Technical Report 10: Distance-based Learning to Introduce Primary Health Care Training and Service Delivery: A Case Study in South Africa

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LIST OF KEY ABBREVIATIONS

BASICS	Basic Support for Institutionalizing Child Survival (a John Snow International project)
DBL	Distance-based learning
ECDOH	Eastern Cape Province Department of Health
INTRAH	International Training Agency in Health
JSI	John Snow International
NDOH	National Department of Health
PHC	Primary health care
PRIME	Primary Providers' Education and Training in Reproductive Health (an INTRAH project)
TOT	Training of trainers
USAID	United States Agency for International Development

LIST OF FREQUENTLY USED TERMS IN THIS CASE STUDY

Distance Based Learning (DBL)	Both distance-based education and distance-based learning refer to a learning situation where, at all levels of training, the teacher/ facilitator is wholly or partially separated from the trainee in time and space. Previous experiences with distance-based *education* for rural nurse clinicians in South Africa tended to focus on *theoretical* knowledge acquisition. Distance-based *learning* (DBL) as envisaged by PRIME would be a new approach that would take distance-based education several steps further to include learning both knowledge and skills in more operational (clinical and community) and interactive settings. In the nurse training program, DBL would also be used to foster a change in attitudes necessary to the new PHC orientation.
Facilitator	A trainer (either from the DOH or a consultant) that was technically sound in specific aspects of PHC who served as the principle trainer in any of the modules or sub-modules. Facilitators planned, conducted, and evaluated the face-to-face sessions, wrote or contributed content for the self-study materials, and generally managed the technical aspects of the training event. During the pre-training phase, facilitators finalized preparation of self-study materials, prepared pre and post-tests for each module, and confirmed logistical arrangements with the training coordinator. During face-to-face weeks, facilitators shared training responsibilities with co-facilitators, presenting topics, demonstrating skills, introducing the DBL modules, managing the training process, and generally helping the trainee prepare for the DBL period. Facilitators also supported on-site trainers of the trainees (the co-facilitators and mentor-preceptors). Throughout the training program period, facilitators were involved in evaluating and assessing the training modules and related materials and skills of the trainees. This included preparing training activity reports and briefing the DOH and USAID on the training program activities.
Co-facilitator	Normally a regionally-based trainer or program administrator from the DOH who had participated in the PHC working groups that developed the program curriculum and materials, co-facilitators were experienced in one or more aspect of PHC. Co-facilitators helped to finalize training modules and face-to-face sessions, functioned as co-trainers (with facilitators) during the face-to-face week, and provided regular on-site support to mentor-preceptors and trainees in their region during the DBL period. Co-facilitators monitored the progress made by trainees and served as the principle trainee and training program advocates to the regional DOH managers.
Mentor-Preceptor	Based close to or at the same service site as the trainee, mentor-preceptors were service providers or supervisors who had experience, technical competencies, and skills in one or more PHC area. Mentor-preceptors were the on-site support persons for the trainee as he or she studied the DBL materials and learned new PHC and training skills in the work place.
Primary Health Care	The operational definition of PHC used by the Government of South Africa could be described as: an integrated health service delivery system that included promotive, preventive, curative, and rehabilitative interventions for and with the community. PHC would promote community involvement in health services at the national, provincial, district, and local levels. To achieve PHC required de-centralizing health system management functions, revising health information systems, refocusing provider attitudes to be more consumer-oriented, and re-distributing health resources to ensure equity in access to essential, basic services. A '*PHC model'* or '*PHC approach*' incorporated these elements and attitudes into service delivery.

Trainee or Nurse-trainee	Trainees were nurses who participated in the PHC Comprehensive Skills for Trainers Program. They received training in PHC clinical skills and interactive training skills and knowledge, and were expected to adopt/model client-centered attitudes necessary for PHC. After successfully completing the training course, nurse-trainers were expected to train other service providers in PHC topics and skills, using a DBL approach similar to what they experienced in their training program.
Training Module	A training module was a package of structured training materials destined for trainees. Modules were designed to expand the introductory presentations offered during the face-to-face week. Each training module was self-contained and consisted of lessons (sub-modules) that the trainees had to study on their own during the DBL period. Each lesson had learning objectives, materials to read and work through, self-assessment questions, activities, self-tests, and other interactive instruction. Additional readings and references were included for trainees who wished more information on a subject.
Training Program	The training program is the generic term for the 18-month PHC Comprehensive Skills for Trainers Program that trained 21 nurses in PHC skills and interactive training. Note that the actual *training course* for the nurse-trainees lasted about 6 months. Note, too, that oftentimes the training program was called the 'PHC Comprehensive Clinical Skills for Trainers Program,' with the word 'clinical' being used to mean skills used with clients in any type of setting, whether in the health facility or in community outreach settings.

Distance-based Learning to Introduce Primary Health Care Training and Service Delivery: A Case Study in South Africa

EXECUTIVE SUMMARY

In 1994, the Republic of South Africa began a profound political transition post-apartheid. The social fabric of the country was changing and part of the transition included beginning the process to integrate the existing and separate health care systems into one unified national system. Covering the period from May 1995 through February 1997, this case study presents INTRAH's PRIME project and John Snow International's BASICS project activities in assisting the National Department of Health (NDOH) and the Eastern Cape Province Department of Health (ECDOH) to reorient training and service delivery from an essentially fragmented and vertical health service delivery system to one that used a primary health care (PHC) approach. The 18-month PHC Comprehensive Skills for Trainers Program was part of a larger USAID-funded project called the Bridging Activities project, which created a programming bridge to the later EQUITY project.

The purpose of the case study is: (1) to analyze the innovative distance-based training program that was developed by PRIME/BASICS in close collaboration with the NDOH and the ECDOH, (2) to reflect on achievements and lessons learned in using this type of training approach to help support systems changes; and (3) to provide enough detail about the DBL program so that program managers might understand the management and technical issues involved in such an effort. The case study will be shared with South African organizations involved in training as well as with those agencies striving to develop innovative and sustainable instructional strategies.

Description of training program and training innovations

The goal of the PHC Comprehensive Skills for Trainers Program was to increase the availability and quality of integrated and comprehensive PHC services by developing training capability and capacity in the Eastern Cape Province, a province created in 1994 by the new government. The new province had 6.7 million inhabitants served by 818 district-level primary health facilities that needed to re-organize services to a PHC orientation. The goal was accomplished by training rural nurses as PHC trainers. These nurse trainers then trained other service providers in PHC in the Eastern Cape.

The absolute number of trainers and service providers to train was large. The DOH wanted nurses (the trainees) to stay at their work sites as much as possible due to a severe shortage of rural health care providers. To respond to these and other DOH program parameters, PRIME/BASICS developed a unique 6-month training course that bridged the gap between distance-based *education* to improve *theoretical knowledge* and distance-based *learning* to develop *knowledge and skills* in PHC and interactive, participatory training. The approach

had never been attempted on a large scale before, and these pilot efforts would provide the basis for expansion of the training and service re-orientation throughout the Eastern Cape and other provinces.

The core program made use of carefully constructed distance-based learning (DBL) materials designed to ask that the trainee learn skills. It was assumed that a training approach that used self-study of printed materials as well as self-practice of new skills alone could not assure that a trainee would learn the desired skills. Subsequently, while respecting the features of distance learning, the self-instructional course made use of 2 complementary training approaches to provide an applied basis for skills acquisition: First, intensive group training by facilitators *prior* to beginning the self-study period was designed to provide the opportunity for trainees to observe critical skills and to be oriented to the self-study materials. Second, mentoring, which occurred during the self-study period, complemented the distance-based and intensive group training approaches. Regional co-facilitators and local mentor-preceptors visited trainees regularly at their work sites to support and ensure that the trainee was mastering the DBL materials and applying skills correctly at the work site.

The training program offered another unique feature—the DBL print materials themselves. The way that the materials were designed, both graphically and as interactive programmed instruction, helped to maximize learning. The text and the lessons within each text were formatted to create visual interest and highlight important aspects of the text. The various elements within the text, such as the behavioral objectives, the self-assessment questions, the lesson summaries, the self-tests, were designed to reinforce each other.

Two elements of the DBL print materials, in particular, were important for maximizing the linkages between knowledge gains and skills development: learning activities and self-tests. *Learning activities* focused on trainee problem solving, such as solving a case study using a real-life clinic service or community outreach example. These activities required a trainee to use acquired knowledge to solve a real-life problem situated either at the clinic or in the community. *Self-tests* occurred in the work place and required the trainee to use both knowledge and skills acquired from self-study to complete a task, such as changing a health facility's vertical delivery of child health services to delivery of integrated management of childhood diseases. Self-tests allowed the trainees to apply a larger set of skills necessary to complete a task and helped create a lasting change in the workplace.

The 6-month course curriculum was divided into 6 training modules that addressed the following subjects, in the order given: (1) Orientation to PHC approaches for service delivery and management; (2) Training (adult learning) and facilitation, epidemiological research, monitoring and evaluation; (3) Reproductive health and women's health interventions; (4) Child survival interventions; (5) Acute and chronic conditions in adults; and (6) Consolidation of content and skill areas from Modules 1-3, covering PHC concepts and techniques, process management, management of PHC services, training and facilitation skills, and reproductive health. For each training module, a module planning week was held by facilitators to prepare

co-trainers (the regional co-facilitators and local mentor-preceptors) for the DBL period and to finalize DBL materials. This planning week was followed by a face-to-face week to orient nurse-trainees to the DBL module and to discuss complex materials and demonstrate critical skills. Then, a 3 to 4-week DBL period began and the trainees worked through interactive DBL materials and programmed learning activities to acquire and gain confidence in PHC and training skills. Through these exercises, the trainees began to re-orient health services at their service sites to a PHC model. It should also be noted that many other people were consulted throughout the training program period to ensure that the reorientation efforts were supported at various levels of the health system, including national and regional DOH directors, regional trainers, and clinic supervisors.

A total of 21 nurses working in clinics in the 5 regions of the Eastern Cape were selected to participate in the pilot program and were trained as trainers of other service providers in their respective regions and districts. In addition to receiving training in a comprehensive set of PHC skills for both clinical and community activities, these nurses were trained as trainers. After the initial 6-month training period ended, the nurse trainers then used modified DBL materials and approaches to train other service providers in their regions in PHC skills (but not in training skills), quickly reaching many providers in additional clinics. The plan was that after the initial training period ended, a field-tested and revised training curriculum and related materials would be available for use by the DOH in the rest of the Eastern Cape Province as well as in other provinces.

Results of the DBL training program

The evaluation of the training program indicated that the DBL training program strategy worked well and that the interactive DBL materials developed by PRIME/BASICS played an important role in developing skills and correct attitudes in PHC service delivery and interactive training.

The training program resulted in a cadre of 21 trained trainers and over 75 service providers. (This number "75" reflects the number of trained providers at the time of the 1997 final project evaluation. More providers have been trained since the time of the evaluation.) These people have improved participatory training and PHC skills and knowledge, based on participants' self-assessment of changes post-training and on participant pre- and post-test scores for various modules. For example, the sub-module scores on family planning showed a 14% increase in knowledge and skills, when comparing mean pre- and post-test scores. Mean scores obtained for the sub-module on sexuality and life-coping skills showed a 9.8% increase in knowledge and skills, when comparing mean pre- and post-test scores. Equally important, the training resulted in developing a network of PHC trainers throughout the Eastern Cape Province.

The program also helped create many changes in health service delivery that could be attributed in large part to changes in knowledge and skills brought about by the training.

In sites reached by the training program, there were clear indications of a shift towards an integrated package of PHC services, new provider attitudes regarding clients, and outreach into the community.

Participants liked the training program very much, an important finding since the program would be replicated in other provinces. Indeed, those who participated in various ways in the training program, including nurse-trainees, facilitators, co-facilitators, mentor-preceptors, regional directors, deputy directors, and clinic supervisors, felt that the training activities were valuable. All were impressed with the program content, design, and consultants. The evaluation by participants of Module 2, the module with the most complete evaluation information, indicates their satisfaction with the course: A full 100% agreed that the course was relevant to their work; 100% felt that self-study sessions contributed to learning and applying new concepts; and 90% felt that lecture methods were not useful for adult learning. As the course ended, many participants expressed that other health professionals should be trained in PHC skills and philosophies using a modified version of the curriculum and DBL materials.

Lessons learned and recommendations

The experiences of designing, testing, and implementing the DBL training program provided many recommendations for future training. Important lessons learned and recommendations are presented below:

Use of DBL training innovations that allowed trainees to gain both knowledge and skills

1. The innovative training strategy of using multiple training methods to support trainees in distance-based learning worked well and resulted in improved PHC training capacity of trainers. At the facility level, the training resulted in helping re-orient the Eastern Cape Province health care delivery system to a PHC approach.

2. The design of the DBL print materials themselves, particularly the use of practical and situation-specific self-tests and lesson activities that demanded thorough and active learning by the trainee, worked very well.

Recommendation:

- The idea to address skills using a distance-based learning approach is a promising one and the costs and effects should be explored more rigorously, and perhaps in more stable health care delivery settings, to determine how far the approach can go in terms of trainee skills development. Clearly, the ability to transfer skills from a distance widens greatly the potential uses of distance based learning programs.

Value of a comprehensive training needs assessment for curriculum development and program evaluation

3. An effective curriculum and related learning materials was developed using findings from a general needs assessment and information obtained in discussions with DOH officials. Still, due to a lack of appreciation of the importance of training needs assessments, the program planners were not able to conduct a comprehensive training needs assessment of those targeted to participate in the training program. The assessment would have allowed the program developers to fine-tune the design and content of the training program and to focus better on gaps in trainees' information, attitudes, and skills in PHC and training. The training needs assessment would also have assessed the training needs of trainers and other support persons, ensuring that the training program set time aside to train co-facilitators and mentor-preceptors in techniques to support the trainees better at their work sites. The curriculum and related materials would have responded better to the needs of the trainees.

