related to the training related competencies.
- Establish clear criteria for reviewing each record, for example: clinical decisions made, consultations or referrals, care and treatment, outcomes and documentation.
- Discuss your observations with the learner.

Final Summative Assessment to Determine Qualification

Situation 7-4: You have been asked to conduct a course for tuberculosis and HIV integration. In this course you will be presenting information to the learners, and they will be practicing clinical skills with anatomic models and with clients. During the course overview, one of the learners asks you, “How will you make sure we are qualified to manage tuberculosis and HIV?” How do you answer this question?

As a proficient service provider in his/her own right, the trainer observes the learner’s performance in this setting and ultimately considers the following required areas of achievement:

- Knowledge. To be qualified, a learner must earn a passing score on the course’s final knowledge assessment. Did the learner pass the post-course knowledge assessment provided?

- Skills. To be qualified, a learner must demonstrate satisfactory performance of clinical activities and skills as evaluated by the clinical trainer using a competency-based skills checklist. In determining whether the learner is competent, the clinical trainer will observe and rate the learner’s performance for each step of the skill or activity. The learner must be rated “satisfactory” in each skill or activity to be evaluated as competent and eligible for qualification. Did the learner demonstrate mastery of the skills with clients, based on the checklist provided?

- Practice. To be qualified, the learner must demonstrate the ability to provide client services in the clinical setting. During the course, it is the clinical trainer’s responsibility to observe each learner’s overall performance in providing client services. This will include summative knowledge and skills assessments, but also review of the learner’s case log, skills portfolio and medical records. Also, as part of this evaluation, the clinical trainer can assess the impact on clients of the learner’s attitudes—a critical component of high-quality service delivery. Only by observing how the learner applies his/her newly acquired knowledge and skills
with actual clients can the trainer make the final determination of whether the learner should receive that statement of qualification. *Can the learner be considered ready to provide beginning-level services to clients—safely, effectively and independently?*

If the answer is “yes,” to all of these questions, the trainer has determined that the learner should be qualified.

**Objective Structured Clinical Examinations (OSCE)**

OSCE can assess knowledge, skills and attitudes. It is not so much an assessment method as an “administrative structure” in which a variety of assessment methods can be incorporated. Through OSCE, learners typically rotate through a series of “stations” in which they answer questions (orally or written) or perform tasks while being observed. When OSCE is used summatively, only prescribed, validated methods/tools should be incorporated.

**Samples:** See Sample B-10. Final Pre-Service Clinical Practice Feedback Form and Sample B-11. Final In-Service Clinical Practice Feedback Form in Appendix B.

**CHAPTER SUMMARY**

- Clinical practice is the best opportunity for learners to synthesize the knowledge, skills and attitudes expected in a “real-life” situation that is as similar as possible to their actual workplaces.

- Building on simulated practice, learners acquire simple to complex skills with actual patients—moving toward greater independence.

- It is the trainer’s responsibility to ensure a “humane experience” by ensuring that client safety is a priority and client rights are observed, and by managing learner stress.

- Depending on your type of training program, clinic staff may provide a supervisory role and need to be prepared and provided with the appropriate assessment tools. This requires careful preparation and ongoing, close collaboration.

- You, as the trainer, are responsible for the quality of the learning experience and for completing the assessments required.
SECTION THREE: PLANNING, MANAGING AND FOLLOWING UP A CLINICAL SKILLS COURSE
PLANNING FOR A CLINICAL SKILLS COURSE

INTRODUCTION
A successful training course does not come about by accident, but rather through careful planning. This planning takes thought, time, preparation and often some study on the part of the clinical trainer. Well-planned and well-executed classroom and clinic sessions will help to create a positive learning environment, thereby making the course as effective and efficient as possible.

This chapter will help support the candidate clinical trainer in planning a clinical skills course, and will continue to be a key resource once the trainer is qualified to lead training activities independently.

COURSE PLANNING OVERVIEW AND TIMELINE
Planning a clinical training course requires a considerable amount of time and attention to detail and ideally should begin at least six months before the course. A typical timeline for planning activities is presented in Exhibit 8-1.

Once the need for a course has been established, basic elements of the planning process for the trainer may include several or all of the following elements:

- Establishing roles/responsibilities
- Ensuring that basic logistics are being coordinated
- Becoming familiar with the course and course materials (including making adaptations as needed to fit the local setting, unusual time constraints, etc.)
- Selecting, inviting and meeting learners
- Choosing and preparing the classroom space
- Choosing and preparing the clinical facility(ies); and clinical staff
- Preparing for specific course sessions/activities
Chapter 8

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

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

GENERAL PLANNING ISSUES

Roles/Responsibilities

Well before the course begins, the qualified clinical trainer can obtain information about the classroom and clinical requirements for the course, as well as the materials, supplies and equipment needed for each learning activity, from the course outline in the Facilitator’s Guide/Trainer’s Notebook. The clinical trainer is responsible for making sure the sites are prepared and that all necessary materials are available, organized and ready for use before the course begins. She/he is also responsible for the following, which require prior planning and a significant time investment:

- Ensuring that the course is carried out essentially as is designed and that validated tools are not modified in any way, while adapting (or assisting in adapting) materials/methods to the local setting as needed (discussed further in Exhibit 8-2);
Conducting classroom sessions and clinical practice sessions, which are an integral part of a clinical skills course, appropriately and according to established principles;

Facilitating presentations, discussions, skills demonstration and practice sessions, and other skills development and assessment activities, appropriately and according to established principles.

The trainer may also be responsible for other aspects of the course and should work closely with program staff to clarify his/her exact role, as well as those of others, to avoid duplication of effort and logistical gaps.

**Note:** Although clinical trainers may adapt an existing course to the local setting (e.g., to emphasize diagnosing malaria in pregnancy as part of focused antenatal care in a malaria-endemic area), they do not develop courses. Course design is the domain of master trainers. This is because a trainer needs special training, knowledge and experience in order to write primary and enabling objectives, select appropriate training methods and materials, etc. These topics lie beyond the scope of this manual.²

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### Basic Logistics

There are a number of administrative arrangements for which the clinical trainer will likely have no direct responsibility, such as arranging for housing accommodations or per diem payments. In the interest of minimizing problems at the beginning of the course, however, the clinical trainer should work closely with the person who is handling these arrangements to make certain that all administrative details are taken care of promptly. These details include:

- Scheduling classroom and clinic site(s) and informing appropriate staff of upcoming training
- Confirming financial support, including how travel costs, per diem payments or housing allowances will be paid to or on behalf of the learners
- Making arrangements for learners, including housing accommodations and transportation to and from the course
- Making arrangements for refreshments (for morning and afternoon breaks) and meals
- Providing pertinent information to learners (e.g., course syllabus, financial and housing arrangements) before the course begins
- Obtaining learning materials, equipment and supplies needed for course activities, including for clinical practice (if necessary)

### Course/Course Materials

**Situation 8-1:** You have been conducting very successful 10-day IUD courses. You are asked to conduct the same course for the same number of learners, but to do it in only five days. How would you respond to this request?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

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As discussed, use of standardized learning materials helps to ensure consistency in the transfer of knowledge and skills and in objective evaluation of learner performance. Clinical trainers therefore are typically provided with fully prepared, pre-tested LRP, which contain all of the materials the trainers and learners need for the course. A typical learning package consists of:

- **A content-specific reference manual**: From a content perspective, the reference manual provides all of the essential, “need-to-know” information for conducting the course in a logical manner. Because it serves as the “text” for the learners and the “reference source” for the clinical trainer, special handouts usually are not needed. Because the manual contains only information that is consistent with course goals and objectives, it becomes an integral part of all classroom and clinical activities—as well as a readily available reference for learners upon return to their home clinics or hospitals.

  **Note**: Country-specific supplemental material may be prepared and included in the course as appropriate. Examples: the country’s demographic profile, medical records and reporting system; national or local health care guidelines; local drug lists.

- **Courseware for the learner and trainer** (e.g., a learner’s handbook and trainer’s notebook):
  - The **learner’s guide** (or “notebook,” “handbook”) serves as the “road map” to guide the learner through each phase of the course. It contains a model course syllabus and schedule, as well as all supplemental printed materials such as the pre-course knowledge assessment, skills development checklists, learning exercises and tools, and the course evaluation.
  - The **trainer’s guide** (or “notebook”) contains the learner’s materials as well as trainer-specific information such as the model; course outline, answer keys to the knowledge assessments and certain exercises, and competency-based knowledge and skill assessment instruments. Before the course, the clinical trainer should: (1) review the outline carefully with the local setting in mind, and (2) determine what changes, if any, are needed regarding allocation of classroom and clinic time (Exhibit 8-2).

- **Anatomic models and audiovisual or other learning aids**: Such materials are used for classroom demonstrations and practice of skills and activities. Examples include a pelvic model (ZOE) for IUD skills training, an audiovisual demonstration of active management of third stage of labor, and flip charts or whiteboards to reinforce key information or capture important points that arise during discussion.
Exhibit 8-2. Guidance on Adapting Materials

When trainers are just learning to use a standardized LRP, the focus is on how to use the components of the package to conduct the course “as designed.” But as trainers become proficient at delivering the standardized course, they will begin to see ways to adapt materials to better meet course requirements or learner needs. The model course outline included in a standardized package is intended to serve as a model for the clinical trainer, and is designed to permit the course learners and clinical trainer the widest possible latitude in adapting the training to the learners’ individual and group learning needs.

There are a number of reasons a trainer might adapt the LRP/outline for a clinical skills course, including:

- The number of days available to conduct the course differs from the number of days in the model course schedule.
- The number of learners is significantly larger or smaller than the number specified in the course syllabus.
- New information or skills need to be added to a course. For example, a group of learners in a male circumcision skills course needs refresher training in infection prevention.
- Clients are available only at specific times.
- Specific types of clients are available only at specific times.
- The results of the pre-course knowledge or skills assessment indicate a need to emphasize or de-emphasize certain topics, which results in changes to the course schedule.
- Learners must finish early each day because of organizational or institutional commitments.

Note: The schedule and learning activities for a course with a clinical skills component can be adapted or modified only to the extent that client safety is not compromised.

If a course outline is modified, some parts of the standard learning package (e.g., the course schedule) will need to be revised also to reflect the changes. Learners should receive a copy of the new documents on the first day of the course. Again, other items—particularly the final knowledge assessments, skills checklists and training performance standards—should not be changed for individual courses.

Learner Selection

Situation 8-2: During the introductions at the beginning of a clinical skills course for service providers, you discover that one of your learners does not meet the selection criteria and should not be participating in the course. What would you do?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Selection of appropriate learners is critical to the success of any course. The trainer may have an excellent course design, materials, clinical and classroom facilities and supporting audiovisuals, but these mean very little if the wrong learners attend the course. Having clear, agreed-upon criteria for course learners is crucial.

For most courses there is a syllabus, which contains a range of information about a course. A key element of the course syllabus is the learner selection criteria, which should be considered when selecting learners for a clinical skills course (e.g., IUD, male circumcision):

- Must be health care providers (e.g., nurses, nurse midwives, physicians) who are currently providing health services.
- Should have an interest in providing the health service(s) upon which the course is based.
- Work in a facility (e.g., clinic, hospital) that is capable of offering the health service(s) upon which the course is based (i.e., has adequate caseload, staffing,
Should have the support of their supervisors or managers, which is necessary to achieving improved job performance. Trainers should open the lines of communication with them—ensuring that they:

- Endorse the clinical training,
- Encourage attendance and participation,
- Actively participate in the transfer of new knowledge and skills to the workplace, and
- Provide support when the clinician who has received training begins to apply newly acquired skills on the job.

In addition:

- Two individuals from each site should be invited to attend training, when appropriate. Training pairs of clinicians makes it more likely that the new skills will be used when learners return to their sites, because they will be able to assist and coach each other at their workplace.

- They should be selected and notified two to three months in advance of the course, whenever possible. As part of their invitation, learners (and their supervisors, if appropriate) should be sent, at minimum:
  - Basic information about the course (dates, location and logistical information); and
  - A copy of the course syllabus from the learner’s handbook. The syllabus describes the course and its goals, learning materials, learner selection criteria and how the learners will be evaluated.

- If all the learners are coming from the same geographic area and the trainer has the organizational and financial support to do so, she/he should visit the clinical sites of some or all of the learners before the course. This:
  - Enables the trainer to observe clinical skills, infection prevention practices, counseling procedures, etc.—to ensure that course objectives, content and activities will match the needs and capabilities of the learners; and
  - Gives learners a chance to begin establishing a relationship with the trainer and to gain a clearer understanding of what they will learn in the course.

**CLASSROOM SELECTION AND ARRANGEMENTS**

**Situation 8-3:** You arrive early on the first day of the course. You find that the classroom is large enough, but contains only chairs. There are no tables or audiovisual equipment in the room. Outside of the room there is a table for registration, but you see no area for the morning tea break. What could have prevented this problem? What should you do right now?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.
Group-based training is typically held in a facility compound, training center or hotel. The classroom for a group-based course is usually located close to, or in the same building as, the clinic where the clinical portion of training will be held, or it is in a hotel where the learners are staying. Either way, you will also want to ensure that it is convenient to the clinical site, keeping in mind the following:

- If the classroom is too far from where the learners are staying or from the clinical site, this will mean additional expenses and logistics to manage.
- If the classroom (and this is where the clinical portion of training will be held) is in the learners’ workplace, they may become distracted by job obligations.