   The lack of baseline information also made it difficult to quantify changes in PHC training capacity and service delivery that were due to the training program. The final evaluation of the program was not as rigorous as it could have been.

Recommendations:

- Training program managers and the DOH should, in future, discuss and reach agreement to co-conduct a comprehensive training needs assessment prior to designing a DBL (or any) training program. This agreement should occur before any training activities begin in order to ensure that there is political and moral support for the exercise, and that future courses respond accurately to the needs of the trainees.

- National training policies should include comprehensive training needs assessments as an essential step in the process of developing training programs.

Importance of participatory processes in training program development and implementation, and in ensuring the continuation of the new PHC orientation

4. Group processes, which involved people with different skills who came from a variety of disciplines, played an important role in determining a shared vision of PHC service delivery, since PHC had not yet been operationalized in the work place. Involving stakeholders at different levels of the health system in determining and then supporting the new PHC training and service delivery orientation ensured that there was strong support for the changes that would be brought about by the training program.

   Working groups guided the overall program development and helped to develop the training program curriculum and related training materials.

Group processes were also critical in developing the course contents. Participatory work helped PRIME/BASICS to understand the South African context of the training program (since all cooperating agencies were new to South Africa), to become acquainted with counterparts and to allow counterparts to be acquainted with PRIME/BASICS, helping to ensure a common set of expectations of the work of each party in the training program.

Group work also allowed PRIME/BASICS the possibility to provide on-the-job technical assistance in PHC approaches and development of a DBL curriculum and materials, which helped ensure sustainability of new training skills and participatory PHC approaches once the program ended

Group processes to develop the program curriculum and materials development were too slow, though. In large part, the delays were due to inexperience of working group members in PHC service orientations and DBL program design. Unfortunately, in situations where one task of a working group depended on the accomplishment of preceding tasks, some of the potential program benefits were lost: Materials development was not as systematic as it should have been. Trainees were not always well prepared to return to their service sites for the DBL period because not all materials had been finalized yet. On a more global level, the project did not have sufficient time to refine the carefully assessed materials after they were field tested, losing some of the cost-savings inherent in distance-based education, where materials are revised and finalized before being replicated on a large scale.

Recommendations:

- A small team of subject matter experts, curriculum development experts, and user representatives should be made responsible for overseeing the development of the training materials, and ensuring that project design and content experts be brought into the working groups, as needed, to develop materials. A larger group could be used to review developed materials and develop consensus and support for the work.

- Future technical assistance in training systems development should include building the capacity of selected trainers in DBL materials design.

Management support needed by the DBL training program

5. Management of the training program proved to be problematic due to a variety of factors, most of which were external to the training program. This meant that the program was not at times adequately supported. Because the DOH was being re-structured as the training

program was being implemented, staffing problems existed and there was an inability to assure consistent training policy guidance and timely program management.

Added to this, both PRIME and BASICS were new to South Africa. The respective roles of the DOH and PRIME/BASICS were not well defined as the program began. Further, PRIME/BASICS had no established office to support consultants and staff and coordinate program activities for the first 6 months of the training program. Consequently, the program was also not always coordinated as well as it should have been.

In fact, the DOH was field-testing and supporting a complex DBL training program that had not been attempted before. The program provided the opportunity for training program managers and supervisors to experience a DBL management "learning curve," prior to further expansion of the DBL program. These initial efforts in DBL program management shed light on the areas in which managers and supervisors needed to take more of a lead role.

Recommendations:

- Roles and responsibilities between the consultants and the DOH (national and provincial) should be clearly defined and understood by all.

- When international agencies begin work in new country situations where the capacity and availability of resources is unclear, a field office (even if temporary) to coordinate program activities is essential and should be one of the first items put into place.

- Lessons learned regarding the management of the DBL program should be written and disseminated to other training program managers, as the course is being expanded to other provinces.

- To ensure coherent approaches and timely decision-making by the DOH, DOH staff authorized to make a certain level of decisions should be seconded to help lead training team efforts.

Professional accreditation for successful completion of the training course

6. The possibility of receiving professional accreditation for successfully completing the training course was never resolved during the training program period. An important means of motivating trainees to master DBL materials and skills was lost. Nevertheless, the PHC Comprehensive Skills for Trainers Program was designed using behavioral objectives and guided by performance standards. This leaves open the possibility of accreditation. Outstanding actions that should be taken by the DOH include: (1) finalize and make official the PHC service and training standards; (2) determine who will evaluate/judge performance and knowledge of the trainees at the provincial level; and (3)

determine who will have the authority to issue accreditation (with the perspective of determining future training job prospects and/or promotion for those successfully completing the program).

Recommendation:

- Accreditation standards and processes should be finalized before future PHC training occurs.

Conclusion

An innovative DBL training program was developed and field-tested in the Eastern Cape. Evaluation results strongly suggest that it was successful in transferring knowledge and skills and promoting client-oriented attitudes necessary for PHC. The training program offered a creative solution to a difficult problem: how to respond quickly and effectively to an expressed, critical need of the South African government for assistance in developing a PHC-based health system.

The project laid the groundwork for future DBL training efforts that will focus on skills acquisition and not just knowledge gain. An innovative, basic instructional format, which had not been used in previous training events and which met the goals of the government, was tested and proven. A great deal of knowledge was gained as to who should be trained, by which category of facilitator, and how. A first cut at defining content and designing materials was both successful and useful for uncovering problems.

The number and quality of training resource persons improved. Key and competent staff were identified for the follow-on EQUITY project. A total of 21 potential PHC trainers were trained. Changes in service delivery have occurred in clinics that have staff who received the PHC training in clinical and community participation and outreach skills.

Perhaps most important, PHC is now more than a theory. Many people at many different levels were exposed to the program at different times. Because the training program was small enough, it could be experimental and innovative and develop a group of lessons learned for future PHC training. It also uncovered areas of training need and project management and training policies that needed to be addressed by the stakeholders in operationalizing the PHC delivery system.

1. INTRODUCTION

In 1994, the Republic of South Africa began a profound post-apartheid political transition. The social fabric of the country was changing and part of the transition included beginning the process to integrate the existing and separate health care systems into one unified national system. Covering the period from May 1995 through February 1997, this case study documents the INTRAH/PRIME project and the John Snow International BASICS project activities to assist the National Department of Health (NDOH) and the Eastern Cape Province Department of Health (ECDOH) in the reorientation of training and service delivery, from an essentially fragmented and vertical health service delivery system to one that used a primary health care (PHC) approach.

The purpose of the case study is to analyze an innovative multi-method training program that was developed by PRIME/BASICS in close collaboration with the NDOH and the ECDOH. The program was unique because it used a distance-based training approach to develop PHC knowledge *and skills* of service providers as well as *interactive training skills* of trainers to support the re-orientation of PHC trainers and service providers, something that had never been attempted on a large scale before. The case study explains the training program's strategy and processes, explores problems that occurred along the way, discusses results of the training effort, and suggests lessons learned in using this type of training approach to help support systems changes. These lessons and subsequent recommendations will be shared with others working in South Africa as the primary health care transition continues in other provinces. The lessons will also be shared with agencies striving to develop innovative and sustainable instructional strategies.

2. STUDY CONTEXT

2.1 A system in transition: South Africa's health delivery system in the mid-1990s[1]

One result of the profound political changes that occurred in South Africa during 1994 was an administrative re-organization that resulted in the formation of new provinces. The Government of National Unity recognized the need to restructure and shift resources to increase equity and improve access to social services. Based on a common vision that reflected the principles of the new government's Reconstruction and Development Program, the National Department of Health proposed 5 health sector strategies:

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[1] The policy information presented in Section 2.1 is drawn from *Towards a National Health System for South Africa*, Department of Health , undated, *circa* 1996. Statistics presented in this section are drawn from *Health Care in the Eastern Cape: Implications for Planning*, Health Systems Trust, ECDOH, and the DOH, 1996.

1. The health sector must play its part in promoting equity by developing one unified health system
2. The system will focus on districts as the major focus of implementation and will emphasize the PHC approach
3. Local authorities, NGOs, and the private sector will unite with the public sector in the promotion of common goals
4. Central, provincial, and district levels will play distinct and complementary roles
5. An integrated package of essential PHC services will be available to the entire population

Prior to 1994, the government emphasized curative health services, with the preventive services and health promotion activities that were available found in fragmented and vertical programs. Health services were unevenly distributed and the rural populations had inadequate access (in terms of both health facilities and service providers) to health care. Communities were regarded as passive receivers of health care services. The process of integrating the existing parallel health care delivery systems began in 1994. The adoption of a PHC approach implied that the government was willing to re-distribute health resources and to establish a structure to promote community participation at national, provincial, district, and local levels. The goals of this rationalization exercise were to remove the fragmentation of services that existed and to decentralize the management of the health services in order to increase efficiency, encourage innovation, and promote local empowerment.

After years of political isolation and limited international donor contact, South Africans in the mid-1990s were also adjusting to the new realities of international cooperation with other governments and multi-lateral agencies, balancing a strong national sense of pride and self-determination with the need for and use of external assistance. During the apartheid years, South Africa had become isolated from many national governments and had little opportunity to use external technical and other assistance. With in-country technical assistance alone, the country had made some remarkable advances in health care. Because the above political, health system transition, and social changes were occurring as the training program was being implemented, there were at times situations that challenged the assumptions and expectations by all involved parties.

One of the new provinces created in 1994 was the **Eastern Cape Province** (see map in Annex F), comprising a vast area with an average population density of 39 people per square kilometer and an estimated population of 6.7 million. Because the Eastern Cape was one of 9 provinces chosen by Government of South Africa to be the focus of a 7-year US bi-lateral project scheduled to begin in mid-1996, it was eventually chosen as the site where the PRIME/BASICS pilot training approach was developed and tested. (See map at left.)

As the 1996 *Health Care in the Eastern Cape* report noted: "The Eastern Cape Province, of all the 9 provinces in South Africa, has had the most difficult task of reconstruction and is faced with the worst consequences of the apartheid era. It had to unify 2 underdeveloped and (relatively) densely populated so-called Independent States (the former Ciskei and Transkei

states) with the wealthy, well serviced areas of the cities and extensive commercial farming, in the former Cape Province…(There was) wide-scale fragmentation of services…between curative and prevention work, between "races" and between vertical services."

The *Health Care in the Eastern Cape* report also indicated the many training and administrative challenges that would be faced in re-orienting the Eastern Cape health care system. In terms of the absolute numbers of service sites that would need to adopt the new PHC approach, 818 of the 1,021 public health facilities in the Province (80%) rendered district-based primary health services.[2] Some 52% of the clinics and health centers had no grid electricity and 46% were without an adequate water supply.

The users of the health care system also reflected some of the challenges and potential benefits ahead in developing a PHC system more responsive to the consumer. The mean number of visits to health facilities per annum by children under 5 was extraordinarily low at 0.92 visits per child per year. Antenatal visits per delivery were between 4 and 6, but only 1 in 4 women came for postnatal visits. Certain regions had serious access problems, measured by the percentage of MCH visits seen by mobile units. In one region 30% of women received MCH services from a mobile service point.

Finally, the Government of South Africa and other stakeholders needed to see PHC results quickly.

The situation presented a great training challenge in terms of numbers to be trained and systems changes to be effected during a period of profound change, and required decisions regarding how best to proceed quickly and effectively.

2.2 Donor response to assist the transition: the USAID Bridging Activities project and the subsequent EQUITY Project

At the request of the Government of South Africa, the Bridging Activities project was designed. The USAID project was to be an interim project, supported by both USAID/Washington and USAID/South Africa. Operating from May 1995 through February 1997, the Bridging Activities project would address several high priority PHC activities: (1) conducting a demographic and health survey that would include information on PHC; (2) conducting a situational analysis in the areas of PHC and population; (3) developing and implementing a training-of-trainers (TOT) program in comprehensive PHC skills for rural nurse clinicians; and (4) developing and implementing a national TOT program in PHC services management.[3] The project would provide a programming 'bridge' to the 7-year bi-lateral EQUITY project, planned to begin in 1996. This follow-on project was designed to

[2] District-based primary health facilities included clinics, satellite clinics, community health centers, community hospitals, and mobile centers.

[3] In reality, only activities 3 and 4 of the Bridging Activities project were implemented and completed during the period of this case study. Others were completed after the period of the case study.

assist the National Department of Health efforts to develop systems that would help correct the fragmentation of health services and to render those services more equally accessible to all South Africans by providing more unified health services based on a PHC approach.

USAID in South Africa invited 2 cooperating agencies to become involved in the PHC skills training component of the Bridging Activities project. INTRAH (PRIME project) and John Snow International (BASICS project) were invited to design and implement a PHC Comprehensive Skills for Trainers Program for rural nurse clinicians.[4]

[4] Note that two other cooperating agencies, the Centers for Disease Control (Data for Decision-making project) and Management Sciences for Health (FP Management project) were invited to design and implement the PHC management TOT program. Several joint pre-training activities were conducted by all 4 of the cooperating agencies involved in training.

3. METHODOLOGY

A retrospective descriptive and exploratory case study design was chosen to describe and analyze the new training strategy. PRIME and BASICS were designing and testing a training program based on a theoretical multi-method training model. The case study design would allow PRIME to analyze and document the proposition that distance-based learning or self-study, combined with (i) intensive group learning prior to the self study period, and with (ii) later mentoring of learners at their work site during the self study period, would allow trainees to acquire both PHC and training knowledge *and skills* at a distance, without the benefit of a full classroom situation.

A case study evaluation was the design of choice for several reasons. A case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context" and is especially useful "when the boundaries between phenomenon and context are not clearly evident" (Yin, 1994). The PHC skills training program reflected this phenomenon: The new training strategy was implemented within the context (at the time of the training program) of a complex and changing health system. The program results would be determined by a multitude of variables and subjects and there was no clear, single set of outcomes. PRIME needed to describe as well as analyze changes due to the training program, and the case study analysis would enable PRIME to identify systematically the key internal and external factors in the training intervention, to assess their influence on the health care delivery system, and to look at some of the inter-relationships among those key factors. It would allow the evaluators to identify reasons why the model did or did not work well and would provide detail about some of the issues involved in a large DBL effort.

The information collection plan drew on both qualitative and quantitative data. Qualitative data were derived from a large variety of information sources (refer to **Annex A**), with information triangulated wherever possible, that is, information was verified as valid if cited in several, independent information sources. Stein and Banda (1997) collected and analyzed this information and developed a draft case study, from which much of the information and analysis of the present case study in drawn. Data sources for the Stein and Banda report included trip reports that described specific planning and implementation activities; several summary reports; a variety of communications, agreements, memoranda, and official documents; training materials; information from a variety of training participants; background documents; and interviews with PRIME project staff who were directly involved in the training program.

The training program designers developed a monitoring and evaluation plan to collect information to assess the modules as they were field-tested and to measure changes in trainee knowledge and skills prior to and after each module. For a variety of reasons, the plan was only partially implemented during the training program period. Nevertheless, the quantitative

information that was collected and analyzed corroborates the qualitative findings of the case study evaluation, increasing the validity of the results.

Finally, this case study also used information collected and analyzed in (primarily qualitative) post-training project evaluation studies. These 3 studies, undertaken by W. Kogi-Makau (February 1997), C. Carr (May 1997), and N. Shelver (December 1997), permitted further analysis of the training program effects and impact. Although each of the evaluations was conducted by a different evaluator, had a different scope of work, and collected information from different key informants, the reports frequently drew similar conclusions regarding the effects of the training program. Again, the similarity of these post-training program results strengthens the validity of the findings of the present case study evaluation. (Refer to **Annex B** for a comparison of the 3 evaluation terms of references and information sources, as well as to **Annex A** for the different informants interviewed by the different evaluators.)

Several study limitations should be mentioned. First, the case study is written from the perspective of PRIME and focuses on PRIME's (and to a lesser extent BASICS') training program activities. There were other institutions and agencies involved in the project, including the National and Eastern Cape Departments of Health and USAID. While their training program perspectives were obtained during the case study information-gathering period, not all individuals involved with the training program were interviewed, and thus, not all experiences are necessarily represented in this case study. There may be elements of the larger Bridging Activities project (refer to **Section 2.2**), too, that might have influenced the PRIME/BASICS training activities and outcomes but that are not included in this case study. Finally, although a monitoring and evaluation plan existed for the training program, there were problems in gathering quantitative baseline and end-of-project data. Thus as noted above, it was not possible to *quantify* rigorously many important changes resulting from the training program, in terms of improvements in trainee performance, in the training system, and in PHC service delivery. Therefore, while the evaluation results cannot be generalized, the indications of success described in this case study warrant testing the model more rigorously in new training situations.

4. DESCRIPTION OF THE TRAINING PROGRAM MODEL AND DISTANCE-BASED INNOVATIONS USED TO RE-ORIENT TRAINERS AND SERVICE PROVIDERS TO PHC SERVICE DELIVERY AND TRAINING[5]

4.1 General overview of multi-method DBL training

The goal of the PHC Comprehensive Skills for Trainers Program was to increase the availability and quality of integrated and comprehensive PHC services by developing training capability and capacity in the Eastern Cape province. In the process of achieving this, the national DOH had several requests for a training course. First, the DOH expressed a desire for the program to address both knowledge and *skills* that promoted the strengthening of training and PHC delivery skills. Second, the severe shortage of rural health care providers required that trainees remain at their work site as much as possible. Building on a tradition of distance-based education for DOH service providers, a distance-based training program would allow learners to remain at their jobs with minimal displacement for group training activities. The DOH wanted to use existing South African personnel as training resources as much as possible. The DOH also wanted the PHC Comprehensive Skills of Trainers course to last between 6 and 12 months, so that those who completed the course successfully would eventually receive accreditation and recognition. Finally, although not stated explicitly, for political, social, and project duration reasons, there was a need to show results quickly. Because of the short project period, PRIME and BASICS proposed, and it was accepted, that the PHC skills training program be piloted in only one province, the Eastern Cape.

Given these parameters, PRIME and BASICS, in collaboration with the Eastern Cape DOH and in consultation with the NDOH, decided to use a cascade approach to training. A total of 21 nurses working in clinics in the 5 regions of the Eastern Cape would be selected and trained as trainers of other service providers in their respective regions and districts. In addition to receiving training in a comprehensive set of PHC skills for both clinical and community activities, these nurses would receive training as trainers. After the initial 6-month training period ended, the nurse trainers would then train other service providers in their regions in PHC skills, quickly reaching many additional clinics.

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[5] Much of the descriptive information in this section is drawn from PRIME trip reports that identified problems and reported successes.

[6] Both distance-based education and distance-based learning refer to a learning situation where, at all levels of training, the teacher/facilitator is partially or wholly separated from the trainee in time and space. Previous experience with distance-based *education* for rural nurse clinicians in South Africa tended to be used for *theoretical* knowledge acquisition. Distance-based *learning* as envisaged by

Prior to conducting training, a curriculum, divided into 5 training modules, and related training materials needed to be developed. The modules addressed the following subjects, in the order given: (1) Orientation to PHC approaches for service delivery and management; (2) Training (adult learning) and facilitation, epidemiological research, monitoring and evaluation; (3) Reproductive health and women's health interventions; (4) Child survival interventions; (5) Acute and chronic conditions in adults; and (6) Consolidation of content and skill areas from Modules 1-3 (*NB: This last module was added later.*)

The Comprehensive PHC Skills for Trainers program used an innovative, multi-method distance-based *learning* approach.[6] PRIME and BASICS agreed to share the responsibilities as follows: PRIME would take leadership for the design of the overall distance-based training program, and develop curricula and oversee training activities for the first 3 modules of the 6-month course. BASICS would use and enrich the established training program design to develop instructional materials and oversee training activities for the remaining 2 modules. The total time to develop and implement the program was 18 months, limited by the length of the Bridging Activities project. Administratively, BASICS would manage the training program as well as provide technical assistance for the training modules that addressed child and adult health. PRIME would provide technical assistance, in curriculum development processes; the assessment of the various training modules; and topical areas for training modules that addressed PHC concepts, communication, reproductive and women's health, training and facilitation, and training evaluation.

PRIME would be a new approach that would take distance-based education several stops further to include learning *both knowledge and skills* in a more operational (clinical and community) and interactive settings. DBL would also foster a change in attitudes necessary to the new PHC orientation.

4.2 The multi-method training model

Diagram 1 on the next page summarizes the training model. All modules were organized and followed the same [planning / orientation / DBL learning] cycle as shown in the shaded boxes in the diagram. Training modules were designed to build on and expand skills learned in the previous modules. Note, too, that a sixth module was added to consolidate learning from Modules 1 through 3 and that Modules 4,5 and 6 were allocated more time during the face-to-face and/or DBL phase in response to lessons learned from implementing Modules 1, 2, and 3.

Each *module planning week* brought together facilitators, co-facilitators, and resource persons to finalize the training module, the content of the face-to-face week, and outstanding DBL training materials.

Each *face-to-face training week* was a centralized, group training event conducted by facilitators and resource persons including PRIME/BASICS consultants and the co-facilitators. Training during this week was designed to introduce the content of one of the modules, using didactic as well as participatory techniques that were new to the trainees. The face-to-face training week entailed intensive and interactive contact with co-facilitators, who functioned as regional resource persons. (The co-facilitators would later support both trainees and mentor-preceptors during the DBL period.) Facilitators and co-facilitators were expected to explain or demonstrate new, technical, and complex concepts and procedures, map out practical work, and prepare the learners for the self-instructional, distance-based learning activities at the work site.

Trainees were expected to attend face-to-face sessions to be introduced to and become familiar with different subjects so that they could study the materials on their own during the DBL period.

These sessions were also used by trainees and co-facilitators from each region to share experiences of the previous module's DBL materials and their application at the work site. Areas of difficulty or problems experienced by either trainers or trainees were discussed, analyzed, and solved together. The sessions also monitored progress in achieving objectives of the previous modules. Since the Eastern Cape is large and transportation is difficult, a fair amount of travel was required from some participants.

The *distance-based learning period* immediately followed the face-to-face week and occurred at the trainee work site and home (the latter for the self-study portions of the DBL training module). Each module was divided into a series of lessons to be covered during the 3 to 4 weeks at the work site, and learners were advised to cover at least 3 to 4 lessons per week. The materials for each DBL module were self-contained and written in a highly interactive manner to facilitate trainee participation. For example, the print materials used

DIAGRAM 1: SCHEMATIC REPRESENTATION OF TRAINING PROGRAM MODEL

TRAINING MODULES: (1) Orientation to PHC approaches; (2) Training & facilitation, epidemiological research, monitoring & evaluation; (3) Reproductive and women's health interventions; (4) Child survival interventions; (5) Acute & chronic conditions in adults; (6) Consolidation module (basic management, evaluation, and applied epidemiology)

PRE-TRAINING ACTIVITIES

A. ASSESS NEEDS; DEVELOP TRAINING STRATEGY; DEVELOP PLAN, CURRICULUM, AND MATERIALS
(Participants: NDOH task force and ECDOH working groups, PRIME/BASICS)
B. HOLD CURRICULUM CONSENSUS WORKSHOP
(Participants: ECDOH policy/mgmt officials, ECDOH working groups)
C. HOLD OFFICIAL LAUNCH OF TRAINING PROGRAM
(Participants: ECDOH policy/mgmt officials, working group, reps of educational instit's & health facilities, NGOs, trainees

MODULE PLANNING WEEK

Purposes: To finalize module's face-to-face training plan, distance-based learning materials, M&E instruments. To conduct process evaluation of prior module and related DBL materials.

Learning/training techniques: Limited on-the-job training in DBL materials development, training logistics/management, stand-up training delivery using interactive techniques, and participatory evaluation techniques (for process evaluation)

Facilitators: PRIME/ BASICS staff and consultants, South African resource persons

Participants: Facilitators, co-facilitators, South African resource persons

Location: Centralized training site (hotel or hospital conference room)

FACE-TO-FACE WEEK

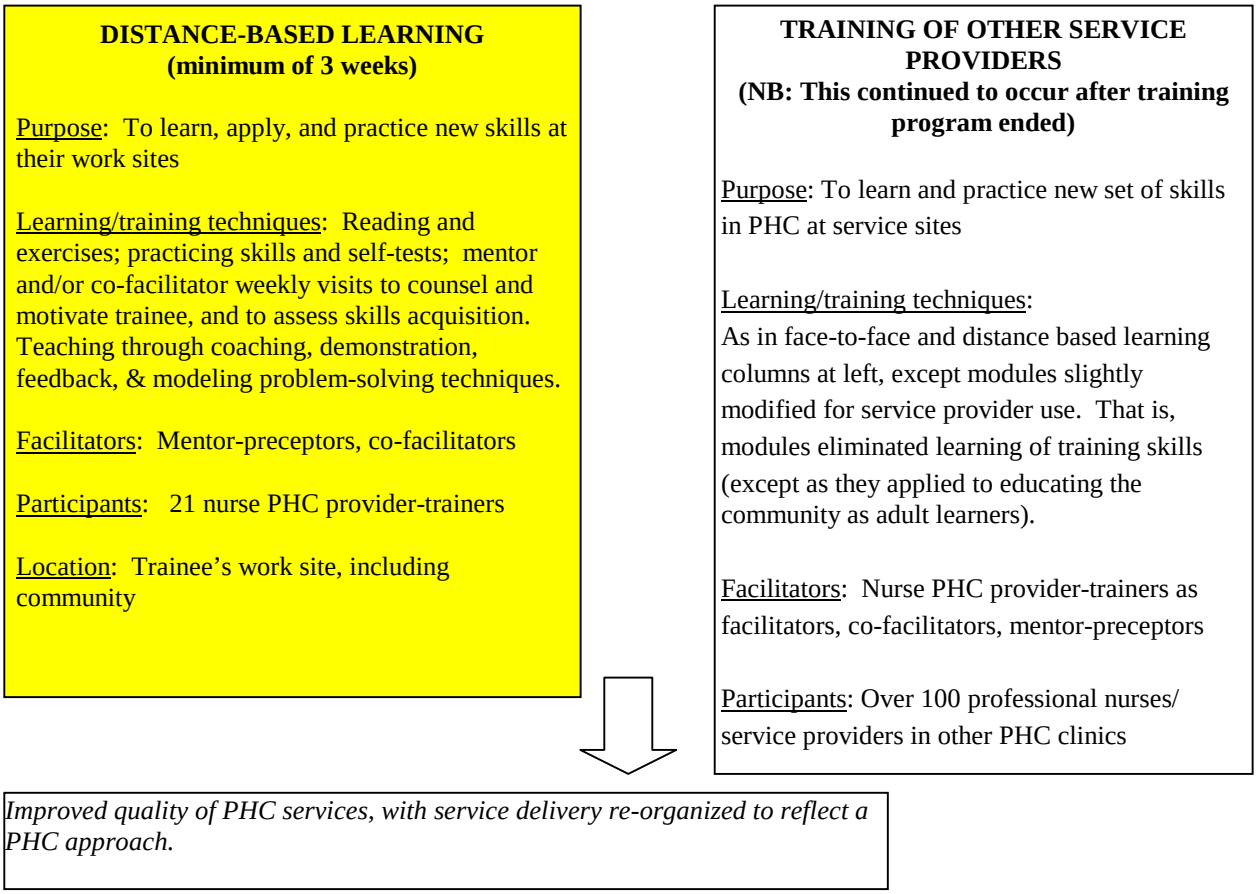
Purpose: To orient/coach/train nurse trainers and DBL mentors and supervisors in key contents of module, use of DBL module and activities, and use of participatory training methodologies

Learning/training techniques: Group exposé to DBL period activities; discussion; role-plays; presentation of technical concepts; demonstration of technical procedures; videotapes

Facilitators: 5- 10 resource persons & co-facilitators (co-facilitators representing all 5 regions), supported by PRIME/ BASICS consultants

Participants: 21 nurse PHC provider-trainers, mentors, co-facilitators

Location: Centralized training site (classroom, workshop, and/or field visit site)



motivational devices such as behavior-oriented objectives, self-assessment or self-test questions in reading texts, practical activities, summaries, and additional readings. This was intended to enable the trainee to interact easily with the text. As trainees worked through the interactive text, they were expected to perform practical activities and self-tests designed to build skills in PHC and training.