Here are some other important considerations when selecting a site for your “classroom.” Ensure that:

- This course is the only event scheduled in the room for the entire time period (e.g., 10-day course) to avoid having to move equipment, pack up models, remove flip chart pages from the walls, etc., at the end of each day.
- The space is large enough for the number of learners and to accommodate:
  - Tables arranged in a U-shape or other formation that will allow as many of the learners as possible to see one another, the trainer and a projection screen, writing board, etc.
  - A table in the front of the room where the trainers can place their course materials
  - Audiovisual equipment (e.g., flip chart, screen, overhead projector, video player, monitor)
  - Small group activities (i.e., either space to arrange chairs in small circles or work around the tables or, ideally, separate breakout rooms)
  - Simulated clinics (e.g., for activities with anatomic models or counseling practice)
- The room is comfortable and conducive to learning:
  - Is “temperature controlled”—properly heated or cooled—and ventilated
  - Has adequate lighting (and can be darkened enough to show audiovisuals and still permit learners to take notes or follow along in their learning materials)
  - Is quiet (away from distracting sounds) or can easily be made quiet
  - Is adequately furnished with tables, comfortable chairs, desk(s), etc., or such furniture is available
  - Has an adequate, reliable electrical power supply (and you should have a contingency plan in case the power fails)
- The room has (or can accommodate) all of the following equipment, which should be in working order:
  - A writing board with chalk or marking pens as appropriate
  - An information board for posting notes and messages for learners
Audiovisual equipment (with spare bulbs, a video monitor large enough that all learners can see it well, etc.)

- Sufficient electrical connections, extension cords, electrical adaptors and power strips (multi-plugs)
- Back-up power source and surge protector for the box light projector, laptop, etc.

- The facility has toilets that are adequately maintained and telephones that are accessible and in working order (and emergency messages can be taken).

**Note:** The trainer will likely be involved in planning meals and refreshments for morning and afternoon breaks. She/he will need to work with others to determine whether learners will eat inside the classroom, in another room or in the cafeteria; what will be served and how; etc.

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**Before the course begins (the day before at the latest),** the trainer must ensure that the classroom is completely ready to receive learners. She/he should have all of the training materials, materials for the learners, audiovisual aids, anatomic models and other equipment arranged and ready to go.

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**CLINIC SELECTION AND ARRANGEMENTS**

**Situation 8-4:** On the third day of the course, you take the 12 learners for a tour and introduce them to the staff of the clinic where they will have their practice sessions. You meet the clinic supervisor and learn not only that staff did not know that you and your learners were coming, but that there will probably be an insufficient number of clients with whom the learners can work. What could have prevented this problem? What should you do right now?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

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**Establishing Clinical Practice Sites**

Many teaching institutions have arrangements with health facilities for clinical practice sessions. As a clinical trainer, you should visit the clinical practice site before the course begins. Ideally, training programs develop specific training sites over time by establishing relationships between facility management and staff, improving service delivery practices and upgrading facilities when needed. If not, clinic visits prior to the course are essential to begin establishing relationships and obtaining support you need from management and clinical staff.

When assessing an existing or a potential new clinical site to ensure learners’ exposure to a variety of appropriate and relevant clinical experiences, consider the following:

- **Are the service delivery environment and practices consistent with the skills being taught?** The clinical site operates in a way that is consistent with what is being taught. And staff should provide high-quality services, including recommended infection prevention practices, in accordance with the performance standards or national guidelines and protocols promoted in course.
Is the facility appropriate for this group of learners? It is also important that clinical practice occurs in a facility similar to the type of setting in which the learners actually work in.

Are staff receptive to supervising learners? Ensure that staff are receptive to having learners come to their site to practice applying their new skills.

Note: If working regularly with a facility, you may be able to implement changes or create incentives to enhance the staff’s and facility’s ability to host learners. One strategy might be to provide the staff/facility supplies, training or facility upgrades, or other items of value. Another might be to motivate staff by reminding them of the benefits of their assistance, not only to learners but also to clients, and by adequately preparing them and paying them to work as clinical preceptors when appropriate.

Is the facility physically adequate and well-equipped to accommodate the learners and learning experience? The clinical site should be large enough that everyone—learners, the trainer(s), and patients and staff—can move about without interrupting patient flow and service provision, and without compromising patient safety and quality of services. You should also confirm the availability and quality of instruments, equipment and supplies needed.

Will there be enough clients (of the right type) to provide sufficient opportunities for practice and assessment for every learner in each of the essential skills? Carefully consider the objectives that must be met and competencies that need to be practiced within the clinical setting. Ensure that the numbers and types of clients coming to the clinic who require care involving the skills being practiced are sufficient to provide adequate practice and assessment opportunities for all learners.

Will there be enough clinical trainers or instructors/preceptors at the clinical site to ensure proper supervision for each clinical practice session? Ensuring that learners get what they need (experience with clients) with proper supervision—while avoiding overcrowding a clinic or area of a clinic—is a complex but critical issue that may require a complex solution (Exhibit 8-3).

Exhibit 8-3. Planning to Maximize Learner Opportunities

<table>
<thead>
<tr>
<th>To maximize learner opportunities for working with real clients, while ensuring the quality of the learning experience and safety of clients, the trainer may need to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Schedule clinical practice for times that have heaviest client flow. This strategy alone greatly increases learners’ chances of being exposed to greater numbers of clients who are relevant to course objectives. You may need to adjust the schedule so that, for example, classroom sessions are in the afternoon and clinical practice is during the morning, when the clinic is busiest.</td>
</tr>
<tr>
<td>• Divide the learners into smaller groups and schedule different rotations (staggering the times when learners do their clinical practice session); this allows smaller groups of learners to rotate through a larger numbers of facilities, and thus gain more individual access to more clients.</td>
</tr>
<tr>
<td>• Conduct the course in the facility itself, if possible, or very close to it, and keep a flexible schedule for the clinical practice component. This enables learners to more readily participate in emergencies or unusual clinical situations that may occur.</td>
</tr>
<tr>
<td>• Spread clinical practice out over a network of clinical practice sites, where experienced staff headed by a clinical preceptor have been prepared to supervise the learners’ practice in the clinical training. Use several separate clinical sites.</td>
</tr>
</tbody>
</table>
Is the site easily accessible for learners and trainers and others on the training team? Is the site close to the teaching institution or easily accessible using public transportation? Will special arrangements need to be made for transportation? Select a site that is as easy to reach as possible. But again, if the clinical practice site is near a learner’s workplace, the learner may not be able to focus on learning, being distracted by other obligations.

Is this clinical site up-to-date in meeting learning needs? If it is an existing clinical practice site, is it still appropriate? It is important to periodically review whether or not existing sites are meeting the learning objectives of a course.

Consider all of these factors when selecting clinical sites. It is most important that the clinical site and staff practice in a manner consistent with what you are teaching. As few clinical sites will meet all of the criteria, providing adequate clinical practice is often a challenge. This is one reason humanistic learning is so important—if the learner comes to the clinic well-prepared to work with clients (having reached a certain level of competence with models), this makes the best use of everyone’s time.

Selecting and Preparing Clinical Staff

Perhaps the most important aspect of planning for a clinical skills course is selecting and preparing the clinical staff who will assist with clinical practice sessions. Prepared clinical staff may already be in place at certain clinical practice sites, or they may need to be recruited. Either way, these individuals should have the following attributes:

- Time available and a desire to work with learners
- Proficient health care delivery skills that are consistent with what is being taught
- Excellent interpersonal communication skills
- Organizational skills
- Teaching skills

The assistance provided by clinical staff ranges from providing supervisory support to the trainer to acting as on-site clinical instructors, working right alongside learners—demonstrating procedures, observing them practice and providing feedback to them as they work with patients. If staff will be playing this more active role, the trainer must ensure that:

- Their clinical knowledge and skills are up-to-date and consistent with what is being taught; and
- They have the training/facilitating skills—such as demonstrating with models, coaching and providing feedback, observing and performing assessments—that they will need in working with learners.

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7 Teaching institutions will sometimes have standing agreements with clinical sites to provide clinical practice opportunities for their learners. There may be a documented agreement between a teaching institution and clinical practice site that describes performance expected from the learners, trainers, clinical instructors, clinical staff and others involved with teaching. If a formal agreement does not exist for the clinical practice site, clarifying expectations is even more important.
Building these skills initially may require considerable effort, including providing workshops, educational materials, etc. Thereafter, the staff’s clinical and training skills should be assessed and updated periodically.

Whether the trainer’s relationship with the staff is ongoing or newly established, she/he should visit the facility well before the course begins to:

- **Clarify staff roles.** Will they be sharing in supervising and/or training learners?

- **Observe staff to verify that they have the skills** needed to perform their designated roles. There may be time to work with staff members to improve their skills, if needed.

- **Discuss the course objectives and specific competencies that learners will be practicing with actual clients.** Regardless of their level of involvement, staff should be familiarized with checklists and know how to use them.

- **Review the general plan for integrating training with normal facility operations.** Will the learners be split up into groups, work in rotation, etc.?

- **Discuss the feedback the trainer would like to receive from them about the learners** (see Exhibit 8-4).

### Exhibit 8-4. Guidelines for Designing a Clinical Staff Feedback System

When designing the feedback system, the trainer should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinic staff, who already have a very busy schedule. It is best to keep the system as simple and easy to use as possible.

Issues to consider when arranging for gathering such feedback from staff include the following:

- **Will it be oral, written or both?** If written feedback is needed, and the LRP does not contain such a form, the trainer should design an instrument or form to guide the clinic staff. The trainer should furnish a sufficient number of copies of the form and instruct the staff in its use. Samples B-10 and B-11 (in Appendix B) are clinical practice feedback forms for pre-service and in-service training respectively. The trainer should develop a form that staff members can complete quickly and easily.

- **How frequently will feedback be provided?** Daily? Weekly? Only at the end of training? Daily feedback may be most appropriate/helpful for new clinical practice sites, whereas weekly or even end-of-training feedback may be sufficient for more “seasoned” sites.

- **Do staff understand that both positive and corrective feedback should be provided?** Make sure they understand that their feedback can help improve an individual learner’s performance, as well as the overall effectiveness of the training. The trainer will need to decide if, when and how to provide corrective feedback to a specific learner, but ideally it should be provided as close to the point of care as possible.

- **Are there appropriate administrative channels through which the feedback should be transmitted?** In some clinics, for example, staff members provide their feedback to the individual in charge of the clinic who then prepares a report for the trainer.

**Note:** Trainers should also solicit clinic staff members’ feedback on the training as well (logistics, effect on clinical care, suggestions for improvement, etc.).
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Laying the Groundwork for Success in the Clinical Setting
At the very least, staff should understand the overall purpose and objectives of the course, as well as the importance of the clinical practice component. Ultimately, the trainer will need to rely on the staff’s cooperation in notifying him/her of unique, unusual or especially pertinent client situations and allowing learners to provide services to these clients.

Preparing the Clinical Practice Environment

Prepare for the clinical practice session by making sure the **physical environment** will support your objectives. Once an appropriate site has been selected, consider all the different aspects of clinical practice as you prepare for the activity—the physical environment, logistics, patient caseload and the clinic staff. Consider the following questions when preparing for clinical practice:

- **Has a room been reserved for gathering the learners for discussion or small group activities?** You will need some space for meeting with learners before and after each clinical experience. If there are times when there are no patients, the meeting room can be used for the learners to participate in case studies, role plays or other small group activities. Arrange for a room or space before the clinical practice session.

- **Again, are the essential drugs, supplies and equipment available?** For example, for IMCI, the essential IMCI drugs and supplies must be available for learning to treat the sick child. Clinical facilities must have enough instruments and supplies to provide services to patients on an ongoing basis. It may be necessary to supplement the clinic’s basic supplies of consumable items (e.g., gloves) and to bring additional instruments needed for the procedure to be taught (or even to ask learners to bring supplies/equipment).

Another important aspect of preparing the clinical practice environment is managing **logistics**. Consider the following as you prepare:

- **With whom do you need to coordinate clinical practice?** Who in administration, the clinic or floor management needs to assist you in making arrangements for and conducting clinical practice? Arrange times with site administration and the head of the related floor or area for the clinical visit.

- **Is practice scheduled at a time when patients are available and that is convenient for clinical staff?** You should schedule practice at times when learners will have enough exposure to patients but not interfere with regular service provision.