During this self-study period, trainees were supported on-site by local resource persons. The role of these mentor-preceptors (and to a lesser extent the co-facilitators) during the DBL period involved teaching through coaching and demonstration, giving feedback, clarifying concepts, and modeling problem-solving techniques in the PHC clinic and community based case management. During site visits to trainees, co-facilitators reviewed the answers or results to selected self-tests and practical activities in order to assess the application and mastery of the acquired skills. Co-facilitators were also expected to administer post-tests for the more clinically oriented modules after each module was covered, so that the grade could be counted towards a final course grade (once this was established).

The trainees were also expected to carry out an Assignment Project during the DBL period to be completed by the end of the fifth module. This Assignment Project was to be given to the

trainees when they came for the intensive face-to-face week of the second module. Note that the planned Assignment Project was never realized due to slowness and delays in completing some of the DBL training modules.

The sixth month of the training program was used to consolidate the learning and complete the required assessments and trainee evaluations. At this point a sixth training module was eventually added to cover some earlier sub-modules that needed reinforcement.

Trainees were awarded a certificate at the end of the training, if they completed the program, complied with the exit requirements, and had a satisfactory assessment based on the stipulated expectations of the program. These nurse trainers then began training other service providers in other health facilities in their region in comprehensive PHC skills, using the same approaches and slightly modified DBL materials that were used during their training program. (The DBL materials were slightly modified because they no longer contained the training-of-trainer subjects.)

One of the important design features of the DBL training model was that it involved providers and administrators at all levels of the health care system to effect changes. Not only trainees and trainers were involved in the program. Managers, supervisors, policy-makers, and other influential persons also participated either prior to or during actual training. This increased greatly the probability that the training would result in sustainable changes in PHC training and service provision because policies and procedures would be in place to support training and because managers and supervisors would have an understanding of the PHC re-orientation. All levels of the health care system could thus support trainees as they used their new knowledge and skills in the work place.

Another important design feature of the model was to link training and service provision functions. Throughout the training program period, nurse-trainees functioned in their double roles of service provider and (after the completion of the course) trainer. As the modules were being tested by the nurse trainees in their own service sites, the trainees could actually begin re-orienting health services. This allowed the trainees and program designers to gain an understanding of issues in re-orienting services, that is, difficulties a trainee would encounter in applying new skills at the service site. These experiences in applying skills on the job could then be funneled back into the training course assessments that allowed subsequent training modules to be adjusted and improved.

The reader is referred to **Annex C**, which presents a copy of the training course guidelines. These *Guidelines* describe the multi-method training design and approaches, how training was structured, the roles of trainees and facilitators, and what learning and training materials were to be used.

4.3 The multi-method training strategy

The innovations of the training program were many and centered on (1) the use of mutually-reinforcing multiple training approaches, and (2) the development of carefully constructed and interactive DBL materials. **Section 4.3** first presents the rationale for using a DBL approach to learn PHC and training skills in South Africa and key questions that needed to be answered to test the model, and then discusses the important innovations of the DBL training program.

4.3.1 Rationale for a distance-based learning approach to training

The choice of a distance-based learning (DBL), supported by other training modalities, was a good approach to use in the South Africa context because it

- Responded to DOH concerns that participants remain at their service sites as much as possible over the 6-month training period, using local resources as training program facilitators and mentor-preceptors as much as possible; and
- Would also build on South Africa's long history and experience in distance-based education.

Additionally, it was expected that training large numbers of service providers with a DBL approach would over the long run be more economical as compared to traditional training in classroom and formal practicum settings (NB: there were staff in almost 820 health facilities to train in the Eastern Cape Province alone). because distance education materials developed one time by one expert (or group of experts) could be used later to reach many people. The up-front costs of developing, piloting, and testing the module curricula and related training materials would be an intensive, one-time investment. Later costs to use the curricula and training materials in other provinces would not include the materials development costs.

There were also several practical advantages to a DBL approach. Given that few service providers or trainers in South Africa had much experience in PHC philosophies or approaches, a DBL approach could maximize the talents of those providers who already had substantial PHC experiences, particularly in the materials development phase. Finally, because the course curriculum and evaluation would be standardized, learning would be standardized. It would, therefore, be possible to give continuing education credits to those who successfully completed the course, thereby valorizing the new PHC approach and encouraging service providers and trainers to make successful PHC transitions in the work place.

4.3.2 Summary of elements of the strategy that made it innovative and important to pilot

The challenge in creating the DBL training program was how to help trainers and service providers learn PHC concepts and approaches, develop training of trainer and PHC skills, and promote positive and caring attitudes *from a distance*, when no master trainer would be

available on a daily basis to help effect the transfer of skills or development of new professional attitudes. It certainly had never before been attempted on such a large scale.

PRIME staff grappled with a series of questions during the design phase of the training program:

- How can one design a distance-based learning course that will move a trainee beyond studying and learning theory to learning skills?

- How can DBL materials be developed to emphasize the application of knowledge and skills training (in this case, acquiring theory and comprehensive PHC skills and participatory training skills that enable someone to re-orient clinical services to an integrated PHC service delivery model)?

- What other training approaches and strategies are necessary to support the distance-based learning, since DBL materials alone cannot achieve the desired transfer of skills for clinical decision-making and training?

- Given the emphasis on skills development, how can training be organized to ensure that skills transfer will occur?

- What training management support is needed to organize and conduct actual training events?

- How can clinical and other skills acquired from DBL and intensive group sessions be distance-monitored and evaluated without direct PRIME/BASICS involvement?

- Given that adult education courses often do not provide professional accreditation to trainees successfully completing the course, how could distance-based training include elements of standardized performance evaluation to provide deserved recognition to those successfully completing the course?

4.3.3 Novel use of complementary training approaches

Developing the course required a carefully constructed training design that would result in a transfer of both knowledge and skills if used correctly. One of the unique features of the training program was its use of 3 mutually-reinforcing training approaches: distance-based learning using programmed instruction for both knowledge and skills transfer, group learning, and on-the-job mentoring. **Table 1** on the next page summarizes the different methods and approaches used in the PHC Comprehensive Skills for Trainers Program.

A review of the table indicates that each of the chosen training methods and approaches offsets potential problems or limitations of others, creating synergies and support between the

different methods and approaches, with the end result of maximizing the learning and skills acquisition of the nurse-trainees. Essentially, self-study can be problematic if the trainee lacks motivation or time. Using self-study methods to learn a new skill may result in the trainee learning the skill incorrectly because no instructor is available to correct mistakes and improve performance. The multiple methods of the training program compensated for these potential weaknesses by having intensive face-to-face weeks in which facilitators demonstrated new skills to guide the trainees when they returned to their work sites. Once at the work site, mentor-preceptors and co-facilitators made regular site visits to work with the trainees directly to improve skills, and by virtue of regular visits, helped to motivate the trainees to continue learning.

It was intended that the combination of the 2 distance-based learning methods (for knowledge and skills acquisition) would create a learning synergy that promoted the development of skills. This occurred because each DBL lesson was designed to make learning interesting, stimulating the trainee to *apply* new knowledge. For example, the learner solved case studies derived from real life examples during the self-study period. This type of distance-based learning used printed reading materials, and self-learning activities, to move the learner to the next level of reality, where the learner was required to solve a real issue or perform a real task at the work site.

TABLE 1: Summary of the multi-method training approaches used in the DBL training program

RATIONALE FOR INCLUDING APPROACH	POTENTIAL PROBLEMS/ LIMITATIONS
DISTANCE BASED LEARNING: KNOWLEDGE TRANSFER* From self-study and problem-based learning using print materials	
♦ Allows learning to occur at work site or home at times convenient to trainee using already-familiar print materials ♦ Builds on knowledge gained during face-to-face sessions ♦ Use of self-tests reinforces confidence to apply knowledge, practice, and develop skills ♦ Since printed training materials cover several lessons per module, quicker students can continue learning at their rate	♦ Requires motivation and self-discipline to make effort and time to study and learn the material ♦ Knowledge may not be transferred correctly because no expert is available on-site to supervise trainee at the time of learning ♦ Knowledge may not be reinforced in actual practice or informed by practical realities of work at the service site
DISTANCE BASED LEARNING: SKILLS TRANSFER* from application and practice at service site during work time	
♦ Allows immediate application of new skills as they are learned ♦ New skills application is at trainee work site and in community, therefore reflects job reality of trainee ♦ Allows trainee to apply skills at a time convenient to him/her	♦ Requires motivation and self-discipline to make effort and time to acquire skills ♦ Learning alone denies the trainee the opportunity to interact with peers taking the same course ♦ Skills may not be transferred correctly if no expert mentor is available on-site to supervise trainee ♦ Work site may not support application of new skills ♦ Given that the learner's primary responsibility is to line functions, the DBL self-test and activity instructions may contradict the line function expectation of the learner, thus making learning 'as you work' difficult ♦ There is no time to study the print material except in the evenings after work
CENTRALIZED GROUP LEARNING During face-to-face course of each DBL module with facilitators, co-facilitators, peers	
♦ Allows trainee to gain overview and clarify with facilitator and peers what he/she is expected to learn during DBL period, and introduces new and technically complex concepts and terms ♦ Because sessions cover the module subject matter, provides motivation for trainee to begin studying the DBL print materials upon return to work site ♦ Because co-facilitator has some district supervision responsibilities, promotes training and support linkages between supervision and on-the-job skills training ♦ Strengthens relations between trainee and co-facilitator and mentor-preceptor ♦ Allows group sharing of problems and experiences, facilitating knowledge acquisition	♦ If a trainee misses a face-to-face course, it is difficult to embark on DBL self-study of the same module: The module components include content from the face-to-face week and require DBL practice at the work site using skills that the trainee may have not seen demonstrated before ♦ Requires additional funds to support costs of trainee transportation and accommodation during the week

MENTORING During DBL period at service sites by training facilitators	
♦ In absence of telephone, computer or other means of direct contact, allows trainee to have regular contact with an instructor during self-learning period, including on-the-job support to trainee as he/she learns new knowledge and skills and interacts with clients ♦ Provides timely counseling and encouragement of trainee, offsetting frustrations and difficulties that could result in a trainee dropping out of program ♦ Provides possibility for trainee to correct errors immediately in learning and skills application. ♦ Motivates trainee to learn in a timely manner because mentoring sessions are weekly throughout DBL period ♦ Because mentor-preceptor is normally trainee's on-site supervisor, reinforces positive supervision and performance evaluation roles, and creates supportive environment in which trainee can practice new skills	♦ Mentor-preceptors and co-facilitators may have different PHC skill levels, resulting in variations in learning between trainees, resulting in uneven skills/knowledge in a region ♦ If the interpersonal relationship between trainee and mentor is not good, trainee may not benefit and learn from coaching or mentoring experiences ♦ At time of training, few people in the potential pool of mentor-preceptors in a region had clinical competencies in all PHC areas, making it a challenge to find the correct mentor(s) with adequate skills for a module or modules

** Note that the 2 DBL knowledge and skills areas are treated separately because of the assumption that knowledge alone is generally insufficient to improve performance. Learning skills in a DBL program was the new application that, combined with knowledge acquisition, allowed a trainee to improve performance.*

4.3.4 Special treatment of the DBL print materials to maximize learning

The DBL print materials themselves were another unique feature of the training model. The way that the materials were designed, both graphically and as interactive programmed instruction, contributed to the acquisition of knowledge and skills. The text and the lessons within each text were formatted to create visual interest and highlight important aspects of the text. The various elements within the text, such as the behavioral objectives, the self-assessment questions, the lesson summaries, learning activities, and the self-tests, were designed to reinforce each other. This allowed the trainee to build on information and skills that had been learned in the past and to make connections between new and old material that would deepen learning.

In particular, 2 elements of the DBL print materials were important in maximizing the linkages between knowledge gains and skills development because the way they were constructed to require that the trainee learn skills. These 2 elements were the learning activities and the self-tests.

Learning activities were found throughout the text and are action-oriented and focused on discrete activities that were part of a larger set of performance skills that a trainee needed to learn. These exercises were designed to encourage the trainee to use *knowledge* acquired from self-study to solve a real-life program. Activities were presented in the form of an exercise, a case study, a situation to be analyzed with related questions to be answered, or as a problem-solving scenario using a real-life situation. The trainee's answers to the various learning activities were shared and discussed with the trainee's mentor-preceptor and co-facilitator during site visits, allowing the visitors to offer different perspectives to the trainee's analysis thereby enriching the learning experience.