- **What preparations are needed to ensure adequate and appropriate patient flow for clinical practice sessions?** The patient caseload has already been considered during selection of the clinical site, so preparations involve ensuring appropriate patient caseload and flow for each clinical practice session. Consider the following as you prepare:
  - Will you need to schedule patients? Certain skills (antenatal exams, breastfeeding assessment and counseling) may require scheduling patients to ensure a sufficient caseload. Coordinate with the staff to arrange for a sufficient number of appropriate patients for the clinical practice visit.
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- Are there appropriate types of patients in the appropriate numbers? The type of patients is just as important as the number of patients. If patients who request certain procedures or who have specified health problems are needed, arrange with clinic staff to schedule appointments or help select appropriate patients from the wards.

Well before the course begins, recruit clients through a health education campaign and have them sign up to receive targeted services during the clinical practice part of the training. This can be done by posting flyers in the facility and surrounding area well in advance. The flyer should state the purpose of the training and welcome clients to participate. Clinic staff can also help spread the word.

Using Objectives to Plan Clinical Practice Activities

After the learning objectives have been reviewed and defined, work with clinical staff to determine which objectives are best met in the outpatient department, the inpatient ward or even in the home setting.

**Outpatient Department**

The outpatient department provides many excellent opportunities for learners to develop health care delivery skills. The outpatient department is the point of first contact with most patients and, therefore, is the most appropriate place to practice interviewing and interpersonal and counseling skills as well as clinical skills. Below are some examples of learning objectives that can be met in the outpatient setting:

- Use effective communication techniques when interviewing a patient
- Perform a physical examination
- Observe an IUD insertion
- Provide family planning counseling and methods
- Classify the severity of an illness or suggest a diagnosis
- Provide counseling and testing for HIV
- Educate and counsel a patient or caretaker
- Advise a mother about when to return to the clinic

**Inpatient Ward**

In inpatient settings, patients are usually seriously ill, and have already started a care plan and specific treatments. Inpatient wards are a good place to teach patient management, practice health care delivery skills, and demonstrate management of rarely seen conditions. The inpatient ward may help learners meet some of the following skill objectives:

- Assess clinical status
- Perform specific clinical interventions such as administering an intravenous solution
- Document information on the patient’s plan of care, treatment and changes in condition
Communicate clearly with clinical staff and family (as appropriate) the findings about a patient

Review diagnostic test results and apply them to the patient’s condition

External Clinics and Home Visits
Some programs have a community or home-based component, and some may depend on distant clinics for clinical practice opportunities. These sites may be useful for meeting objectives around the following skills:

- Assessment of environmental hazards
- Group and individual education skills
- Communication skills
- History-taking skills
- Infant and postpartum visit assessment skills

PRE-COURSE TRAINER TASKS
Preparation for training falls into two categories: getting ready for the course in general (e.g., obtaining necessary supplies and equipment), as previously discussed; and planning for individual training sessions and learning activities, which is the focus of this section.

The foundation of effective training is organization—both at the “course level” and at the individual “session/learning activity level.” It is critical that trainers be well-prepared as there are so many different components and elements to manage and coordinate, as well as unknown variables. A major focus of preparation is addressing logistical details and anticipating possible challenges to ensure that the course/session flows smoothly, which limits distractions, reduces stress and makes the most of precious time during the course. In this way, good preparation also demonstrates to the learners that the trainer values and respects them and their time and supports their commitment to learning.

Course-Level Preparation
Preparation before the course is essential. If the trainer is involved in conducting training needs assessment related to the course, he/she will be in a better position to revise the course if needed to meet the identified learning needs. If the trainer is not involved in the needs assessment, there is still a lot of basic, course-level preparation to do. This includes reading and reviewing the course materials, gathering basic information about the learners if possible, practicing all clinical procedures if needed, and checking all supplies and equipment.

- **Review the materials.** As previously described, a typical learning package contains a reference text, learner’s materials, trainer’s materials, audiovisual accompaniments (e.g., a computer-based slides presentation) and any other necessary resources (e.g., an anatomic model). Some courses may include an electronic media component as well, delivered via the Web, CD-ROM, flash drive or other means. In reviewing the course materials, the trainer should pay special attention to the following:
- **Course syllabus and schedule**: These present learner selection criteria, course goals and objectives, assessment methods and an overview of daily activities.

- **Model course outline**: This provides general guidance for conducting the individual sessions and learning activities, identifying the materials needed to facilitate each; a close review of the course outline will help the trainer plan for each day.

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The Trainer’s “Toolbox”

As a trainer, you have a range of key tools available to you to help you develop a workable plan for the course. Use them!

- **Defining the plan**: The learner’s syllabus and schedule, the trainer’s outline, and the various assessment tools and exercises are critical in organizing the overall course and individual sessions.

- **Revising the plan**: These same tools are important in revising/modifying a course based on any specific training needs identified (either through a pre-course needs assessment, pre-course knowledge assessment or other means). You would begin by adapting the course schedule and then revise the course outline accordingly. But remember: although some assessment tools and exercises may also be modified to meet specific needs, others (i.e., final knowledge assessments and skills checklists) should be used as is.

- **Fine-tuning the plan**: Many of the same tools also provide a basis for trainer’s notes, which you will need to prepare for each activity. Learning packages vary in terms of the amount of detailed guidance they offer, and trainer’s notes help close the gap between what is provided and what an individual trainer needs to conduct sessions and activities most efficiently and effectively. Essentially, these notes are your reminders to yourself—of key questions to ask to assess learner understanding or progress, of relevant materials to reference at specific times to reinforce important information, of logistical details to address to improve the flow of an activity, and the like. (Trainer’s notes are further discussed on pages 116–117.)

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- **When possible, find out about the learners who are attending, as well as the results of any training needs assessments that were done.**
  - If possible, find out about their educational backgrounds, job responsibilities and the facilities in which they work.
  - Review results from a training needs assessment if conducted (or if your program has used standards to identify training needs).
  - Use any additional information you can gather as the basis of planning/revising the course, increasing time for training needs identified and reducing time spent on areas that are already performed well.

- **Practice all skills that you will be teaching using assessment tools provided** to be sure you are ready to demonstrate them correctly (and in the “standardized” way). If clinical simulations are included in the package, review them to be sure that you are ready to facilitate those activities. Also complete any exercises and take the pre- and post-knowledge assessment to be sure you know the content well.

- **Check all equipment and supplies** to make sure everything is in good working condition and available in adequate quantities. Check audiovisual equipment, anatomic models, instruments or other equipment and supplies required for the
course. Make sure you have all of the print materials you need for training, including any handouts, job aids or other materials.

**Tips for Preparing for a Blended Learning Course**

If you are facilitating a “blended learning course” that requires the learners to complete the content component of a course (which focuses on acquiring new knowledge) before they attend a group-based session (which generally focuses on skills training), here are some tips for preparation:

- Build in time and assign staff to provide materials needed for the content component and follow up to ensure learners have completed it in time. This can be done through phone calls and e-mail reminders, or arranging for learners to come to a central location to complete this component (such as having them come to an office in small groups), or setting them up at the office or the sites where they work. Such measures also apply for training approaches that involve paper-based individualized learning in a facility before skills training—learners need support (time, resources, follow-up) to complete this first component before they practice skills in simulation and ultimately work with clients.

- If the course involves the use of computers to complete the content, then training programs need to address the issue of computer-competency of learners. In some programs, learners have never really worked with a computer, so they will need some basic coaching before they get started. In other programs, access to computers may be more of an issue. Whatever the case, you should ensure that everyone can get to a computer and use it in order to complete the content component of the course in a timely fashion.

- Create a plan for “remedial” updates for learners who have not completed the required content in time for the group-based skills component of the course. Programs can allot time for these staff to catch up on the first day of the course. Alternatively, they may establish a policy whereby those who have not completed required content in time are disqualified from attending the group-based session (but may attend a later one, once they have completed the content component).

**Samples:** Refer to your clinical LRP for examples of a course syllabus, model course outline and model course schedule; and/or see the samples from a Lactational Amenorrhea Method skills course in the Resources folder on the ModCAL flash drive—Samples R-6, R-7 and R-8, respectively.

**Session/Activities-Level Preparation**

Here are some key tips for planning for individual sessions or learning activities.

- **Plan to keep on time.** Indicate time limits in your trainer’s notes or note the time limit in the course outline. And while it may sound basic, make sure there’s a clock where you are training so you can keep track of time. This is very important for tight training schedules.

- **Prepare the questions you want to ask in advance and document them using trainer’s notes.** Remember how important questions are for checking understanding and helping involve learners. Take the time to plan what to ask and when to ask it, and then write it down so you don’t forget!

- **Be prepared.** Be ready for changes in time; for example, be ready with the next activity if you move more quickly than expected, and be ready to cut something out if you fall behind in time.

- **Create detailed learning activity plans that expand upon guidance provided in the outline, if needed.**

**Sample:** See Sample B-12. Detailed Learning Activity Plan for IUD Course in Appendix B.
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- **Make, and plan to use, your trainer’s notes.** Trainer’s notes are essential for staying organized. Use them to note times, introduction methods, key points to highlight, questions to ask, and summary for the activity. There are several different ways to do this (Exhibit 8-5).

Exhibit 8-5. Getting and Staying Organized with Trainer’s Notes
Good trainers are organized trainers. A great way to get organized, and maintain that sense of organization throughout the course, is to prepare trainer’s notes for each activity. As described previously, trainer’s notes help you navigate the course most effectively and efficiently, while getting the most out of your learners. Here are several approaches to preparing trainer’s notes.

- **Mark up a reference manual.** Highlight key information in the reference manual or write notes on the pages—list questions you plan to ask, underline key terms or points you want to highlight.
- **Use a printout of your computer slide presentation.** Many trainers use this approach to indicate where they want to ask questions and make key points.
- **Annotate the course outline.** While not as useful on a “micro-level,” this approach can be very useful for providing overall trainer guidance and keeping organized for the day. There’s not a lot of room to note questions and other details, but some trainers like using the course outline to keep themselves focused.
- **Use training tools.** Often these are handouts, activities, or instructions from the learning resource package. You can prepare your own copy with specific notes and additional guidance about that activity.

**CHAPTER SUMMARY**

Effective planning of a training course is a process that starts well before the course begins. As a trainer, you will function in different roles during this process, ensuring that the participants, course materials, and training and clinical practice sites are all appropriately selected and adequately prepared for their part in supporting the learners in achieving competency. When the training course begins, and as it continues to go smoothly, the trainer will find that such careful planning was well worth the effort, and has helped to create an environment where the successful transfer of knowledge, attitudes, and skills can occur.

- Standardized learning materials help to ensure consistency in the transfer of knowledge and skills and in objective evaluation of learner performance.
- Selection of appropriate learners is critical to ensure that the types of individuals selected to attend are those for whom the event was designed.
- Appropriate and well-prepared clinical practice sites and staff are critical to supporting the learners as they progress toward achieving the desired competencies.
- A good trainer is an organized trainer. And the foundation of effective training is good preparation—both at the “course level” and at the individual “session level.” A major focus of the trainer’s preparation is taking care of logistical details and anticipating possible challenges to ensure that the course/session flows smoothly, which limits distractions, reduces stress and makes the most of precious time during the course.

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**Samples:** See Samples B-13 and B-14, training preparation checklists, in Appendix B.
MANAGING PROBLEMS THAT MAY ARISE DURING THE CLINICAL SKILLS COURSE

Preparation—The Best Assurance of Success and of Handling Possible Problems

The best way to avoid potential problems in conducting a clinical skills course is to be well-prepared, but there is no way to ensure that nothing will go wrong. The trainer should, therefore, be able to anticipate and recognize the kinds of problems that may occur and have strategies to cope with them if they do. Problems do not mean that the trainer or learners are incompetent, nor do they indicate that the course is doomed to fail. They only mean that adjustments need to be made—to some aspect of the course—in order to get things back on track. In this too, the trainer has a great opportunity to model problem-solving skills for learners, as well as demonstrates his/her commitment to ensuring a positive learning experience for them. In the end, working through problems may be as valuable as any other experience in the clinical skills course.

INTRODUCTION

Throughout the course, the trainer must manage the day-to-day activities, ensuring that the materials needed are in place and logistics continue to flow smoothly. She/he works to facilitate learning activities and practice sessions in the classroom, while keeping learners engaged and interested and maintaining a positive learning environment. In the clinical setting, the trainer must make the best use of limited time and opportunities—working with clinical staff and learners to maximize learners’ exposure to clients, while putting the comfort and safety of clients first. In the midst of all of this activity and effort, the trainer must also recognize problems that may arise and have strategies at hand for promptly managing them.

HOW TO IMPROVE THE LEARNING ENVIRONMENT

Strengthening Group Process

With practice, the effective clinical trainer becomes confident—about both the content being presented and the status of the group interaction. Knowing when to intervene in the “group life” and when to stand back is a skill that is developed over time. Trainers should seek feedback from co-trainers, or if training alone, arrange to have another trainer come to observe them. Such input can be very helpful, especially regarding more subjective training skills such as maintaining healthy group dynamics. Here are some other practical strategies for gauging the energy of the group and keeping them moving forward.

- **Maintain/reinforce group norms**: Behavior-modeling a calm and professional demeanor is an excellent way to create a calm and professional atmosphere, but it is not always enough. Use the group norms flip chart when needed to remind the group of norms that are not being honored. You can ask the group if they are committed to the norms or if they want to change them. But remember: you are dealing with adult learners; if the group feels that the norms need to be changed, change them. And remain calm, professional and flexible.
- **Manage communication:** To keep group communication on track, survey the learners every now and then, asking questions such as: “Do you see any patterns or trends in the way people are communicating?” “Which seem helpful?” “Which do not?” When there are side conversations, move close to the individuals involved—they will usually stop. Actively involve quieter learners to ensure that other learners do not dominate discussions.

- **Address any obvious tension:** If you have been observing and paying attention to the group, usually you will know the cause of tension when it arises. In some situations, talking to certain individuals separately from the group may be an appropriate strategy. In other situations, engaging the group as a whole may be more effective.

### Cooling Down with Warm-Ups

“Getting-to-know-you” warm-ups are good ways to ease tension. They can be played any time throughout the day to lighten the mood and improve cohesion—or just for fun, to keep energy levels high. See the Resources Folder on the ModCAL for Training Skills flash drive for sample Warm-Ups, as well as sample Icebreakers and Introductions.

As a result of the interactive methods used and the trainer’s management of the group process, a group identity gradually emerges. As they get to know one another in the interactive sessions, learners begin to view the others with respect and value their contributions and questions. This results in an open and trusting climate in which learners can learn.

### Managing Learner and Trainer Stress

Another important aspect of creating a positive learning environment is managing stress—both in learners and clinical trainers. Stress can interfere with the learning process on an individual level, as well as have an impact on the learning environment—affecting the entire group.

Here are some strategies the trainer can use to **identify, understand and respond to learner stress**:

- Remember that learners may be anxious, so **be aware of and sensitive to anxiety**. Observe learners’ behavior and level of participation. If you identify a potential problem, ask individual learners or the group open-ended questions, such as, “How do you feel about how the training is going?” “What would make the training better?”

- If learner anxiety or stress is identified, **try to understand the cause.** Is it related to their performance? The group dynamics? The pace of the course? Again, this may be achieved through talking to individual learners or the group.

- When the cause of learner anxiety or stress has been determined, **respond appropriately.** (Obviously, the response should be based on the cause.) Does the pace of the course need to slow down? Do certain learners need different topics or timelines to master the materials? Is translation help needed? Are there things that can be changed in the environment to reduce stress?
Once action has been taken to address the cause of learner anxiety or stress, ensure that these actions have indeed addressed the problem. Assess learners’ response through observation, questions or anonymous input. It is important to make sure learners feel capable, not overwhelmed and that their opinions count.

New and even experienced clinical trainers may also face stress for a variety of reasons. Here are some strategies for preventing it from affecting the learning experience. Trainers should:

- Be aware that this happens and pay attention to their own stress level, taking steps if necessary to ensure that it does not affect learners.
- Keep their concerns about the course private. Share them with a co-trainer or friend, but do not burden the learners with these issues.
- Manage and reduce their stress. One practical way to do this is to be prepared: review trainer’s notes and any activities they have planned for the next day, practice on their own if needed, arrive early and be sure they have everything ready.

All of these measures, along with self-awareness, will help trainers manage their stress level.

**Make Room for Fun!**

Another great way to keep the stress/anxiety level low is by keeping training fun. For example: Use ice-breakers that you and learners participate in together, as a way to get to know one another and feel more comfortable as a group. Warm-up activities and silly energizers also reduce stress by adding levity to the session and stimulate readiness to learn by keeping everyone engaged. You can even organize “outside” events between sessions, such as a Karaoke or Dance Night—inviting learners to enjoy one another’s company during their “down time.” Specific warm-ups and energizers are described in further detail below.

**Building and Maintaining Learner Energy/Enthusiasm**

The trainer should keep a steady eye on the energy level in the classroom, paying special attention to learners’ readiness and eagerness to learn. Warm-ups and energizers are an effective means of building and maintain energy and enthusiasm. They may be designed and led by the trainer earlier in the course, or be assigned to individual learners or groups of learners later in the course. Whoever leads the activity, she/he should actively engage everyone in the room—trainers, learners and any observers. Warm-ups and energizers:

- May be used in many ways. They can introduce the day’s activities or individual segments, help learners get to know one another, relieve stress or fatigue (or even boredom!) or help to introduce or summarize a concept. They are particularly good for helping learners get to know each other and for raising the level of energy and enthusiasm.
- Can take many forms. They may be games, physical activities or exercises (which are great for after lunch or in the afternoon!). They may be jokes, songs or even friendly competitions.
Are appropriate for any time of day. They are often used in the morning, as people are settling in, or after a break, as people return to the classroom. They are also effective as “transitions” between activities or any time learners seem tired and to be losing attention—such as around 2 pm, after a big lunch!

(Again, see the Resources Folder on the ModCAL for Training Skills flash drive for sample Warms-Ups, as well as sample Icebreakers and Introductions.)

Dealing with Problem Learners

As addressed in Chapter 8, anticipating and managing logistical problems (in the classroom or clinical site) through organization and preparation are a major responsibility of the trainer. Problems with individual learners are more difficult to foresee, but they can pose just as much of a threat to the learning environment and overall success of the course. Experienced clinical trainers can share many stories about difficult moments with individual learners or training groups. A necessary training skill for every trainer to learn is how to handle problem learners without decreasing the motivation and rate of learning of all of the other learners. The majority of learners in a clinical skills course who cause interruptions do so unintentionally, without realizing the effect they are having on others. To further complicate matters, the disruptive behaviors of one or more learners can quickly spread to the others in the group.

Although there is no one way to handle a problem learner, there are a few basic strategies that can be helpful:

- Never embarrass or “put down” the problem learner in front of the others.
- Handle the situation early, before it becomes a serious matter.
- Always use tact and diplomacy.
- Manage personal feelings and remain in control; never show annoyance or lose your temper.

Below is a list of common situations with problem learners that can occur during a clinical skill course, and the corresponding potential solutions that trainers can use to deal with them.

**Problem:** A learner wants to talk all of the time.
**Possible Solutions:**
- Show that you are actively listening by summarizing the learner’s point of view, and then move the discussion forward.
- Ask other learners for their input.
- Ask the problem learner to hold off until a break.

**Problem:** A learner wants to talk about a topic unrelated to the current discussion.
**Possible Solutions:**
- Ask the problem learner to wait until later in the course (if appropriate).
- Ask the learner to meet with you during the next break or at the end of the day to discuss the topic.
Problem: A learner continually talks with another learner.
Possible Solutions: Use nonverbal methods to regain their attention (e.g., make eye contact, move closer).
Ask the problem learner a question (make sure to say the learner’s name first).
Ask these learners if they have a question.
Ask them (privately, if possible) to refrain from talking.

Problem: A learner strongly expresses disagreement with what the trainer says.
Possible Solutions: Summarize the learner’s point of view and ask other learners for their opinions.
Agree to disagree.
Agree in part and then state how you differ and why.

Problem: A learner has a distracting habit (e.g., pencil tapping, pen clicking, paper shuffling, etc.).
Possible Solutions: Use nonverbal methods to get the learner’s attention (e.g., eye contact).
Ignore the behavior if it is not detracting from the session.
Privately ask the learner to stop.

Problem: A learner is working on something else during the training session.
Possible Solutions: Use nonverbal means (e.g., eye contact, smiling) to draw the person into the discussion.
Direct discussion questions to the learner.
Interact with the learner during breaks.
Ask the learner to be the leader in a small group activity.

Problem: By arriving late or coming and going at will during the course, a learner does not respect the training schedule.
Possible Solutions: Adhere to the course schedule; do not let everyone else suffer because of one learner’s lateness.
Remind learners of the course schedule.
Ask the learner a question about content that was presented when this person was not in class, not to embarrass but to show that important information is being presented.
Privately request promptness (as a courtesy to the rest of the group, not just to the trainer).

Problem: A learner does not participate at all during the discussion.
Possible Solutions: Use nonverbal means (e.g., eye contact, smiling) to draw the person into the discussion.
Direct discussion questions to the learner.
Interact with the learner during breaks.
Ask the learner to be the leader in a small group activity.

Problem: A learner does not complete assignments.
Possible Solutions: Reemphasize the purpose of the assignments.
Be sure always to discuss assignments after they are completed to show the value of the assignment.
The ways in which problem situations are handled will give further credibility to the clinical trainer’s leadership. Dealing with problems promptly and effectively will allow more time to concentrate on giving presentations and leading discussions. Whether presenting or conducting group learning activities, as presented in the next section, keep in mind the principles of group process (fully discussed in Chapter 2) to keep learners focused and on track.

**DEALING WITH CLINICAL PRACTICE PROBLEMS**

**Learners Are Not Getting Enough Exposure to Clients**

**Situation 9-1**: You are the trainer for an IUD clinical skills course. Having completed the classroom portion, you are now in the clinic area supervising six learners. In the first two clinical days, there was an adequate number of clients to enable all learners to demonstrate competency in performing a pelvic examination. This is the third day, when according to your plan, the learners should begin inserting IUDs with clients. Today, however, the weather has suddenly become cold and rainy. Only a few clients have come to the clinic and no one has chosen the IUD as her contraceptive method. What do you do with the learners now that there are no clients to be seen?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

**Situation 9-2**: It is the second day of clinical practice in a contraceptive implants clinical skills course. The four learners whom you are supervising have many questions about how to manage the side effects of contraceptive implants, but no clients with problems have come into the clinic. You and the learners are about to have an extended post-clinical practice meeting about recommended infection prevention practices as observed in the clinic. At this time, a client arrives complaining of heavy prolonged vaginal bleeding since her implants were inserted six months ago. You had planned on discussing this and other side effects and their management at tomorrow’s post-clinical meeting. What do you, as the trainer, do in this situation?

Write your response on a piece of paper and then compare your response with the one found in Appendix A.

Even with careful planning, ensuring that every learner gets adequate time with actual clients requires flexibility, creativity and cooperation among trainers, learners and clinic staff. Several strategies for increasing learners’ exposure to clients have been discussed, many of which are most successfully undertaken in the planning period. During the course, the trainer should work closely with clinical staff to modify the schedule to increase exposure. In addition, the schedule should be flexible enough so that if there are unforeseen, potentially beneficial occurrences at the facility (e.g., a client presents with a condition that is especially relevant to the course, the facility becomes unexpectedly busy at a time when learners are engaged in other activities), the trainer and learners can take advantage of these situations.

Even with the best planning, rarely will all learners have the opportunity to work with all types of clients. The clinical trainer will need to supplement, with case studies, role plays and other activities, the practice done with actual clients. The trainer should identify important but uncommon client situations (that are unlikely to occur on a given day in the clinic) and prepare activities to cover these skills in advance. Actual cases seen in the clinic may also serve as the basis for such activities. These can then be used during clinical sessions to expand the learners’ range of experiences.
Inevitably there will also be times when there are few or no clients in the clinic. The trainer should have ready activities for the learners to do during these “down times.” During pre-clinic meetings:

- Identify learning activities that learners can practice independently without your supervision, such as practicing infection prevention skills or reviewing job aids.

- Ask learners what they will do in between cases. For example, have them consider any gaps in their experiences with actual clients and ask them:
  
  “What simulations (e.g., taking a history, diagnosing illnesses based on patient information, even clinical decision-making) can you practice and assess (either through self- or peer-assessment)?”

  “What role plays, case studies and other activities might be most helpful to you now?”

Even when there are no clients, learning must continue—the trainer must keep everyone engaged and continuing to work toward objectives. Leaving the clinic site early or taking extended breaks are not acceptable options.

**Training Is Interfering with Normal Facility Activity (or Vice Versa!)**

As has been previously discussed, there should not be more learners than can be accommodated comfortably in one area of the clinic at the same time, as this can interfere with normal facility activity. Generally, three or four learners are the most that a specific area of a clinic can absorb without affecting service delivery. If there are more, and the trainer has not already done so, she/he should plan a “rotation system” that allows each learner to have equal time and opportunity in each clinic area. For example, two learners can be assigned to the counseling area, two to the screening area and two to the procedure rooms, with others completing special assignments. They can change work areas every few hours, every day or every few days—whichever seems most appropriate.

Alternately, there are times when the clinical environment is so busy or chaotic it may interfere with learning and, worse, compromise the safety of clients. Heavy client flow or an emergency situation may require the trainer to balance maximizing learner exposure with minimizing stress and reducing risk. The trainer should discuss the situation with learners and the clinical staff and then develop an appropriate plan. For example, the trainer may decide to approach only those clients requiring services that are most related to the needs of the learners. Alternately, the trainer may negotiate to have a qualified staff person assigned to a designated examination room, where a reasonable number of clients are being seen.

**WHEN COURSE OBJECTIVES ARE NOT BEING MET**

At some point in a course, a trainer may begin to realize that the course objectives are not being met—learners are not learning what they are there to learn. She/he may come to this conclusion through:

- **Formal and informal assessment results**—Learners are not demonstrating increasing competency in the skills they are there to learn.
Feedback from learners—Learners express lack of clarity about what is expected of them, and doubts about their ability to develop the desired competencies.