Learning activities had the following features:

- Were active rather than passive (i.e., the trainee has to do something, such as make a list, draw, complete a chart, look up reference materials)
- Asked the trainee to be analytical (eg, the trainee has to study a situation and choose or select an option, and support the choice with a sound rationale)
- Involved using or applying specific knowledge and/or skills to make a decision, present an analysis, or complete the learning task
- Was situation-specific rather than generic (ie, the activity focuses the trainee on his or her community, clinic, life, clients)
- Used and built upon a trainee's previous knowledge of content or context in the learning environment (eg, the community)

Self-tests were a major self-assessment tool for *skills* development and were found throughout the DBL text. The results of self-tests were shared and discussed with the trainee's mentor-preceptor and co-facilitator. Self-tests were different from learning activities because self-

tests were designed to learn a *set of knowledge and skills* that comprised a complete task. Essentially functioning as a practical exam, self-tests were presented in the form of an activity or actual knowledge, test, or skills checklist and were designed to allow the trainee to test his/her new skills and related knowledge and attitudes in a holistic manner. They empowered the trainee, too, because he or she saw the changes and could evaluate the outcomes of the change (ie, whether it improved or worsened the service delivery or community relations and outreach).

Self-tests had the same features as those noted for learning activities, above. They also had the following characteristics that were unique to the training program:

- The trainee was asked to carry out specific on-the-job assignments directly of value to the organization, either within the health facility or at the community level, such as providing new or integrated clinic services or developing a stronger relationship with the community. The trainee benefited from testing new knowledge and skills in real life work setting and subsequently gained competence and confidence in using the new skills. The health facility equally benefited because an PHC-oriented change had occurred
- The trainee was asked to share the results of the self-test assignment with work colleagues, supervisors, managers, or the community. By explicitly sharing with colleagues the changes that improved health care, the value of the new PHC approach was reinforced at various levels

The reader is referred to one of the training sub-modules used in the Comprehensive PHC Skills for Trainers Program in **Annex D**, which shows the format and presentation of a module and related learning activities and self-tests.

5. PROCESSES TO DEVELOP AND ASSESS THE DBL TRAINING PROGRAM

Like all good training, the development of the training program involved many activities prior to conducting actual training. During this *pre-training stage*, training needs assessments were conducted to gain an understanding of the training and service delivery environments. Working relationships with South African counterparts were established to develop consensus on PHC services and approaches, since the PHC idea was only being introduced in South Africa and had not yet been operationalized. To ensure a South African perspective and reinforce the participatory nature of the PHC system, multi-disciplinary working groups were used to develop the training program curriculum and related training materials. The management of the training program and activities also had to be addressed in advance to ensure that all elements to support the nurse-trainees were available at the service sites and to ensure that training would be adequately monitored and evaluated. Finally, those individuals who acted as training facilitators and co-facilitators also needed to be oriented to the multi-method training approaches and materials and to PHC approaches if necessary, before any training could be conducted.

The actual *training of trainers* guided by the training model functioned essentially as the *field testing of the training program* and was critical in assessing and working out the normal administrative and content problems that arise when implementing a new program. Experience from this first effort would ensure that future programs would function better. During this stage, the training approaches and curriculum were used, tested, evaluated, and revised before expansion of the training program to other service sites in the Eastern Cape and other provinces.

It should be noted that the unique timing of the Bridging Activities project complicated the training program development and implementation greatly: Training would *not* be conducted with a goal of supporting and improving existing health services within a stable health care delivery system, the normal occurrence. Rather, training would be conducted during a period of profound reorientation. In effect, the goal of training in the Bridging Project was to assist the Eastern Cape DOH to use training and other inputs to restructure and reorient as quickly as possible the existing health systems into one PHC-based health system.

At a more global level, pressures to show results in the new PHC system were being exerted at many levels by many stakeholders, including the general population. Everyone wanted to proceed quickly, but much of the groundwork had not yet been completed. Thus, while there was occasional resistance in establishing partnerships, there was also great pressure to move the training process forward, and not always as rationally or thoughtfully as could have happened.

Section 4.2 already described the actual training activities, as part of the description of the training program model. The rest of **Section 5** touches briefly other elements of the training program: (1) the pre-training stage of program development and the assessment, and (2) the assessment of the DBL program and related training materials.

5.1 Pre-training activities

5.1.1 Assessing the capability of national and provincial training systems to support training

During the initial stage of the project, the 4 cooperating agencies involved in PHC and management training activities and the national DOH conducted a very general training needs assessment of 4 provinces (including Eastern Cape Province) over a 2.5-week period in mid-1995.

The PHC general training needs assessment indicated that while certain elements of a national training system were in place, other elements needed to be improved. DOH trainers existed at national, regional, and district levels, and the training system already took into account the linkages between training, supervision and service delivery, and eventual support to the trainee at his or her service site. Certain DOH service and training parameters had not yet been established, though, because the integrated service package was still under discussion at the policy level. Many standards and service guidelines had not yet been formulated to guide integrated service delivery, training, or the evaluation of the training program. Related to this, the PHC Comprehensive Skills for Trainers Program for rural nurse clinicians was being designed with the eventual goal of accreditation for those who participated, but no guidelines had been set regarding acceptable performance standards. There was an on-going debate regarding on which authority would provide accreditation of the trainers once they completed training. Finally, the general training assessment indicated that the capability of training managers to manage all aspects of a multi-method training program needed strengthening. For example, at the beginning of the program the training managers did not understand the value of (and thus did not see the need for) assessing training needs. They also had no substantial experience in designing a DBL program with a PHC orientation that focused on skills acquisition and depended on updated and clinically experienced mentor-preceptors to help achieve skills transfer to trainees at the service site. This meant that INTRAH/PRIIME/BASICS had to adjust the training strategy along the way to reflect the realities of the training system.

5.1.2 Assessing the needs of service providers and trainers

The 1995 general needs assessment showed that service providers were interested in adopting PHC approaches and looking forward to change. Certain providers had already taken the initiative and were making efforts to improve community participation. For example, some health providers were trying to incorporate traditional healers in their activities to improve the quality of care. Barriers to overcome included the following: services were still highly

focused on curative services for individuals, and were not adequately balanced with population-based strategies aimed at prevention and health promotion. In rural clinics, the assessors observed staffing shortages and inadequate basic supplies and equipment. No standardized and integrated service provision of the proposed, essential package of services was observed. Many service providers lacked a client-oriented approach. Nurses in rural clinics did not have the time or skills to expand and extend community-based interventions. At the same time, service providers were not using community health workers to help expand outreach.

The assessment also showed that considerable training resources were available locally. The in-service training approaches that were most frequently used were workshops or other centralized approaches that required personnel to be absent from their posts for prolonged periods. There was a need to explore options for distance-based learning.

While the assessment provided a general snapshot of the training and service delivery situation, it did not provide in-depth information on the gaps in knowledge, skills and attitudes of service providers, which types of service providers needed to be targeted to improve their performance, or which institutions needed to be targeted to improve services. It did not assess training and program management skills of the ECDOH trainers to guide the training program more precisely. As per normal procedure, PRIME/BASICS preferred a more comprehensive assessment. The ECDOH, though, interpreted the scope of a training needs assessment differently. Officials felt that the service managers already knew the performance gaps that existed, and could thus identify the topics of the training program. From their perspective, a training needs assessment did not necessarily have to be related to the jobs of individual providers or trainers, or to job descriptions. It should be noted, too, that the health system was in transition and staff were uncertain about securing future positions; such an environment was also not conducive to conducting a thorough needs assessment that focused on provider performance. Thus, a comprehensive training needs assessment was never conducted, and this led to later problems, particularly in the development of training materials and in the evaluation of the program.

5.1.3 Establishing relationships with key stakeholders and developing parameters to support and guide PHC skills training

As democratization was sweeping the new South Africa, consensus-building and multi-level consultations became highly valued processes. These processes were complementary to developing a PHC approach, to reinforce a participatory style of working and of eventually providing health services. Additionally, it was necessary to involve more than actual course instructors and trainees in the development of the training program. Without the support of key stakeholders in defining the new PHC approach and how it should be supported, it was unlikely that the service providers and trainers would be well supported after the training program ended. Stakeholder involvement would encourage sustainable changes in service delivery by the health program managers, supervisors, or policy makers. Thus,

PRIME/BASICS and counterpart cooperating agencies made extensive use of participatory group methods to develop key stakeholder relationships and establish the parameters of the PHC Comprehensive Skills for Trainers course and the PHC Management TOT course. Examples are presented below.

5.1.3.a National Planning Task Force to define global PHC guidelines

A group of about 25 people formed a task force during the initial May 1995 workshop of key stakeholders, described in the next sub-section. Charged with the responsibility of prioritizing activities to overcome listed obstacles and to developing a Provincial Action Plan and training and PHC guidelines, the group clarified the anticipated changes in the decentralized service system, identified potential and priority cadres to be trained, training needs (based on existing documents), and a training strategy.

5.1.3.b National workshop of key stakeholders to develop a shared vision of PHC

An initial orientation workshop was also held in May 1995 to develop a shared vision for the South African training program (both the comprehensive PHC skills and management programs). Thirty participants were expected. However, because of the great interest, approximately 80 participants from all 9 provinces attended, drawn from provincial DOHs, training institutions, professional statutory councils, the national DOH and Department of Education. The vision that was defined during the workshop was in keeping with national policy, and emphasized the importance of PHC. There was a strong consensus that training should occur in local settings, and that training be based on a holistic, multi-disciplinary, integrated, and needs-based approach. The participants defined structural obstacles to implementation (already discussed in the needs assessment) and a broad agenda that would require much information gathering by the South Africans prior to a follow-on workshop planned for October 1995.

5.1.3.c PHC Working Group to develop the training course and materials

In developing the training plan, the ECDOH provided the general content areas that they thought should be included in the training program. Using these parameters the training program was structured to have the following 5 training modules:

1. Orientation to PHC approaches for service delivery and management
2. Training (adult learning) and facilitation, epidemiological research, monitoring and evaluation
3. Reproductive health and women's health interventions
4. Child survival interventions
5. Acute and chronic conditions in adults
6. Consolidation of content and skill areas from Modules 1-3 (*NB: This module was added later*)

During the stakeholders' workshop in October 1995, a sub-group of about 25 participants formed a PHC Working Group to focus on developing the PHC Comprehensive Skills for Trainers course. The PHC Working Group met several times over a 13-month period to develop a training plan, which would make the training strategy operational. Although there were delays and problems with the working group in producing training materials (refer to the 'lessons learned' section for further detail), the curriculum and training package for the first training module were ready when the training program was officially launched. (Refer to **Annex E** for a description of the curriculum.)

The ceremony to open the training program on July 1, 1996 was held with great fanfare and officiated by ECDOH policy and management officials, ECDOH PHC working group members, representatives of education and service delivery institutions, NGO representatives, the 10 regionally-based co-facilitators, and the 21 nurse-trainees.

5.2 Assessment of training activities

As a training program experimenting with a new and innovative DBL model that should result in changes in knowledge, attitudes, and skills, it was critical to assess discrete elements of the training program in order to have a larger perspective on how successful was the DBL training program.

To capture the information needed to assess the different elements of the training program PRIME/BASICS developed a comprehensive *monitoring and evaluation plan* prior to training. (Refer to the training program guidelines in **Annex C** for a description of the monitoring system that was created for the training program.) Basic program monitoring information was collected. Facilitators of each face-to-face week training session recorded the attendance of participants. As the training co-facilitator visited various service sites to observe activities during the DBL period, trainees were monitored regarding where they were in the course, which mentor-preceptor or co-facilitator supervised them during the DBL period, and whether they had begun to make changes in service delivery.

The DBL materials and training modules were continuously assessed by both trainers and trainees to determine how well the knowledge and skills transfer was working. Assessments occurred during site visits and in later group sessions during the face-to-face week. During site visits, co-facilitators identified and discussed problems that trainees had as they worked through the written materials. They also observed the application of new skills and discussed performance problems that were observed with the trainees. For the more clinically oriented skills modules (Modules 2-5), participants took pre-tests before beginning the module and a post-test upon completion of the module, that was graded by a facilitator. Using standard PRIME participant reaction forms, trainees were asked how satisfied they were with each module after its completion, and gave suggestions to improve each module.

All of this information was systematically collected and analyzed for use in improving subsequent training modules. For example, after a series of visits to trainee work sites, co-facilitators suggested that the program designers develop a DBL checklist for mentor-preceptors to use with trainees. BASICS extended the time to complete Modules 4 and 5, based on timing problems experienced in earlier modules. PRIME added a sixth module to consolidate learning (primarily covering the first 3 modules) when there was insufficient time for participants to gain confidence in new skills. Essentially, all modules were to be revised after assessing their use and testing in the field.

6. SYNTHESIS OF MAIN ACHIEVEMENTS AND CHALLENGES

Two program evaluations were conducted just prior to the end of the training program, and focused on the program results. Because there was insufficient time during the 18-month Bridging Activities project period to focus on analyzing training program *impact*, money was set aside by the follow-on EQUITY Project to evaluate the program. The results of 3 training program evaluations that were conducted in 1997 are discussed in **Section 6**.[1]

As stated in the Methodology Section, each of the 3 evaluations was conducted by a different evaluator who gathered information from different key informants. This is important to note because the validity of the present case study results, which are mostly qualitative, are strengthened when similar conclusions are cited by more than one independent evaluator.

6.1 Main achievements

The various evaluations of the DBL training program indicate that it was very successful and achieved its objective of assisting the ECDOH to re-orient training and service delivery to a PHC approach. The DBL approach to training and PHC skills development worked well. Trainees improved their skills in PHC and interactive training. With these new skills and a modified DBL curriculum, the nurse-trainers went on to train other service providers in PHC skills. The re-orientation of health services to a PHC model in the Eastern Cape was the major impact of the program; this change can be attributed in large part to the application of new PHC and training skills by the nurse-trainers and service providers at their work sites.