Based on the situation, the trainer may need to make changes to the schedule or his/her approach to better meet the needs of learners. Remember, though, major changes to the course should only be made in collaboration with master trainers, and validated assessment tools should never be modified.

Revising Training Based on Assessment Results
As has already been discussed at length, assessments of learners provide the trainer with critical information about the learners’ progress and ability, but also about the course itself—specifically how it could be strengthened or modified to better meet learner needs.

- Results of ongoing assessments can reveal areas that need more attention (e.g., gaps in knowledge, missing steps in clinical simulations, poor attitudes toward “clients” during role plays); the trainer can then revise the schedule or learning activities to focus more on those particular competencies.

- End-of-course assessments can provide important information that trainers can use to refine the course for future learners, increasing its effectiveness and efficiency in developing the desired competencies.

Revising Training Based on Learner Feedback
Assessing learners’ reactions to the course is also important in the clinical training process. It should occur both during and at the end of the course. To determine how learners like the course and how they perceive its value, trainers can ask learners to use one of several methods.

On a daily basis and at the end of the course, it is important to review learners’ feedback. If there is more than one clinical trainer conducting the course, they should hold a brief daily meeting as well as a post-course meeting to discuss the learners’ reactions and suggestions, as well as their own individual assessments of the course. This exercise will help identify elements of the clinical training that need to be changed—either during the present course or, subsequently, in future courses—to better meet learners’ needs and course goals.

If the trainer suspects that the problem may lie in his/her level of competency as a trainer, she/he should consult a master trainer to discuss his/her doubts and concerns. A trainer in this situation can arrange to be observed by a master trainer, interacting with learners, in the classroom and/or clinical setting. Any problems noted may be easily remedied through targeted mentoring, or additional steps can be discussed and decided.
CHAPTER SUMMARY

- The trainer may need to intervene if the group’s dynamic seems to be interfering with a positive learning environment. This may involve reviewing/reinforcing group norms, managing communication and addressing any obvious tension.

- Two other important aspects of maintaining a positive learning environment are managing stress—both in learners and clinical trainers—which can also interfere with learning, and building energy/enthusiasm when needed.

- If there are “problem learners” in the course, the trainer will need to have strategies for dealing with these learners and keeping the training session moving forward.

- When learners are not getting enough exposure to clients or the course is interfering with the normal operations of the facility, the trainers must work with clinical staff to devise solutions.

- Supplemental activities should always be available for when learners are not working with actual clients, to keep them engaged in the learning process.

- If learning objectives are not being met (based on assessment results and learner feedback), the training may need to be revised to better meet the needs of learners.
CHAPTER TEN

POST-COURSE ACTIVITIES

Ensuring and Extending the Value of the Course
What happens in a clinical skills course may be nothing short of miraculous—learners may come away with greatly improved skills and a greater sense of confidence and pride in what they do, as well as a renewed commitment to the women and families they serve. Trainers may have a similarly positive experience, feeling that they have learned and grown in ways that will enable them to reach learners more effectively and efficiently than before. And yet, there must be mechanisms in place to “capture” what has been accomplished and to ensure that it will translate into actual benefits—for women and their families, as well as for the programs that are there to help them—and can be sustained over time. The trainer plays an important role in post-course activities that support such mechanisms.

INTRODUCTION
After the course, the trainer’s job still is not done. She/he or she will use a variety of evaluation techniques to determine the effectiveness of the course. He or she should also document and report findings as part of an ongoing effort to strengthen training activities. Depending on their programs, trainers may also visit course graduates and their immediate supervisors in their workplaces, to ensure that the knowledge, attitudes and skills acquired during training have been transferred to the site, resulting in improved performance and better care for clients.

FINISHING UP
Documenting Qualification
Qualification means that the learner has been deemed competent to provide the services targeted by the course at a beginning level independently, given an enabling environment. It is a stepping stone into a world of greater responsibility and, it is hoped, greater reward. Certainly, the providers have increased their capacity to provide better care to the women and families of the communities they serve. It is critical to ensure that the assessment of each learner is properly documented and signed off on by the trainer. This will involve compiling the results of knowledge assessment and observed performance of essential skills with checklists, along with the statement of qualification (if applicable).

Sample: See Sample B-15. Statement of Qualification in Appendix B.

Action Planning
Each learner should clearly understand whether she/he has been qualified as competent, and “passed” the course, or not. If not, an action plan for meeting competency must be developed by the trainer and shared with the learner. This type of action plan will outline specific steps the learner can take to become qualified.
Action plans also represent a key strategy to facilitate transfer of learning to the workplace. As such, the trainer, course graduates and relevant supervisors should all have a copy of any action plan created. Such action plans outline goals for applying new competencies in the workplace. When possible, the trainer should have teams of learners from the same department or facility develop a team-based action plan together, listing specific activities that will support transfer of learning to their workplace. Action plans are also used during follow-up visits to graduates on the job to assess transfer of learning and help them overcome any obstacles in applying their newly competencies.

AFTER THE COURSE

Evaluating the Course

Evaluation is an integral part of the clinical training process. Evaluation can determine whether the training has met its goals (i.e., whether learners’ knowledge, attitudes and skills improved) and identify aspects of the course that should be strengthened. Evaluation of the course is not only an end-of-course activity performed by learners, filling out a form. It is an integral part of the learning experience, conducted both formally and informally, and may occur several times during the course; it may provide not only learners, but also clinic staff and others, many opportunities to weigh in on how the course is going and to effect change when needed.

At the end of the course, however, it is especially important to ensure that all of the essential elements are completed, and that the proper course documentation is in place. The trainer should use the learner’s course evaluation to obtain feedback on the course and his/her performance as a trainer. Trainers should also do self-evaluations after a course is completed and request feedback from co-trainers and others about how the course went—as part of their continuous learning as a trainer.

Documenting and Reporting Results

End-of-course activities also include gathering required feedback, as a means to improve the course or your own training skills and approaches; to document that learners satisfactorily completed the course and are deemed competent; to facilitate transfer of learning after the end of the course; and to verify that you have all the learner data and course information you need before learners leave.

Before the training begins, the trainer should understand exactly what information she/he needs to obtain, and fulfill the responsibility as close as possible to the course end. Each country, each organization, each program may have its own data forms that need to be completed. Usually each learner must complete a training information form, and there may also be an overall training information form that the trainer must fill out. These forms will usually be supplied by program staff or those who have organized the training course. Whatever the individual requirements for a specific course, the trainer should:

- Compile and share data. Complete or compile any data required by your program and share it with the required personnel.
Prepare a training report that summarizes main findings and recommendations. This may or may not be required by your program or sponsors. If it is required, they will provide guidance on reporting.

Debrief program staff or sponsors on training outcomes, in-person or virtually. This may be done using a training report, phone call, e-mail or other means. Again, the training debrief should include a summary of findings and recommendations for the future.

Both the trainer and the participating agency should keep copies of this form for future reference. It is recommended that, if possible, course graduates be observed in their institution, within three to six months of completing a course, by a course trainer or other qualified individual.

Sample: See Sample B-16. Form for Recording Learner Data in Appendix B.

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

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

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

New skills and activities such as postpartum family planning counseling, ARV management and AMTSL need to be practiced soon after training or they will be lost and never applied.

Effective Transfer of Skills
Before training starts, there should be a clear idea of how the learners will use newly acquired clinical skills. The clinical trainer should know that all parties—supervisors, learners and other trainers—understand and agree to what the learners will be expected to do after returning to the job. Any resources, including time, staff support, equipment and supplies needed to carry out the new skills should be planned for before the learners enter training, not after resuming their work.

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

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

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

**Contracting**

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

To be effective, these contracts should include the following elements:

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

**Follow-Up Sessions**

Most clinical trainers know that training follow-up is essential, but few actually do it. The excuses are many and include:

- “I have no time.”
- “I have no budget.”
- “I have other courses to conduct.”
Perhaps clinical trainers would take follow-up more seriously if they realized that relapse (learners who go back to their pre-training ways of doing things) rates can be as high as 90% without follow-up.

Follow-up can be almost any contact between the clinical trainer and learners that helps the learners apply what they learned more effectively. The more intensive and frequent the follow-up, the more likely it will support transfer of learning. For effective follow-up, the clinical trainer can:

- Send relevant articles to learners after training
- Exchange correspondence about successes and problems
- Encourage learners to “network” and support each other
- Send equipment or supplies to support the work
- Make personal visits to consult on problems or meet with supervisors
- Organize refresher training to renew and extend skills
- Arrange follow-up meetings with training groups to share experiences and discuss mutual problems

Depending on the program, a course trainer, program staff member or other qualified individual may be able to follow up in person. It is best to observe graduates practicing their newly acquired skills at their institution within three to six months of completing a course. The main objective of this visit should be to assess to what extent the trained provider is supported in her/his work environment. To make this determination, the observer/evaluator may:

- Have a discussion with the trained provider
- Have a discussion with the trainer provider’s supervisor
- Observe the trained provider and the facility
- Review records
- Review Standards-Based Management and Recognition (SBM-R®) or other performance improvement reports related to the targeted service delivery area (if such activities are being conducted)

This post-course evaluation or follow-up activity is important for several reasons:

- **First**, it provides the trainer and learner the opportunity to discuss any start-up problems or constraints to service delivery (e.g., lack of instruments, supplies, support staff, supervision).
- **Second**, and equally important, it provides the training center, via the trainer, key information on the adequacy of the training and its appropriateness to local conditions.
- **Third**, it affords the trainer an opportunity to identify possible problems in the performance of the trained provider.

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8 Developed by Jhpiego in the field, SBM-R is a practical management approach for improving the performance and quality of health services.
Without this type of follow-up, newly acquired competencies may not be successfully transferred to the workplace.

CHAPTER SUMMARY
After the course, the trainer still has work do, most of which is aimed at ensuring that learners will be able to continue practicing and become proficient in the new skills they have learned. The trainers must all gather information the program needs to continue its work and strengthen future training interventions.

- Following the course, trainers will conduct an evaluation to determine the effectiveness of the course and their teaching skills; they should gather and report documentation as required.

- Using action plans developed with the learners, the trainers can help them develop specific strategies for supporting transfer of learning to the workplace.

- Some trainers may visit service providers and their immediate supervisors on the job to ensure that the knowledge, attitudes and skills acquired during training have been transferred to the site, resulting in improved performance and better care for clients.
APPENDIX A: SITUATION RESPONSES

SITUATION 1-1 (page 6)

Acknowledge that the service provider obviously has a positive attitude and strong interest in becoming a trainer. You should point out, however, that to be an effective trainer, the service provider must first be a proficient service provider. After completing the clinical skills course, the service provider should work hard to become a proficient service provider. In addition, he will need to attend a clinical training skills course to learn to be a trainer. At that point, he will be ready to co-train.

SITUATION 1-2 (page 7)

It is natural to feel nervous on the first day of a training course, especially when you are unfamiliar with the other learners and the trainer. In fact, it would be highly unusual for a learner not to feel somewhat nervous or uneasy. The learner should take some comfort in knowing that all of the other learners are probably experiencing the same feelings.

In this situation, the trainer is focusing on her needs (to share her background) and is not being sensitive to the needs of the learners. The trainer should limit her introductory remarks to about five minutes, and then ask the learners to describe the experiences they bring to the group and their expectations for the course. This will help to establish a positive learning climate.

SITUATION 1-3 (page 8)

Anatomic models are used to prevent harm to clients while learners are learning new skills. In training courses using models, demonstrations or practice procedures can be stopped for discussion, several learners can practice at the same time and learners can practice their skills until they feel confident to work with clients.

SITUATION 2-1 (page 12)

Effective presentation skills include using a set of notes and supporting audiovisuals, projecting your voice, moving around the room and asking questions to encourage interaction. Suggestions for improvement include avoiding looking too much at notes in order to maintain eye contact, using voice inflection to prevent speaking in a monotone, moving around the entire room and asking questions of all of the learners.

SITUATION 2-2 (page 16)

The aspect of group interaction involved in this situation is group norms. The new trainer has several options. The trainer can include in the evaluation of the day a comment on the importance of all the group members arriving on time so that the group can adjourn on time. Engaging the group in this discussion will encourage the learners to jointly establish the norms for the group.
Another option would be for the trainer to initiate a discussion about the group norm of arriving and ending on time as an important issue that trainers need to consider. This approach treats the situation as a training issue rather than focusing on the failure of some of the learners.

If neither of these options works, the trainer can speak to the learner privately. This is the least desirable approach because it goes against a training norm that any situation that arises in the group should be resolved in the group in order to encourage and maintain an open, safe learning environment. Furthermore, the trainer does not want to set an example in which a difficult situation is dealt with in private. Rather, the trainer should model behavior by dealing with difficult situations openly in the group, thereby helping to create a safe environment for managing problems.

SITUATION 2-3 (page 19)
There are many advantages to asking questions during a classroom or clinical presentation. Questions require the learners to think about and apply the information they have learned during the course. Using questions also affords the trainer an opportunity to involve all learners, use their names, provide positive feedback and encourage learners to ask questions. Responses to questions also let the trainer know how effectively information is being transferred to the learners.

SITUATION 2-4 (page 20)
Asking the learners for questions is an excellent technique as part of a summary. The trainer, however, should have a few key questions ready in the event there are few or no questions, which often happens, or if an important topic is not addressed by the learners’ questions.

SITUATION 5-1 (page 53)
As a learner in a course, you are probably interested in the course goals and objectives; the identity and background of the other learners; the course schedule and specific learning activities that will occur; and the learning materials you will be using. You might also appreciate the opportunity to share your expectations.

SITUATION 5-2 (page 60)
Include some close-ended questions (or statements) based on the course goals and objectives (e.g., “I feel confident in managing tuberculosis and HIV”) with an appropriate rating scale. Include also some open-ended questions (e.g., “What did you like the most about this course?”) to allow learners to share their feelings about the course.

SITUATION 6-1 (page 64)
Beginning an introduction with a series of questions is an excellent technique because it will focus the learners’ attention on the topic. Following the questions with a clear statement of the objectives will then let the learners know where the presentation is leading. The only suggestion for improvement would be not to get into lengthy
discussions around the introductory questions, as this will confuse the learners and reduce the impact of the introduction.

**SITUATION 6-2** (page 64)
Suggest to the trainer that she highlight key words or phrases in the reference manual. This will allow her to glance at the page, focus on a few key words and bring her attention back to the learners. She could also put the key points on overhead transparencies or flip chart pages. These techniques will allow her to move around the room to interact with the learners more effectively.

**SITUATION 6-3** (page 65)
Planning some small group role plays during a counseling session is a good idea. Where the trainer went wrong was deciding to do this suddenly without sufficient planning. The trainer should have given the learners a short break and then taken a few minutes to write the activity instructions on the flip chart. This would have given the trainer time to think through the activity, and the learners could have referred to the flip chart when working in their groups.

**SITUATION 6-4** (page 74)
In addition to reviewing the steps in the checklist and asking for questions, the trainer should have used supporting media (video or photos) and then demonstrated the skill using the anatomic model. The trainer could then have asked one of the learners to repeat the demonstration. When there were no additional questions, the learners should have moved to the practice session.

**SITUATION 7-1** (page 86)
Obviously, you cannot be in four places at one time. One option is to ask staff members to supervise three of the learners while you supervise one. To feel comfortable doing this you will need to know the skills and abilities of the staff, which can only come through working and communicating with them before such a situation arises. Based on your assessment of their skills, you can decide which learner you will supervise. For example, you may want to supervise the learner performing the pelvic exam as that is a more advanced skill, especially if you have doubts about the staff’s skills in this area. Or you may want to accompany the learner who will deal with side effects of combined oral contraceptives, if that is a new topic or one with which learners have had difficulty.

If you cannot use the staff to supervise some of the learners, you have a long and very busy clinical practice period ahead of you! You need to set priorities for the types of skills that need supervision. If learners have had considerable practice in one or two of the areas in question, those areas are not top priorities. The staff may need to go ahead and deal with those clients to avoid having them wait for a long period while you supervise other learners and clients. You could also set priorities by how long the activity will take. The Depo-Provera injection, for example, should take only a few minutes to give, so you could supervise that first and then move on to other learners. You will constantly be struggling throughout the clinical practice with this problem,
However, if you cannot rely on the staff members to help supervise learners practicing with clients. It is worth investing some time to get to know them and their skills, and even help them improve, in order to have some help in the clinic.

**SITUATION 7-2** (page 88)

It is important that you step in and stop the conversation right away in a low-key manner. Suggest that you all move to a more private location. Once there, ask the learners why they think you had them move and then discuss the importance of confidentiality and privacy as essential elements of clients’ rights and quality care. The learner’s anger at being “rejected” by the client should also be explored. Emphasize that this too is a key part of clients’ rights and should not be taken personally; perhaps that client has had a bad experience with a “new learner” in the past.

**SITUATION 7-3** (page 94)

You should let the learner know what she is doing well while she is performing the procedure. A few brief comments such as “nice job,” or “well done,” said in a moderate tone are adequate. This is not necessary for every step in the procedure, but enough to let the learner know that she is doing well. When the learner gets to a step where there is a problem, such as in this case of applying the tenaculum to the cervix, you may want to make a few calm, supportive statements indicating how to overcome the difficulty. Some examples include: “Try holding the tenaculum with your thumb and middle finger,” or “Turn the tenaculum over; that may make it easier.” Again, these should be said in a calm, straightforward manner. Do not let the learner struggle for very long before you offer advice. If she continues to have trouble, be prepared to step in and take over. Although this is not a life-threatening step for the client, it is uncomfortable, and you do not want to prolong the procedure. After the insertion is complete and the client is on her way out of the clinic, find a quiet place to spend a few minutes providing feedback to the learner, including more detailed information on what her problems were and ways to overcome them.

If the step is an important one, as in the second example (forgetting to swab the cervix), as soon as you realize that the learner is about to make an error, you need to intervene. In this case, as soon as it is clear that the learner is going to apply the tenaculum without cleaning the cervix, you might ask her to wait and consider the next step carefully. A hand on the shoulder may also convey the message to stop, and think before proceeding. If the learner is unable to identify that she is skipping a step, tell her what to do. Again, this should be done in a calm, direct manner in such a way that it does not prolong the procedure.

The third example, pushing the IUD inserter tube into the uterus, is a potentially dangerous or even life-threatening mistake. Use the same approach as above—stopping the learner, having her think for a minute, and so on—but if she is not able to identify the problem and correct it, you **must** step in and finish the procedure to ensure the client’s safety.
SITUATION 7-4 (page 98)
The best way to assess competency is the demonstrated performance and the application of knowledge, skills and appropriate attitudes in the clinical setting. Tell the learners that they will self-assess their competency using the portfolio, and you will evaluate their knowledge (did they pass the final exam?), their skills (have they demonstrated mastery with clients?) and attitudes (do they display the appropriate attitudes?) to decide if they are “qualified” to work with clients.

SITUATION 8-1 (page 103)
This is a very common and challenging situation for the clinical trainer. The model course design calls for a specific number of days needed to deliver a course. When you receive a request to modify the course schedule, you will have to consider a number of factors (presented in this chapter). The primary issue is the point at which client safety becomes a concern because learners are unable to achieve all of the course objectives. Although it may be easy to conduct the course in 9 days, it becomes more difficult when it becomes 8, 7 or fewer. If you feel that the quality of the shortened course will jeopardize client safety, do not conduct the course!

SITUATION 8-2 (page 105)
This is a common problem and one that is not easily handled. Ideally, the trainer should approach the learner and try to determine why the individual is attending the course. What is the learner’s understanding of why s/he was selected and what s/he is expected to do as a result of attending the course? If it appears that there has been a misunderstanding and that the individual is able to leave the course without embarrassment, this is the ideal situation.

If, due to any number of circumstances, the individual must remain in the course, make it very clear to the learner (and her/his supervisor if possible) that this person will not in any way endanger clients or impede the progress of the course. This learner should receive a “statement of participation” as opposed to a “statement of qualification” when learners in the course are being qualified as service providers.

SITUATION 8-3 (page 106)
This problem could have been prevented by talking with someone at the training site in advance and explaining specific needs with regard to room furniture and its arrangement, audiovisual equipment, plans for breaks and meals, and many other items presented in this chapter. Arriving early and checking on arrangements the evening before the course will also help to prevent these types of problems.

The best solution at this point is to quickly arrange the room as well as you can before the learners arrive, using whatever furniture you can locate easily. Start the course on time and explain the problem to the learners. At the first tea or lunch break, find out what other furniture and equipment, if any, is on the premises and can be brought to your classroom. Continue working on these arrangements at the next break or at the end of the day. If possible, find someone at the site to assist with locating tables and audiovisual equipment, either on the premises or elsewhere, and bringing them to the classroom.
SITUATION 8-4 (page 108)
This is a major problem and could have been avoided if the trainer or faculty member had visited the site in advance, talked with the supervisor, toured the clinic and discussed course objectives, number of learners, client caseload and related matters.

Given that the course is under way, there are several alternatives. First and foremost, apologize to the supervisor and explore any alternatives within that clinic. Second, consider looking for another clinic site (which may require additional transportation and an additional clinical trainer). Third, consider dividing the learners into two groups. One group can work in the clinic while the other practices in the classroom (e.g., working with models, participating in role plays).

SITUATION 9-1 (page 124)
Prior preparation is vital at a time like this. You should already have prepared a number of activities, including case studies, role plays and other assignments that can be used when there are no clients. You should then gather the learners in a place where they will not interfere with clinic routines and get them started on an activity. If you have nothing prepared, you will need to come up with something QUICKLY! Learners must not stand around doing nothing, nor should they go home early because you, the trainer, are unprepared. Situations like this occur in almost every clinical practice, so it is very important that you think ahead and are ready with alternative activities. Once you have them ready, you can use them again and again with different groups of learners.

SITUATION 9-2 (page 124)
Now is not the time to keep to the planned schedule! Not only is the management of contraceptive implants side effects of interest to the learners, it is uncommon to see these clients in the clinic. You should take advantage of this opportunity to have learners work with this client. It probably will not be possible for all four learners to interact with her, because you risk overwhelming her. You will have to decide which two learners will have this experience. You should note who had this practice, so that the next time such a client comes in, different learners can be given the opportunity to work with her. You should supervise the client-learner interaction. Afterwards, during the post-clinical meeting, the two learners should share their experience with the others, and discuss alternative ways of helping this client. It is probably a good idea to have the more detailed discussion of side effects and their management that is planned for the next day. The infection prevention discussion can be postponed until tomorrow.
FACILITATION SKILLS: SELF-ASSESSMENT GUIDE
(For learners with prior experience as instructors)

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

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

Those facilitation skills I feel competent in using include:

Those facilitation skills I would like to improve include:
**CLINICAL DEMONSTRATION SKILLS: SELF-ASSESSMENT GUIDE**

(For learners with prior experience as instructors)

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

<table>
<thead>
<tr>
<th>DEMONSTRATION SKILLS</th>
<th>YES</th>
<th>SOMETIMES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I use trainer's notes, a personalized manual or learning guide.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I state the objective(s) as part of the introduction.</td>
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<td></td>
</tr>
<tr>
<td>3. I present an effective introduction.</td>
<td></td>
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<tr>
<td>4. I arrange the demonstration area so that learners are able to see each step in the procedure clearly.</td>
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<tr>
<td>5. I never demonstrate an incorrect procedure or shortcuts.</td>
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<tr>
<td>6. I communicate with the model or client during the demonstration of the activity/skill.</td>
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<tr>
<td>7. I ask questions and encourage learners to ask questions.</td>
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<tr>
<td>8. I demonstrate or simulate appropriate infection prevention practices.</td>
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<tr>
<td>9. When using a model, I position the model as if it were an actual client.</td>
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<tr>
<td>10. I maintain eye contact with learners as much as possible.</td>
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<tr>
<td>11. I project my voice so that all learners can hear.</td>
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<tr>
<td>12. I provide opportunities for the learners to practice the activity/skill under direct supervision.</td>
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</tr>
</tbody>
</table>

Those demonstration skills I feel competent in using include:

Those demonstration skills I would like to improve include:
COACHING FOR CLINICAL SKILLS: SELF-ASSESSMENT GUIDE

(For learners with prior experience as instructors)

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

<table>
<thead>
<tr>
<th>COACHING SKILLS</th>
<th>YES</th>
<th>SOMETIMES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEFORE PRACTICE SESSION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I greet the learner.</td>
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<tr>
<td>2. I ask the learner to reflect on her/his performance in previous practice sessions.</td>
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<tr>
<td>3. I ask which steps or tasks the learner would like to work on during the practice session.</td>
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<td>4. I review any difficult steps or tasks in the learning guide that will be practiced during the session.</td>
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<tr>
<td>5. I work with the learner to set specific goals for the practice session.</td>
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<tr>
<td><strong>DURING PRACTICE SESSION</strong></td>
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</tr>
<tr>
<td>1. I observe as the learner practices the procedure.</td>
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<tr>
<td>2. I provide positive reinforcement and suggestions for improvement as the learner practices the procedure.</td>
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<tr>
<td>3. I refer to the learning guide during observation.</td>
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<tr>
<td>4. I record notes about learner performance on the learning guide during the observation.</td>
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<tr>
<td>5. I am sensitive to the client when providing feedback to the learner during a clinical session.</td>
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<tr>
<td>6. I provide corrective comments only when the comfort or safety of the client is in doubt.</td>
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<tr>
<td><strong>AFTER PRACTICE FEEDBACK SESSION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I greet the learner.</td>
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</tr>
<tr>
<td>2. I ask the learner to share feelings about the practice session.</td>
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</tr>
<tr>
<td>3. I ask the learner to identify those steps performed well.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. I ask the learner to identify those steps where performance could be improved.</td>
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</tr>
<tr>
<td>5. I refer to my notes on the learning guide.</td>
<td></td>
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</tr>
<tr>
<td>6. I provide positive reinforcement regarding those steps or tasks the learner performs well.</td>
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<tr>
<td>7. I offer specific suggestions for improvement.</td>
<td></td>
<td></td>
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<tr>
<td>8. I work with the learner to establish goals for the next practice session.</td>
<td></td>
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</tr>
</tbody>
</table>

Those coaching skills I feel competent in using include:

Those coaching skills I would like to improve include:
GUIDE FOR USING AUDIOVISUAL AIDS (JOB AID)

Follow these steps to select and use visual aids:

1. Select one or more of the following visual aids for use during your course:
   - Paper handouts
   - Writing board
   - Flip chart
   - Computer graphics/slides (e.g., PowerPoint)
   - Video

2. Follow the guidelines in this module to develop your visual aids.

3. Practice using your visual aids in advance.

4. Set up or prepare your visual aids in the room before the learners arrive.

5. Check that all audiovisual equipment is working before the learners arrive.

6. Make sure that all learners can see the writing board, flip chart, screen, video monitor, etc.

7. Prepare any copies of handouts in advance and have them in the room when the learners arrive.

8. When appropriate, have questions or instructions for exercises (e.g., case studies, role plays) prepared for use after using the visual aids.