The important outcomes of the training program are presented in **Table 2** on the next page. Note that because there was no systematic needs assessment conducted prior to training, it was not possible to quantify training capability and service delivery improvements, although there were clear indications of improvements at both levels. (The letters in parentheses after each finding indicate in which evaluation study(ies) the result was presented: CC for the Celeste Carr evaluation, NS for Norah Shelver, and W K-M for Wambui Kogi-Makau.)

[1] Results that are reported in this section are drawn from 3 evaluation reports: *Report of the background information collected, organized and presented by PRIME consultant Wambui Kogi-Makau, in preparation for the final evaluation of the PHC comprehensive clinical skills and PHC management skills training courses* (Feb 1997), edited by L N Parker; *The USAID Evaluation Report of the PHC Comprehensive Skills Training Management Training* (May 1997) by Celeste Carr *et al;* and the *EQUITY Project Impact Evaluation of PHC Management and PHC Comprehensive Skills Training of Trainers Under EQUITY* (Dec 1997) by Norah Shelver.

TABLE 2: Achievements of the PHC Comprehensive Skills for Trainers Program

Number of trainers and service providers who received training

- 21 PHC nurse trainers of PHC service delivery were trained, at least one from each district (CC)
- About 20 PHC co-facilitators and mentor-preceptors have improved PHC knowledge and training skills. (Note that formal training for co-facilitators and mentor-preceptors was not conducted as planned due to time constraints; many benefited indirectly from the training provided to the nurse trainees) (CC)
- Over 75 frontline PHC providers were trained and provide improved quality of services (75 was the number reported at the time of the 1997 evaluation. Training of additional service providers was on-going as the case study was being written) (CC)

Effects of training on the Eastern Cape Province DOH trainers and the training system

- Training styles of various trainers have changed and are now more participatory (CC,NS, W K-M)
- The introduction of the PHC Comprehensive Skills for Trainers course and related DBL materials has helped to improve and standardize training capacity between regions and districts (CC,NS)
- There now exists a cadre of inter-disciplinary experts and resource people who can use DBL approaches and related training materials (CC, NS)
- PHC DBL training materials and learning modules are developed, field tested, and ready to be revised (CC,NS,W K-M)
- Those who participated in conducting training using the curriculum have improved facilitation and teaching skills as well as on-site clinical practice skills, and have succeeded in making the PHC approach more practical and feasible (CC, NS, W K-M)
- There now exists a province-wide infrastructure of district trainers, local mentor-preceptors, and regional co-facilitators essential for the implementation of distance-based learning concepts (CC)
- Regional training units/teams have been formed to plan and coordinate (and in some cases to conduct) future training (CC,NS)

Impact of training on the Eastern Cape Province health delivery system

- As nurses began carrying out assigned PHC tasks in the clinics, and using skills that they gained from the course, their performance changed--so much so that clinic attendees witnessed a change in attitude of the nurses and reported this to clinic personnel (NS,CC)
- Many clinics reorganized and began providing integrated services, including the integrated management of childhood illness service. (CC,NS, W K-M)
- Clinic staff reported increased clinic attendance, and staff linked this to improvements in service quality and access, due to service integration (CC,NS)
- Other anecdotal reports indicated that clients favored attending clinics where nurse-trainers were found (CC)
- Providers reported an increased ability to counsel clients (CC,NS,W K-M)
- Record keeping improved (NS)
- Providers now applied informed consent principles for FP clients (prior to the training, the nurse determined the best method for the client) (W K-M)
- Service providers organized many more community activities to improve community participation, eg, coordinating community health forums, developing nutrition program jointly with schools, conducting health surveys. (NS, W K-M)

Sources: *The USAID Evaluation Report of the PHC Comprehensive Skills Training Management Training* (May 1997) by Celeste Carr *et al;* and the *EQUITY Project Impact Evaluation of PHC Management and PHC Comprehensive Skills Training of Trainers Under EQUITY* (Dec 1997) by Norah Shelver; and *Report of the background information collected, organized and presented by PRIME consultant Wambui Kogi-Makau, in preparation for the final evaluation of the PHC comprehensive clinical skills and PHC management skills training courses* (Feb 1997), edited by L N Parker.

6.1.1 Improvements in trainee knowledge and skills

All 3 evaluations explored changes in knowledge and skills of the nurse trainees, who were the main training program change agents to help re-orient the training and service delivery systems. The 3 evaluations concluded that the training program resulted in a cadre of trainers and service providers with improved knowledge and skills in PHC and interactive training. (refer to **Table 2**.) These conclusions were primarily based on qualitative information. The results of pre- and post-tests, taken by trainees before and after completing several of the modules (refer to **Table 3**), corroborate the qualitative findings of improved knowledge and skills. While there were improvements in all subject areas, there were significant gains in knowledge and skills in peri-natal health, early nutrition, family planning, and women's health.

TABLE 3: Nurse trainee pre- and post-test scores of selected sub-modules

Module topic	Mean pre-test score (%)	Mean post-test score (%)	Percent change (%)
Module 3: Intro to reproductive and women's health			
Sub-module 3.1: Sexuality and life-coping skills	49.1	58.8	9.8
Sub-module 3.2: Family planning	44.8	58.7	14.0
Sub-module 3.3: Maternal health	66.5	67.6	1.0
Sub-module 3.4: STDs, HIV/AIDS, and infertility	49.1	58.9	9.8
Sub-module 3.5: Women's health	55.4	69.1	14.0
Module 4: Child survival interventions			
Module 4.1: Peri-natal health	58 (est)	83 (est)	27 (est)
Module 4.2: Early nutrition; optimizing growth	37 (est)	99 (est)	62 (est)
Module 5: Acute and chronic conditions in adults			
All sub-modules combined	58 (est)	65 (est)	7 (est)

Source*: Report of the background information collected, organized and presented by PRIME consultant Wambui Kogi-Makau, in preparation for the final evaluation of the PHC comprehensive clinical skills and PHC management skills training courses* (Feb 1997), edited by L N Parker.
Notes: (1) "Est" indicates that mean scores for these modules were estimated from graphs depicting mean pre and post-test training scores. Precise numerical data were not available. (2) No data were available for Modules 1 and 2, due to participant reluctance to link pre and post-test scores to individuals.

6.1.2 Changes in the training and service delivery systems

The main effect on the training system was that the DBL training program produced a cadre of trained trainers and service providers with improved training capability and improved PHC skills and knowledge. An additional change in the system was increased collaboration and information sharing between trainers. Because the trainers came from 5 different regions in the Eastern Cape, the DBL cross-training helped to develop a network of PHC trainers throughout the Eastern Cape Province, important in sustaining the PHC training effort after the program ended.

The program also helped create changes in health service delivery that could be attributed in large part to changes in knowledge and skills brought about by the training.
Table 3 shows that in sites reached by the training program, there were indications of a shift towards an integrated package of PHC services, improved ability to communicate with clients, and more efforts to move services out to the community.

6.1.3 Participant satisfaction with the multi-method training strategy

If the DBL program was to be expanded to other provinces in South Africa, it was important to determine if those involved in the training liked the DBL approach. All 3 evaluations explored participant satisfaction with the training and stated that the participants gave high marks to the training activities. Indeed, those who participated in various ways in the training program, including nurse-trainees, facilitators, co-facilitators, mentor-preceptors, regional

directors, deputy directors, and clinic supervisors, felt that the training activities were valuable. All were impressed with the program content, design, and consultants. Many believed that other health professionals should be trained in PHC skills and philosophies using a modified version of the curriculum and DBL materials.

Module 2 was one of the modules that provided the most systematic and complete evaluation information on participant satisfaction with the DBL module, using PRIME's standard Participant Reaction Form. For Module 2, 100% of the respondents agreed that the course materials were relevant to their work (28% strongly agreed with the statement). Almost all (95%) agreed that their mentor-preceptor was effective. All (100%) felt that the self-study sessions contributed to learning and applying new concepts (32% strongly agreed with this statement and 68% agreed). Nine out of 10 respondents felt that traditional lecture methods were not conducive to adult learning. One of the common suggestions to improve the program was to use more role-plays to demonstrate skills.

6.2 Operational challenges of the DBL training program

Table 4 presents the important operational challenges and issues of the training program and PRIME/BASICS responses to them. Refer to **Section 7** for a discussion of issues raised in the actual design of the DBL training program and lessons that were learned during program implementation.

TABLE 4: Key operational challenges and issues of the DBL training program

Key challenges	PRIME/BASICS Responses
♦ Developing DBL approaches and materials to transfer skills as well as knowledge and attitudes	♦ Refer to Section 7
♦ Operationalizing a PHC approach to guide training program development *(Policies were still being created as the training program was being developed. The operational vision of what a PHC system should look like at a clinic level or from a training perspective was undefined, but critical in order to develop the training program.)*	♦ Used a national workshop with key resource persons and decision-makers in attendance to facilitate developing a consensus of what should be the overall PHC vision. ♦ Referred to international standards to develop draft policy and service guidelines that supported the service delivery vision and training approach defined by the DOH.
♦ Working in a totally new (South African) environment with no established presence yet, and with unknown counterparts *(INTRAH and BASICS had just established a presence in the country as the training program was getting underway. It took some time for both BASICS and NDOH to establish and staff offices and create administrative systems, which affected the management support to the training program.)*	♦ Used working groups to ensure a South African perspective, to gain a better understanding of operational realities, and to establish and improve relationships with counterparts in actual working situations ♦ Obtained additional administrative support from PRIME regional office during program until BASICS office was well-established in South Africa
♦ Developing and evaluating a training program without having conducted a comprehensive training needs assessment	♦ Made use of existing knowledge of PHC Working Group members and others involved in service delivery ♦ Made use of international standards to help guide competency levels in PHC and training ♦ Used on-the-job training techniques to help working groups develop participatory DBL training materials and curriculum ♦ While program evaluation was conducted, had to limit analysis to general observations since only limited training and service delivery changes could be quantified
♦ Conducting training in a period of profound health systems changes *(Changes and uncertainties were at the forefront during the health system restructuring and future job prospects were not yet clear for anyone in the DOH. This sometimes resulted in an inability to make decisions and assign staff to the training program.)*	♦ Maintained flexibility to respond to changes in training assumptions, training and ECDOH system support, and staffing changes ♦ Used project personnel and consultants when system support was not forthcoming as planned
♦ Working within a very short time frame to design and implement the DBL training program *(The time frame was short given the 18-month project period and the need and desire to use participatory approaches in the DBL training program development. Delays also occurred due to the re-structuring of the health system, which created understandable uncertainty and sometimes unwillingness of certain actors to make decisions upon which to base project development and actual training.)*	♦ Limited the scope of training (training program was limited to E Cape Province) ♦ Used both structured and unstructured on-the-job training techniques to transfer skills in DBL program development to those involved in program design ♦ Balanced working groups with individual work to move training agenda forward

7. SYNTHESIS OF LESSONS LEARNED AND RECOMMENDATIONS FOR FUTURE DBL TRAINING

At the beginning of this case study, several questions were raised about the possibility of extending traditional distance-based education to a distance-based learning approach that would focus on skills transfer and changes in attitudes as well as knowledge gains. The experiences of designing, testing, and implementing the DBL training program helped to clarify responses to these questions and to develop lessons learned and recommendations for future training.

- **How can one design a distance-based learning course that will move a trainee beyond studying and learning theory to learning skills?**

The South African experience has clearly indicated that a well-designed, multi-method distance based learning program can result not only in improved knowledge but also in improved skills and positive PHC attitudes. The combination of training approaches—DBL as the on-site vehicle for knowledge and skills acquisition complemented by strategically timed group learning sessions and on-site mentoring to ensure that skills are well-learned—was a key DBL innovation that supported the trainees well as they learned PHC and training skills. Each of the different approaches included in the training model design offset potential learning weaknesses found in other approaches.

Participant reactions to the training program and the results of the evaluation studies indicated that the approach was very acceptable to those involved in it, and yielded both training and health systems changes. Wherever feasible, program weaknesses that were noted in this case study have been addressed or noted, and should make future training in other provinces in South Africa more efficient.

Recommendation:

> The idea to address skills using a distance-based learning approach is an important one and the costs and effects should be explored more rigorously, and perhaps in more stable health delivery settings, to determine how far the approach can go in terms of trainee skills development. Clearly, the ability to transfer skills from a distance widens greatly the potential uses of distance based learning programs.

- **How can DBL materials be developed to emphasize the application of knowledge and skills training (in this case, acquiring theory and comprehensive PHC skills and participatory training skills that enable someone to re-orient clinical services to an integrated PHC service delivery package mode)?**

There are 2 aspects to this answer, related to the types of DBL materials developed for the training program and the need for a baseline assessment to guide materials development.

First, PRIME/BASICS designed carefully constructed educational materials that made use of learning techniques requiring active learning by the trainee. These DBL materials were an important self-study innovation in creating the bridge between knowledge and skills acquisition. The way that the module text and lessons were written and laid out graphically; the mutually reinforcing roles of the behavioral lesson objectives; the self-assessment questions; the lesson summary; and the practical and situation-specific self-tests and lesson activities that demanded thought and active learning by the trainee worked synergistically to help the trainee acquire both knowledge and skills in a self-study environment. The use of these "extended" distance education techniques and print materials, such as the DBL program's use of hypothetical case studies followed by application in the work site, created effective bridges between the theoretical and the practical.

Second, DBL materials can be developed to emphasize skills acquisition, providing that there is sufficient information *prior* to developing the curriculum. One of the major difficulties that continued to create problems throughout all training stages was the inability of the training program planners to conduct a comprehensive training needs assessment. Gaps in knowledge and skills of those to be trained needed to be identified, especially if using a distance-based approach where mentor-preceptors would not be available full-time to work with a trainee. A description of the characteristics of trainees, instructors, supervisors, and PHC managers were also needed to develop a finely-tuned curriculum. Information about what services were in place, how they were structured, the qualifications and workloads of the nurse trainees and mentor-preceptors, and the availability of experts to help in the training would have provided the program planners with clear information to help in planning and organizing efficient training. Curricula and training materials would have been adjusted to address only topics where there were gaps in knowledge or skills.

A comprehensive training needs assessment would have helped the program avoid many of the problems that it faced prior to and during actual training. This would have made the personal study time of the trainee more effective, particularly since the course required time outside of work to study the written DBL materials. Modules could have been broken down differently, eliminating the timing problems found in skills acquisition at the trainee work site. The assessment would have indicated the need to make time to train mentor-preceptors and co-facilitators in adult-learning techniques to support the trainees.

Recommendations:

Future training program managers and the DOH should discuss and reach agreement to co-conduct a comprehensive training needs assessment prior to designing a DBL (or any) training program. This agreement should occur before any training activities begin in order to ensure that there is political and moral support for the exercise and that future courses respond accurately to the needs of the trainees.

National training policies should include comprehensive training needs assessments as an essential step in the process of developing training programs.

- **What other training approaches and strategies are necessary to support distance-based learning, since DBL materials alone cannot achieve the desired transfer of skills for clinical decision-making and training?**

The mix of group learning and mentoring approaches to complement distance-based learning was appropriate, but sometimes problematic, in the training program.

Group learning sessions. The group learning or face-to-face week worked well and was critical in providing trainees the basis to learn skills independently. Having a group session every 6 to 8 weeks reduced substantially the amount of time that the trainee spent away from the work site and reduced the training-related costs involved in bringing so many trainees together in one place for long periods of time.

Mentoring during the DBL period. Mentoring activities were designed to provide follow-up support to trainees at their work site after the face-to-face week. The program made use of and reinforced the supervision and support skills of local supervisors and resource persons (mentor-preceptors and co-facilitators), who supported the trainees ass they practiced new skills at the work site. Because they were local, these resource persons would be able to continue supporting the trainee once the training program ended, ensuring that newly acquired skills would continue to be used correctly and sustained.

Mentoring could have worked better and several key issues arose around mentoring that will continue to influence future DBL training programs in South Africa: the amount of time it took for a mentor-preceptor or co-facilitator to support a trainee was too much for some, given that they had other responsibilities, and resulted in inadequate support at the work site for some trainees. Some co-facilitators were unable to attend all planning and face-to-face weeks, missing critical information to support the trainees. Because PHC and DBL concepts and approaches were new to most people, not all mentor-preceptors and co-facilitators had adequate skills to support the trainees well in developing comprehensive PHC skills and participatory training skills.

The amount of materials to be covered during the DBL period proved too much for some trainees, who had difficulties juggling learning and self-study with other professional and personal commitments. This made mentoring more difficult since it took more time at each site to work with trainees experiencing problems. (Note, though, that as subsequent DBL training program modules were developed and tested, adjustments were made to reduce time-related problems encountered by the training program participants.)

The problem of covering materials and providing support to trainees was exacerbated by the way trainees were selected. Pre-established participant selection criteria were not rigorously considered as trainees were chosen to participate in the program. Consequently, there were great variations in entry-level knowledge and skills of different trainees, and certain trainees experienced significant problems in completing the training program because they did not have the prerequisite knowledge and skills. From the perspective of mentor-preceptors, since only limited one-on-one support (weekly visits) was available in the DBL period, the job of mentoring became more time-consuming.

Using accreditation to motivate trainees to excel in and complete the course. The possibility of providing education credits for those successfully completing the course was never established during the training program. The DOH remained unclear whether the nurse-trainees would, upon finishing their course, be promoted or become full-time or part-time trainers of service providers. This ambiguity may have negatively affected the motivation of the trainees to master the DBL materials and skills taught in the DBL course, since no clear promotional advantages were provided for completing the course.

Recommendations:

Potential co-facilitators, mentor-preceptors, trainees, and their supervisors should be fully informed of the time commitment to support the training program to ensure that they can fulfill their training obligations adequately.

Until there is a critical mass of people versed in PHC and adult learning techniques, future training programs must set aside time prior to the DBL period to train facilitators and mentor-preceptors in adult education techniques and PHC approaches.

Trainees should be selected according to selection criteria established by the training program.

Accreditation standards and processes should be finalized before future TOT training occurs.

- **What training management support is needed to organize and conduct actual training events?**

A stronger program management base would have helped the training program function more efficiently. Management was a weakness of the training program, with management issues mostly linked to external factors. At the time of the training program, the DOH was starting to gain experience in dealing with international donor and technical assistance organizations in terms of planning visits, supporting consultants during their visits, and understanding the roles and appropriate utilization of external consultants and technical assistance generally. Many training support activities did not occur when planned because roles and responsibilities of the DOH and PRIME/BASICS were not clearly defined as the program began.

Establishing an office in a new country and an operating budget for the training program partners also proved problematic. It took 6 months to establish and staff the training program office. The training program budget was also not finalized as the project began. At times this resulted in inadequate support for the PRIME/BASICS staff and consultants who were working with counterparts to design and implement the training program, but who did not live in South Africa. It was not always clear which training expenses were supported under the training budget. Necessary coordination and guidance could not easily occur in the absence of in-country support persons.

The DOH was also in transition, which resulted in an understaffed DOH with key decision-makers finding it difficult to focus on and give attention to capacity building of the training system. It was difficult to assign one person to ensure coordination of pre-training activities. One person leading the process could have ensured the timely implementation of pre-training and other activities. Because of the uncertainties brought about by the changing health system, trainees were not selected until one week before actual training began. This meant that mentor-preceptors, who had to be located near trainees, could not be selected, trained, and well oriented to their training support roles.

By design, the training program used a cascade approach to training, effectively diffusing training resources and direct control of those resources, as training moved out to the periphery. The design made it important to have the training program organizers take a rigorous approach to the implementation of the training and clarify policy guidelines as needed. However, the ECDOH could not always provide needed training policy guidance and management support. For example, because there was no clarification in training policy, locally available resource persons (from the NGO and other communities) did not participate in actual training delivery nor benefited fully from training in PHC-type activities.

On the other hand, the DOH was supporting a new and complex DBL training program. The program provided the opportunity for training program managers to experience a DBL management “learning curve,” prior to further expansion of the DBL program. This field

testing of DBL program clarified management issues and highlighted where managers needed to take more of a lead role.

Recommendations:

In future, teams need to clarify their scopes of reference and support needs with the DOH *prior* to their arrival.

Roles and responsibilities between the consultants and the DOH (national and provincial) should be clearly defined and understood by all.

When international agencies begin work in new country situations where the capacity and availability of resources is unclear, a field office (even if temporary) to coordinate program activities is essential and should be one of the first items put into place.

Lessons learned regarding the management of the DBL program should be written and disseminated to other training program managers, as the course is expanded to other provinces.

To ensure coherent approaches and timely decision-making by the DOH, DOH staff authorized to make a certain level of decisions should be seconded to help lead training team efforts.

- **How can clinical and other skills acquired from DBL and intensive group sessions be distance-monitored and evaluated without direct PRIME/BASICS involvement?**

As per procedure, PRIME/BASICS designed a monitoring and evaluation plan for the training program. The design specified what information needed to be collected to measure trainee satisfaction with the course and changes in trainee knowledge and skills. The plan also specified continuous qualitative assessment of each training module to improve subsequent modules, revise training content, and improve facilitator performance. Persons who were to be responsible for collecting information were also identified.

Problems arose during the implementation of the monitoring and evaluation plan, though, resulting in these data collection activities not being as systematic as they should have been. The data that should have been available from the various modules were often incomplete, and thus, difficult to use in assessing the training program results and for planning future programs. Evaluation of the program effects and impact would also have been more rigorous and more quantitative if there had been some baseline measures established during the needs assessment period.

There were several reasons for the lack of adherence to the monitoring and evaluation plan. Because of the limited time for training program planners to work with training co-facilitators prior to actual training, co-facilitators were not completely aware of the importance of information gathering and program monitoring of a pilot program. Additionally, training program evaluation within the ECDOH did not appear to be a top priority. PRIME staff and consultants perceived that training program participants feared evaluation for its potential punitive effect instead of viewing evaluation as a tool to improve programming efforts and individual performance. Future use of evaluation may well depend on developing a body of positive experiences in using external assistance and evaluation to improve programming.

Evaluation is a critical tool in providing information upon which to make programming changes. As the national DOH introduces the PHC approach in other provinces, it is essential that they have good information on training and other program effects to maximize the use of training and other resources to effect the systems changes.

Recommendations:

The training program monitoring and evaluation plan was thoughtfully designed and should be used as a basis for developing monitoring and evaluation plans for future training programs.

Because the modules were continuously assessed during the training period, future training for different cadres of health workers will be able to use the existing curriculum as a base.

For future DBL training programs, the DOH should name someone who would be responsible for ensuring that the training program monitoring and evaluation system is functional and follows the pre-determined plan. One of the important responsibilities of this person would be to advocate for using evaluation to improve programming and performance, and to allay fears that evaluation's main purpose is punitive.

In a changing health system environment, where punitive uses of evaluation can be a reality, mechanisms could be established to ensure confidentiality of evaluation results. For example, individual performance information (with codes representing names of individual trainees) could rest with training program planners only and training results presented as group data to other DOH officials.

The formal system of monitoring of trainee performance at the service site should continue and a formal system of monitoring the performance of trainee support persons (facilitators, co-facilitators, mentor-preceptors) needs to be developed for future programs.

While the monitoring and evaluation plan outlined in the 1996 *Guidelines* document were quite explicit, 2 items were neglected that should be considered in future DBL programs: assessment of trainee skills both prior to and after the training, *measured against service standards* (once they are made official by the DOH); and, assessment of co-facilitator and mentor-preceptor skills in supporting the trainee, again measured against a training standard that would need to be developed.

- **Given that adult education courses often do not provide professional accreditation to trainees successfully completing the course, how could distance-based training include elements of standardized performance evaluation to provide deserved recognition to those successfully completing the course?**

The training program included essential tools and information for performance evaluation. The program established behavioral and other learning objectives and related indicators of achievement could have been used to standardize the evaluation of performance. Criteria upon which to judge successful completion of the program had also been established. However, no official performance standards for training of trainers in training or in PHC comprehensive skills had yet been formally recognized by the DOH, making accreditation problematic.

Once the standards exist officially, what remains to be done is to determine: (1) who will evaluate/judge performance and knowledge of the trainees at the provincial level, and (2) who will have the authority to issue accreditation. (Accreditation authority will need to be linked with the authority to determine future job prospects and/or promotion for those successfully completing the program).

- **Based on experience and lessons learned from designing and implementing the training program, what processes should future DBL training program developers use to develop training plans, curricula and related materials?**

The DBL Comprehensive PHC Skills for Trainers course was appropriate to the South African situation, where learners who have different backgrounds and experiences are scattered over a wide area, and where work site facilitators and other resources differ from region to region. The processes inherent in the DBL training program design were equally appropriate, but at times problematic. The lessons learned from designing and implementing the training program point to several slight adjustments that could be made in the design of future programs.

Training needs assessment. As discussed earlier, a comprehensive training needs assessment is a vital part of any training program design process and should be conducted prior to designing future courses.

Use of participatory processes to develop the program. The participatory working groups were an important part of the program development process and should be used in future program development.

By involving people having various responsibilities for service delivery and training in the DBL program, eg, policy-makers, technical support staff, program managers and supervisors, service providers, the training program reinforced the necessary linkages and buy-in within the DOH that would allow continued support to sustain the PHC re-orientation after the program ended. This was especially important since the various actors not only helped determine which service delivery and training changes were to be made pre-training but also supported the changes during and after the DBL period. Thus, the participatory and group processes effectively helped to introduce and then manage the health system changes brought about by the training.

By working with South African counterparts in a participatory manner to develop and conduct the training, the training skills of counterparts were improved and new skills are reportedly being used in other training situations. Team building was a natural result of the group effort because trainers who came from different regions worked together on the training program. After the training program ended, trainers continued to communicate with each other. This has increased cohesion and interaction (networking) between different regions.

Timing issues in developing the training curriculum and materials. The PHC working group was charged with the critical activity of developing the curriculum and related training materials. The work of this group progressed too slowly, though, in great part because members had insufficient experience and skills in certain areas of PHC and DBL and nobody was formally authorized to lead the groups.

Curriculum development and DBL material preparation require a variety of talents and individuals with these different strengths to work together to design a course. Key skills that are needed include: curriculum design and instruction; distance-based learning including distance evaluation of the learning; adult learning and training; mentoring and preceptorship; content expertise in various PHC clinical subjects; and graphic design to develop the DBL print material layout that would be interesting, motivating, and easy-to-use by the learner. The working group that participated in the curriculum development consisted of people with a variety of experiences in PHC but several of the essential skill areas were missing, particularly those used in the preparation of DBL materials. Consequently, the group could not make quick progress in developing the course curriculum and materials, resulting in PRIME taking a larger technical assistance role than initially envisioned, and having to play “catch-up” as key activities were not completed in a timely manner.

Because the working groups did not respect deadlines in producing training materials that were necessary inputs for the development of subsequent materials, materials development was not as systematic as it should have been. As training started, the curriculum content

outline was developed but other training materials and evaluation tools had not yet been developed. Because training started before all materials were developed, trainees sometimes went back to their work sites to begin the DBL period without all the necessary DBL materials in hand. From the perspective of time and budget, the process was not efficient.