9. When appropriate, include questions related to information delivered through the visual aids (e.g., key points from a video) on tests/knowledge assessments.

10. Make notes about how effective the visual aids were in helping the learners learn, and how you might use the visual aids in future presentations.
PRE-SERVICE DAILY PLAN FOR CLINICAL PRACTICE

Date: 07 March 2008

Clinical Site: University Hospital Family Planning Clinic

Tutor: Mary Smith

Clinical Instructor/Preceptor(s): Margaret Jones

Learning Objectives:

- To observe a clinical instructor/preceptor providing Depo-Provera injections to clients (include observation of appropriate infection prevention techniques)
- To practice counseling clients interested in temporary family planning methods under the supervision of a clinical instructor/preceptor
- To practice, and assess as appropriate, pelvic examination skills with clients, under the supervision of a clinical instructor/preceptor
- To practice IUD insertion on the pelvic model
- To develop skills in the management of Depo-Provera side effects by observing a clinical instructor/preceptor while working with clients and through case studies

Activities:

- Pre-clinical meeting: 30 minutes
  - Review learning objectives for the day.
  - Give learners assignments for clinical areas—two learners in the counseling area, two in the examination room and two in the injection room—and remind learners that they will rotate every hour.
  - Encourage learners to practice IUD insertion on the pelvic model if there are no clients available in their area.
  - Distribute case studies to be discussed in the post-clinical meeting that can be read and prepared if there are no clients available.
- Clinical activities: 4 hours
- Post-clinical meeting: 30 minutes
  - Ask each learner to present for discussion one client with whom s/he worked that day.
  - Divide learners into pairs and have them work through the first case study and then report their conclusion for discussion. Do the second case study if time permits.
  - Review plan for the next clinical session.
IN-SERVICE DAILY PLAN FOR CLINICAL PRACTICE

Date: 07 September 2008

Clinical Site: Teaching Hospital FP Clinic

Clinical Trainer: Swaraj Shresta

Clinical Instructor/Preceptor(s): Chandra Shah

Course: IUD Insertion and Removal

Learning Objectives:

- To practice counseling clients interested in using the IUD as their family planning method under the supervision of the clinical trainer or clinical instructor/preceptor
- To practice, and assess as appropriate, pelvic examination skills with clients, under the supervision of the clinical trainer or clinical instructor/preceptor
- To practice IUD insertion on the pelvic model
- To observe and assess the infection prevention practices used by clinic personnel

Activities:

- Pre-clinical meeting: 30 minutes
  - Review learning objectives for the day.
  - Give learners assignments for clinical areas—two learners in the counseling area, two in the examination room and two observing infection prevention practices—and remind them that they will rotate every 2 hours.
  - Encourage learners to practice IUD insertion on the pelvic model if there are no clients available in their area or they complete their observations.
  - Distribute the infection prevention observation guide and briefly review how it is used.
- Clinical activities: 4 hours
- Post-clinical meeting: 30 minutes
  - Ask each learner to present for discussion one client with whom s/he worked that day.
  - Have each pair of learners share the infection prevention practices that they observed and assess how they compare with what they have been taught in the course. Identify possible barriers or reasons for incorrect practices. Discuss ways to improve the IP practices in the clinic.
  - Review plan for the next clinical session.
## CASE LOG FOR PRE-SERVICE EDUCATION

### Neonatal Nursing Care

<table>
<thead>
<tr>
<th>TASK</th>
<th>NUMBER (MINIMUM)*</th>
<th>ASSESSMENT</th>
<th>SIGNATURE(S) OF CLINICAL INSTRUCTOR, STAFF MEMBER OR TEACHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal resuscitation (bag/endotracheal)</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational assessment</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination of normal newborn and identification of high-risk babies</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filling up of neonatal case sheet</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding of newborn</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cup and spoon feeding</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasogastric feeding</td>
<td>01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature recording (axial and rectal)</td>
<td>04</td>
<td></td>
<td></td>
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<tr>
<td>Use of warmer and phototherapy</td>
<td>01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of spacer for asthma</td>
<td>01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous access</td>
<td>02</td>
<td></td>
<td></td>
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<tr>
<td>ARI cases classify and manage</td>
<td>03</td>
<td></td>
<td></td>
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<tr>
<td>Assessment of sick newborn</td>
<td>02</td>
<td></td>
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<tr>
<td>Lumbar puncture</td>
<td>03</td>
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<tr>
<td>Manteaux</td>
<td>02</td>
<td></td>
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<tr>
<td>Laboratory</td>
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<td></td>
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<tr>
<td>Murmur identification</td>
<td>02</td>
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</tr>
</tbody>
</table>

O = OBSERVED, A = ASSISTED, C = COMPETENT

*Numbers do not equate with competency.*
# CASE LOG FROM IN-SERVICE TRAINING

## Male Circumcision

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Training Location</th>
<th>Pt MR #</th>
<th>Target Competency</th>
<th>Self Assessment</th>
<th>Key Challenges and Successes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5/1</td>
<td>Small town PHC</td>
<td>52315</td>
<td>Individual Counseling and Informed Consent</td>
<td>O</td>
<td>Having never counseled a man seeking MC, I asked an experienced provider to demonstrate the best method of doing this for me before I tried myself.</td>
</tr>
<tr>
<td>2</td>
<td>5/1</td>
<td>Big town Hospital</td>
<td>61748</td>
<td>Circumcision</td>
<td>A</td>
<td>I was able to initiate the MC using a dorsal slit method. I needed help with correct injection of local anesthesia.</td>
</tr>
</tbody>
</table>

O = OBSERVED, A = ASSISTED, C = COMPETENT
## STRUCTURED FEEDBACK FORM

**Learner's Name:** ___________________  **Learner's Class/Level:** ________________

**Name of Rotation:** ___________________  **Dates of Rotation:** ___________________

Please circle the description that best represents the learner's performance in each area.

<table>
<thead>
<tr>
<th>AREA OF COMPETENCY</th>
<th>LEVEL OF COMPETENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical knowledge</td>
<td>Lacking</td>
</tr>
<tr>
<td>History taking</td>
<td>Inaccurate</td>
</tr>
<tr>
<td>Physical exam</td>
<td>Major mistakes</td>
</tr>
<tr>
<td>Data presentation (written and verbal)</td>
<td>Confusing and vague</td>
</tr>
<tr>
<td>Care plan</td>
<td>Poorly created and confusing</td>
</tr>
<tr>
<td>Patient education and counseling</td>
<td>Doesn't provide</td>
</tr>
<tr>
<td>Interpersonal skills</td>
<td>Confrontational or judgmental</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Uncooperative</td>
</tr>
<tr>
<td>Attitude toward learning</td>
<td>Negative</td>
</tr>
</tbody>
</table>
Appendix B

What are this learner’s strengths?

Were there any particular areas in which the learner could improve? Please explain.

Other comments:

Did you review this assessment with the learner?  YES  NO

Your name: ___________________________  Signature: ___________________________
Date: ________________________________
**FINAL PRE-SERVICE CLINICAL PRACTICE FEEDBACK FORM**

Date: ___________________________  Clinical Site: ___________________________

______________________________  ________________________________

Learner: ___________________________  School: ___________________________

______________________________  ________________________________

Tutor: ___________________________  Clinical Instructor/Preceptors: __________

______________________________  ________________________________

Please rate this learner in the following areas using the rating scale below. Add any additional comments you feel will contribute to the assessment of this learner.

<table>
<thead>
<tr>
<th>AREA OF ASSESSMENT</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The learner attended all clinical practice sessions.</td>
<td></td>
</tr>
<tr>
<td>2. The learner was on time for each session and remained for the entire scheduled time.</td>
<td></td>
</tr>
<tr>
<td>3. The learner entered the clinical practice with adequate knowledge of family planning.</td>
<td></td>
</tr>
<tr>
<td>4. The learner entered the clinical practice with competency on models or in role plays in key clinical skills (see list below).</td>
<td></td>
</tr>
<tr>
<td>5. The learner was aware of the learning objectives and actively looked for learning opportunities to meet them.</td>
<td></td>
</tr>
<tr>
<td>6. The learner recognized personal limitations and sought help/additional practice when needed.</td>
<td></td>
</tr>
<tr>
<td>7. The learner was respectful toward the clients and respected their privacy and the confidentiality of information about them.</td>
<td></td>
</tr>
<tr>
<td>8. The learner contributed to the efficient and safe provision of family planning services during clinical practice sessions.</td>
<td></td>
</tr>
</tbody>
</table>

Please attach copies of the skills checklists that you used to assess this learner’s competency with clients in each of the following areas:

- Initial counseling for a new family planner acceptor
- Method-specific counseling for the chosen method, including provision of that method using recommended infection prevention practices
- Client screening and assessment
- Pelvic examination, including infection prevention practices
- IUD insertion, including infection prevention practices
Appendix B

What are the areas in which the learner did not achieve competency or in which you feel additional practice is required? Please list these on the back of this form. For each, please indicate what and how much additional work you feel would be needed for the learner to demonstrate competency.
FINAL IN-SERVICE CLINICAL PRACTICE FEEDBACK FORM

Date: ___________________________  Clinical Site: ___________________________

Learner: ________________________  Course: No-Scalpel Vasectomy (NSV)

Clinical Trainer: ________________  Clinical Instructor/Preceptor(s): ___________

Please rate this learner in the following areas using the rating scale below. Add any additional comments you feel will contribute to the assessment of this learner.

5-Strongly Agree  4-Agree  3-No Opinion  2-Disagree  1-Strongly Disagree

<table>
<thead>
<tr>
<th>AREA OF ASSESSMENT</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The learner attended all clinical practice sessions.</td>
<td></td>
</tr>
<tr>
<td>2. The learner was on time for each session and remained for the entire scheduled time.</td>
<td></td>
</tr>
<tr>
<td>3. The learner entered the clinical practice with adequate knowledge of NSV.</td>
<td></td>
</tr>
<tr>
<td>4. The learner entered the clinical practice with competency on models for NSV and in role plays for counseling for NSV.</td>
<td></td>
</tr>
<tr>
<td>5. The learner was aware of the learning objectives and actively looked for learning opportunities to meet them.</td>
<td></td>
</tr>
<tr>
<td>6. The learner recognized personal limitations and sought help/additional practice when needed.</td>
<td></td>
</tr>
<tr>
<td>7. The learner was respectful towards the clients and respected their privacy and the confidentiality of information about them.</td>
<td></td>
</tr>
<tr>
<td>8. The learner contributed to the efficient and safe provision of family planning services, especially NSV, during clinical practice sessions.</td>
<td></td>
</tr>
</tbody>
</table>

Please attach copies of the skills checklists that you used to assess this learner’s competency with clients in each of the following areas:

- Method-specific counseling for NSV
- Client screening and assessment for NSV
- NSV, including infection prevention practices

What are the areas in which the learner did not achieve competency or in which you feel additional practice is required? Please list these on the back of this form. For each, please indicate what and how much additional work you feel would be needed for the learner to demonstrate competency.
**DETAILED LEARNING ACTIVITY PLAN BASED ON A COURSE OUTLINE**

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

10:00  Explain rationale for loading in sterile package.

10:10  Show section of the IUD training video.

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

10:30  Practice (Round I): Ask learners to turn to the *Learning Guide for IUD Clinical Skills* and review. Step 2 of Pre-Insertion Tasks. Divide group into pairs and distribute IUDs in sterile packages.

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

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

11:00  Summarize session, including review of rationale and summary of cost analysis studies for this particular country.
## TRAINER’S CHECKLIST FOR CLINICAL TRAINING COURSE PREPARATION

<table>
<thead>
<tr>
<th>KEY PREPARATION STEPS</th>
<th>WHEN COMPLETE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learner Selection and Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review learner selection criteria in course syllabus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit the potential learners in their clinical sites (if possible).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarify responsibility for learner transportation to and from the course.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange learner transportation to and from the clinical training sites.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarify housing arrangements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarify per diem rates (if applicable).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarify housing costs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide the learners with the phone and fax numbers of the training site and/or person making arrangements, if appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Classroom Logistics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider issues of cost and proximity to work and clinic when selecting a site.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the classroom is sufficiently large and has good light and ventilation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the required audiovisual equipment is available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange for breakout rooms, if applicable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange for breaks and meals, if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange to set up the room the day before the course begins.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure the furniture is arranged appropriately.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinic Logistics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure adequate number of clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that there is adequate space in the clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that adequate supplies are available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that appropriate service provision practices are being followed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that clinic staff are aware that individuals in training will be working in the clinic and that they are aware of the course objectives.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Classroom Preparation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the course syllabus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the course outline.</td>
<td></td>
<td></td>
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<tr>
<td>Review the course schedule.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B

### Training Skills for Health Care Providers

<table>
<thead>
<tr>
<th>KEY PREPARATION STEPS</th>
<th>WHEN COMPLETE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the checklists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the pre- and mid-course questionnaires.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study the reference manual.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare presentation notes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare supporting audiovisuals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check all audiovisual equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare anatomic models, instruments and other equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice clinical procedures with models.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## TRAINING PREPARATION CHECKLIST

<table>
<thead>
<tr>
<th>TASK</th>
<th>PERSON ASSIGNED</th>
<th>DATE DUE</th>
<th>DONE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOGISTICS</strong> (SHOULD BE AT LEAST 1–2 MONTHS PRIOR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the training venue has been appropriately selected (classroom and clinical) and is adequate to create a positive learning climate, conduct the planned activities, and meet the course objectives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Confirm clinical training sites:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Capacity for training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Meet with clinical staff and management.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure that client scheduling is arranged with clinic staff or management as needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prepare clinical staff if additional preceptors are needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure participants have been invited. (Include information on travel reimbursement, per diem provided, lodging facilities, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure any consultants needed are arranged for (SOW and contracts, etc.).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure logistics are being managed: included dietary needs, travel and transportation, lodging and per diem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure transportation to clinic site is arranged (if needed).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MATERIALS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the necessary training materials are prepared in time:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Trainers materials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Participants materials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Training supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reference documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that all the necessary models, instruments and supplies are in good condition and will be available when needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure supplies are in place for projection of AV materials (extension cords, power supply, surge protector).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensure that participant certificates of qualification or participation are drafted, finalized, and printed.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SHORTLY BEFORE

- Review any training needs assessment or learning needs assessment information.
- Review course materials and adapt if needed.
- Take pre- and post-assessments or review for accuracy, practice skills.
- Reconfirm clinical training site arrangements.
- Reconfirm role of consultants.
- Meet with trainers to coordinate roles and responsibilities if needed.
- Make sure training manuals and reference or source materials are there.
- Prepare certificates for statements of qualification or participation.
- Visit classroom and arrange it; check supplies and equipment.
STATEMENT OF QUALIFICATION

(Name of Organization)

hereby attests that

is qualified as an

IUD Service Provider

This is based on the successful completion of the IUD Clinical Skills Course

conducted in/at

(Course Site)

(Month, Days, Year)

Representative of the Organization          Trainer          Trainer
This learner has satisfactorily completed a mid-course questionnaire covering the information presented in this course.

In addition, this learner has demonstrated mastery of the following IUD clinical skills, with both anatomic models and clients:

- Pelvic examination
- Pre-insertion counseling
- Insertion of Copper T 380A IUD
- Pre-removal counseling
- Removal of Copper T 380A IUD
- General counseling
- Post-insertion counseling
## FORM FOR RECORDING LEARNER DATA

<table>
<thead>
<tr>
<th>Learner’s Name</th>
<th>Learner’s Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learner’s Address</td>
<td>Learner’s Profession</td>
</tr>
<tr>
<td>Course Title</td>
<td>Location of Course</td>
</tr>
<tr>
<td>Dates of Course</td>
<td>Trainer’s Name</td>
</tr>
</tbody>
</table>

Pre-course Questionnaire score (if available)

Mid-course Questionnaire score

(Attach questionnaire to this form)

Number of times learner took mid-course questionnaire

Counseling and Clinical Skills Evaluation

Satisfactory

Unsatisfactory

(Attach completed checklist to this form)

Provision of services (Practice)

Satisfactory

Unsatisfactory

Was learner “qualified” as a result of completing this course? Yes No

Skills or clinical services provision in which learner was assessed as competent:

If learner was **not** qualified as competent, briefly state the reason(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
APPENDIX C: ADDITIONAL GUIDANCE ON AUDIOVISUAL AIDS

Building on the basic rules for using any visual aid, the trainer should be familiar with the various uses of specific types of visual aids as well as any additional tips for using them.

PAPER HANDOUTS

Paper handouts are a very useful tool for trainers, especially for sharing detailed/complex information with learners—for instance, summarizing the side effects of common antiretroviral drugs, or presenting data on the World Health Organization medical eligibility criteria for family planning methods. In cases such as these, where the information may be used for reference again and again, handouts are more appropriate than slides/transparencies and other aids that cannot hold a lot of information or provide no permanent record.

Some possible uses of handouts:

- Share detailed/complex graphics or data (e.g., flowcharts, algorithms, dosage information)
- Create exercises or games (e.g., fill-in-the-blank, matching key concepts or terms)
- Provide a job aid that can be used after the course is over, to help facilitate transfer of learning
- Delineate or clarify steps in a task or a procedure

Additional tips:

- Keep handouts visually attractive with the use of white space—in other words, don’t overcrowd them with information, graphics, etc. Although they are ideal useful for presenting a lot of information, they should still be easy to read.
- Always be sure to prepare enough copies and to hand them out at the appropriate time—at the beginning if learners are to refer to, use or annotate them during the presentation/activity, at the end if they might be distracting.

WRITING BOARDS

The writing board is the most commonly used visual aid. It can display information written with chalk (chalkboard or blackboard) or special pens (whiteboard). You can use a writing board for announcements, informal discussions, brainstorming sessions and note taking. A writing board is also an excellent tool for illustrating subjects like anatomy and physiology and for outlining procedures.
Some **possible uses** of a writing board:

- Document ideas during discussions or brainstorming exercises
- Draw a sketch of anatomy or a physiological response
- List points you wish to emphasize
- Diagram a sequence of activities or flowchart for working through the process of making a clinical decision
- Note objectives or outcomes before or after clinical practice sessions
- Record discussions or ideas during small group exercises

**Additional tips:**

- **Try to keep the board neat and the writing clear:** Most trainers use a writing board of some kind. Sometimes the board will look messy at the end of a presentation, with untidy diagrams and no pattern to the words. Before you start, decide what you will illustrate on the board. During the presentation, write the key words or phrases in order, according to the structure of the presentation. Remember that learners tend to copy the words and the layout as they appear on the board. *Make sure that what you write on the board is what you want the learners to write in their notes.*

- **Remember to bring an ample supply of chalk (for blackboards) or markers (for white boards).** White board markers must be of the “dry erase” variety. Ensure that they are all in working order (not dried out) before the event.

---

**Technology Tip!** Take a photo of flip chart pages and writing boards (close-up enough to read the writing) before destroying or erasing them. Images can be organized and given to learners on a CD at the end of the event.

**FLIP CHARTS**

A flip chart is a large tablet or pad of paper, usually on a tripod or stand. You can use a flip chart for displaying prepared notes or drawings as well as for brainstorming and recording ideas from discussions. You can also use flip charts before and after clinical practice visits to introduce objectives and group exercises, or to summarize the experience.

The **possible uses** for a flip chart are the same as those listed for the writing board, plus:

- Provide a broad view of a concept by posting several flip chart pages around the room as the activity or discussion proceeds
- List less relevant issues or questions that may arise during an activity on a flip chart page posted off to the side (to be addressed later), to keep the group on track—this device is known as “the parking lot”
- Brainstorm important reminders (e.g., key terms, norms) and then post pages around the room so that they are visible at all times
Additional tips:
Building on the main tip given for using writing boards—to “Make sure that what you write… is what you want the learners to write in their notes”—when preparing flip chart pages:

- Make it easy to read. Use bullets (•) to highlight items on the page, leave plenty of white space and avoid putting too much information on one page. Print in block letters using wide-tipped pens or markers.
- Make the flip chart page attractive. Use different colored pens to provide contrast, and use headings, boxes, cartoons, and borders to improve the appearance of the page.
- Have masking tape available to hang flip chart pages on the walls during brainstorming and problem-solving sessions.
- To hide a portion of the page, fold up the lower portion of the page and tape it; when you are ready to reveal the information, remove the tape and let the page drop.
- When you finish with a flip chart page, tape it to the wall where you and the learners can refer to it.
- Prepare them beforehand; reuse them whenever possible.

COMPUTER GRAPHICS (SLIDES) PRESENTATIONS
Many computer software packages allow you to create interesting transparencies and electronic computer graphics presentations (slide presentations such as PowerPoint). You can also add high-quality images, video files and sound clips to your presentations, which may be projected onto a screen using the computer and a special projection unit, or viewed by individuals or small groups on a standard computer monitor. Individual graphics/slides can also be printed to transparencies.

Following are some possible uses for computer graphics presentations:

- Provide an overall structure/outline for the trainer and learners to follow in discussing the main points of a presentation
- Show images, illustrations, charts or diagrams to support a topic
- Provide visual support to learners as they make their own presentations and oral reports
- Use at clinical practice sites to share practices and procedures with tutors, learners, etc.

Always have a “Plan B” (an alternative plan) when it comes to anything that requires electricity, Internet connectivity or other more advanced technologies. Have lower-tech options available in case you need them.
Training Perspectives: Keeping Your Presentations Fresh and Relevant

Because transparencies or computer graphics presentations are fully prepared beforehand, trainers often tend to use them “as is,” forgetting that not every slide is needed for every course. A particular group of learners may already know certain information; other information may not be relevant in a given setting. Before presenting computer graphics presentations, always consider the audience and cut (or create) slides as needed. Also, review them to ensure that they are as up-to-date as possible.

Additional tips:

- Preview the presentation to ensure that it is appropriate for the learners and consistent with the course objectives.
- Make sure that the information presented in the presentation is up-to-date with current practices and standards. If there are some minor differences, be sure to tell the learners about them before showing the video. If there are considerable differences, do not show the presentation.
- Arrange the room so that all learners can see the screen.
- Minimize and prepare for technical difficulties:
  - Always check the function of the projection unit before using. Set it up and focus in advance, and know how to trouble-shoot and identify problems. It’s always good to keep a hard copy or printout of your presentation.
  - Make sure that technical assistance is available to deal promptly with problems. Practice using the computer program for creating and projecting your presentation until you are comfortable with it.
  - Always save the presentation on the computer’s hard drive and on a diskette or CD-ROM in case something happens to the computer.

Sample: See Sample R-9. Slides/Graphics from Skills Course Presentations in the Resources folder on the ModCAL flash drive.

VIDEO

Videos are very versatile aids. Videos can be used by a single student for individual learning by a group of learners for independent learning, or by the trainer to initiate a discussion with learners. One of the most important aspects of teaching a skill is showing how an expert would perform it—video is particularly useful for skills demonstration. A bank of prerecorded videos provides a valuable resource for demonstrating various aspects of clinical practice. When the resources are available, you can also use video to record individual learners’ performances, review them together and provide valuable feedback on their clinical skill development.
Video can also be recorded on a CD-ROM to be played on a computer or on a DVD to be played on a DVD player. Video from a CD-ROM or DVD can also be projected onto a screen, allowing a large group of learners to see the video. When this approach is used, external speakers may be needed so that all learners can hear the audio portion of the video.

**Possible uses** for video:

- Provide an overview or introduction to a topic to stimulate interest and discussion.
- Allow the trainer to model a technique or procedure—such as how to counsel adolescents about reducing their HIV risks, assess breastfeeding attachment or insert an IUD—in a clear, step-by-step manner.
- Allow learners to practice identifying clinical signs such as sunken eyes and fast breathing.

**Tips** for using videos:

- Preview the video to ensure that it is appropriate for the learners and consistent with the course objectives.
- Make sure that the information presented in the video is up-to-date with current practices and standards. If there are some minor differences, be sure to tell the learners about them before showing the video. If there are considerable differences, do not show the video.
- If you are using the Internet, ensure that your computer has good connectivity and adequate speed to show the video properly. If you are showing a video from the Web, click play and let it begin downloading (“buffering”) while introducing the topic, and then hit play again when it is about halfway downloaded.
- Arrange the room so that all learners can see the video monitor or screen and hear the audio.
- Prepare the learners for the video:
  - State the objective.
  - Give them an overview of the content they will see on the video.
  - Focus their attention by asking that they look for a number of specific points as they watch the video.
  - Show several short video segments, pausing in between for explanation or discussion, rather than showing one long, uninterrupted video.
BIBLIOGRAPHY