The timing problems noted above also meant that there was insufficient time to revise the curriculum and materials after the first round of testing, necessary to have a final training product that can be used in subsequent training. DBL materials need careful testing and refinement until the right mix of quality elements is determined. This is the up-front investment in DBL materials development that creates later cost-savings in subsequent training. Again, from the perspective of time and budget, the process was not efficient.

Recommendations:

> A small team of subject matter experts, curriculum development experts, and user representatives should be made responsible for overseeing the development of the training materials, and ensuring that project design and content experts be brought into the working groups as needed to develop materials. A larger group could be used to review developed materials and develop consensus and support for the work.
>
> Future training programs should identify technical assistance needs and use technical assistance-both from within and outside of South Africa-to develop the basic content and design of curricula for DBL or any training program (within budget realities, of course).

Future technical assistance in training systems development should include building the capacity of selected trainers in DBL materials design.

8. CONCLUSIONS

An innovative DBL training program was developed, field-tested, and shown successful in transferring knowledge and skills and promoting client-oriented attitudes necessary for PHC. The PHC Comprehensive Skills for Trainers Program offered a creative solution to a difficult problem: how to respond quickly and effectively to an expressed, critical need of the South African government for assistance in developing a PHC-based health system.

The project laid the groundwork for future DBL training efforts that will focus on skills acquisition and not just knowledge gain. An innovative, basic instructional format, which had not been used in previous training events and which met the goals of the government, was tested and proven. A great deal of knowledge was gained as to who should be trained, by which category of facilitator, and how. A first cut at defining content and designing materials was both successful and useful for uncovering problems.

The number and quality of training resource persons improved. Key and competent staff were identified for the follow-on EQUITY project. Twenty-one potential trainers were trained. Changes in service delivery have occurred in clinics that have staff who received the PHC training in clinical and community participation and outreach skills.

Perhaps most important, PHC is now more than a theory. Many people at many different levels were exposed to the program at different times. Because the training program was small enough, it could be experimental and innovative and develop a group of lessons learned for future PHC training. It also uncovered areas of training need, project management issues, and training policies that needed to be addressed by the stakeholders in operationalizing the PHC delivery system.

Several indirect benefits of the training program are also worth noting. The project created a microcosm of the PHC system changes, allowing the national and provincial DOH to work out some of their own changing relations with facilities and providers. Issues related to management responsibilities and supervision were uncovered. Links were established between different sectors and different levels, a process that plays an integral part in the development of a PHC-based health system. This collective knowledge and experience can be applied as the national DOH reorients the health care system. Finally, the participatory nature of the project, which required that individuals work together and get to know each other as people, had the unanticipated effect of helping to break down further the stereotypes of different races among those who participated in the training program.

ANNEX A

INFORMATION SOURCES

ANNEX A.1: Information sources consulted by S. Igras, May-September 98

DOCUMENTS

Carr, Celeste, Kingsley, M, Madikizela, N, and Smit, L. *USAID/South Africa Bridging Training Activities Evaluation Report: PHC Comprehensive Skills Training Management Training*, May 1997

Department of Health of South Africa. *Towards a National Health System for South Africa*, undated, *circa* 1996

Department of Health, Eastern Cape Province and INTRAH/PRIME. Guidelines for the Implementation of the PHC Comprehensive Skills Training of Trainers (TOT) Program, 1996

Department of Health, Eastern Cape Province. *The PHC Comprehensive Training of Trainers Curriculum*, September 1996

Department of Health, South Africa, *The Health Priorities of the Reconstruction and Development Programme*, undated, *circa* 1995

Edmonson, Marilyn *et al*. *USAID/South Africa PHC Assessment and Planning for EQUITY Project Bridging Activities in PHC In-Service Training and PHC Management Training*, (Trip Report #P-25), August 1996

Health Systems Trust and Department of Health of the Eastern Cape Province. *Health Care in the Eastern Cape: Implications for Planning 1996*, October, 1996

Kogi-Makau, Wambui and Parker, Laurie Noto (ed). *Report of the Background Information Collected, Organized and Presented by PRIME Consultant W Kogi-Makau, in Preparation for the Final Evaluation of the PHC Comprehensive Clinical Skills and PHC Management Skills Training Courses*, May 1997

Shelver, Norah. *EQUITY Project Impact Evaluation of PHC Management and Comprehensive Skills Training of Trainers: Eastern Cape Province 1996/97*, December 1997

Stein, Jane and Banda, Eta. Case Study of a USAID-funded Bridging Project to Introduce and Test Innovative Participatory Strategies for Improving PHC Training in the New South Africa: A Report for INTRAH/PRIME, January 1997

Yin, Robert K. *Case Study Research: Design and Methods*, 2nd edition. Thousand Oaks: Sage, 1994.

INTERVIEWS/WORKING SESSIONS
Jedida Wachira,on 11 May, 13 May and 17 September 98

ANNEX A.2 List of data sources compiled by Stein and Banda, January 97

These data includes trip reports that describe specific planning and implementation activities, several summary reports; a variety of communications, agreements, memos and official documents; training materials, participant interviews; and interviews with PRIME project staff. The materials were gathered and reviewed over a 10 day period by 2 independent evaluation consultants at the INTRAH/PRIME regional office in Nairobi, Kenya (RON). Interviews were conducted with Ms. Pauline Muhuhu, Regional Director, and Ms. Jedida Wachira, Regional Director of Programs, who led the PRIME/INTRAH training project in South Africa.

1. Trip reports: dates and description

a. Preliminary assessment visit, May 21-June 9, 1995
b. Preparing detailed plan of action for project, October 15-26, 1995 (Report #P-229)
c. Planning and facilitating workshop for working groups, March 12-28, 1996
d. (Report #P-251)

d. Facilitation of a working group session on PHC comprehensive skills curriculum development, April 8-13, 1996 (Report #P-252)

e. Plan, design, and development of DBL approach for PHC comprehensive skills curriculum, June 3-17, 1996 (Report #P-280a)
f. Planning and conducting Module 2, July 25-August 26, 1996 (Report #P-291)
h. Planning and conducting Module 3, August 25-September 12, 1996 (Report #P237)

2. Other reports: dates and description

a. Summary of PRIME-assisted bridging activities from May 1995-March 1996
b. Summary for mid-project review, April-November, 1996
c. Quarterly report #1, April-June, 1996
d. Kogi-Makau Evaluation Report, February, 1997
e. Celeste Carr USAID Evaluation Report, May, 1997

3. Miscellaneous

a. Newsprint--plans for program and evaluation, November 20-21, 1996
b. PHC clinical training work plan, Nov 4, 1996
c. PHC Clinical Training Program (CTP) Plan, January, 1996
d. BASICS brochure
e. Sample of faxes + summary of questions from BASICS
f. INTRAH/BASICS letter of understanding, July 24, 1996

g. Draft Guidelines for the implementation of the PHC comprehensive skills training of trainers program (awaiting SA input)

h. Memo: PHC orientation workshops for work groups and facilitators, March 7, 1996

i. Portion of debriefing memos, March 4, 1996
j. Debriefing summary report, March 18-22, 1996
k. BASICS status report, April 25, 1996
l. Province of the Eastern Cape Dept. of Health and Welfare, ReHMIS (Regional Health Management Information System) Report, 2nd draft, 1996
n. SA Dept. of Health: The Health Priorities of the Reconstruction and Development Program

4. Case study-specific materials
a. Notes, Jane Stein, October 2, 1996
b. INTRAH regional office-Nairobi thinking notes, November, 1996

5. Interviews
a. Pauline Muhuhu, December 9, 1996
b. Jedida Wachira, December 10, 1996
c. Jedida Wachira, December 13, 1996
d. Jedida Wachira, December 17, 1996
e. Pauline Muhuhu, December 18, 1996

6. Curricula
a. First draft of CTP Curriculum
b. Draft Final version CTP Curriculum

7. Training materials
a. Module 1 face-to-face
b. Module 1 DBL (Bridge final)
c. Module 2 DBL (Bridge final)
d. Module 3 face-to-face
e. Module 3 DBL (Bridge final)

8. Participant information
a. Module 1 Post-test average scores
b. Module 3 Pre & post-test group means
c. Participant reaction to Module 1
d. Participant reaction to Module 2
e. Participant reaction to Module 3
f. Participant reaction to Modules 1 + 2
g. Mentor reaction
h. Co-facilitator reaction

9. DBL Materials

a. Annotated bibliography re DBL training and educational programs, October, 1995
b. Self-Directed Learning handout, George M. Piskurich, Ph.D., Durham, NC
c. Distance Education: The CNEP Model, Phyllis J. Long, CNM, Lakewood, NJ, November 7, 1995
d. INTRAH/PRIME training materials

ANNEX A.3 List of key informants contacted by Kogi-Makau for comprehensive PHC skills for trainers program (Source: Kogi-Makau Evaluation Report, February, 1997)

Staff and Consultants	
Jedida Wachira	PRIME
Pamela Mamogobo	PHC-TOT, National Coordinator, BASICS-SA
Diana Silimperi	Consultant, BASICS-USA
Eastern Cape Province (ECP)	
Alan Wilde	Acting Director, PHC ECP
Zoe Kati	Coordinator, EQUITY Project PDOH ECP
Noses Tshangaan	Coordinator, PHC Management ECP
NGO	
N. Mazaleni	Director, Border Institute of PHC
Ione Sida	Training Coordinator, Red Cross
Mark Lesar	Provincial Manager, SANTA South African National T.B. Association
Region E	
R. Zoleka	Deputy Director Health
Maluti District	
Reuben T. Ned	Acting District Manager, DOH
Julia Tshika	TOT, PHC Management
Group (10)	Maluti District Health and Welfare Council
Nompulelo Sicwebu	TOT, PHC Comprehensive, Mt. Fletcher Sub-district
Group	Community People, Mt. Fletcher Sub-district
Flagstaff/Lusikisike District	
Barbara N. Sekese	Coordinator, District PHC (interviewed in place of District Manager)
Assenath Matwa	LFB District Health Desk, T.R.C.
Greek Zweni	LFB District Council Executive, T.R.C.
Nemanyano Mazeka	TOT, PHC Comprehensive, Bambisana Clinic
First	Community Health Worker
Second	Community Respondent

Region A
Port Elizabeth

Thabo Sibeko	Regional A. PDOH
Graham White	Deputy Director of Health Services
Judy Valentyn	TOT, Comprehensive Facilitator
Karen van Heerden	TOT, Central Clinic, Town Centre

ANNEX A.4 List of key informants for comprehensive PHC skills for trainers course contacted by Carr, et al (Source: Carr *et al* evaluation report, May, 1997)

BISHO PROVINCIAL OFFICE

Dr S Stamper	Deputy Permanent Secretary
Mr A Wild	Acting PHC Director
Mrs Z Kati	PHC Comprehensive Skills Coordinator

REGION A: PORT ELIZABETH

Dr T Sibeko	Regional Director
Mrs B Mayana	Deputy Director Health
Ms J Valentyn	Co-Facilitator-Comprehensive Skills
Mrs B Macay	Comprehensive skills TOT
Ms L Orben	Comprehensive Skills TOT
Ms KNC van Heerden	Comprehensive Skills TOT
Ms B Uithaler	Comprehensive Skills TOT
Mrs B Damons	Working Group
Mrs Baatijies	Clinic Supervisor

REGION B: QUEENSTOWN

Dr V Shaw	Deputy Regional Director
Ms T Nkungu	Co-Facilitator
Ms GN Mpakama	Comprehensive TOT
Ms EY Gawe	Clinic Supervisor
Ms PN Bodla	Clinic Supervisor

REGION C: EAST LONDON

Mrs Loliwe	Nursing Trainer/Co-Facilitator-Comprehensive Skills
Mrs Laura Makalima	Comprehensive Skills TOT

REGION D: UMTATA

Mr MM Sixaba	Regional Director
BB Mgudlwa	Deputy Regional Director
CN Mfingwana	District Manager
MT Tate	District Manager
MP Thipanyana	District Manager
N Mtoba	District Manager
Mrs N Gqulu	Co-Facilitator
Mrs Macingwana	Comprehensive Skills TOT
Mrs Zola	Clinic Supervisor

PRETORIA

Dr W Kogi-Makau	Data Collection Consultant, INTRAH/PRIME
Dr S Hendricks	Director, HRD, NDOH
Ms P Mamogobo	BASICS/SA Coordinator
Mrs C Kruger	BASICS/USA
Ms J Wachira	INTRAH/PRIME

APPENDIX A.5 LIST OF KEY INFORMANTS IN PHC COMPREHENSIVE SKILLS FOR TRAINERS COURSE CONTACTED BY SHELVER (Source: Shelver evaluation report, Dec 97)

Training program participants

Kunjulwa Macingwana	Senior Nurse, Region B
Besty Mackay	Senior Nurse, Region A
Pumla Makalima	Senior Nurse, Region C
Lindiwe Makaula	Senior Nurse, Region E
Nomanyano Maseka	Senior Nurse, Region E
Lulama Matinise	Senior Nurse, Region E
Nomabali Mbombo	Senior Nurse, Region C
Nhlanhla Mpakama	Senior Nurse, Region B
Nolwandle Mseti	Senior Nurse, Region B
Zizilam Ndakisa	Senior Nurse, Region D
Jabu Ngcongo	Senior Nurse, Region E
Francina Ntantiso	Senior Nurse, Region B
Thandi Nqini	Senior Nurse, Region C
Linda Oben	Senior Nurse, Region A
Nombulelo Sicwebu	Senior Nurse, Region E
AM Siphengana	Nurse, Region E
Karen van Heerden	Nurse, Region A
Ndileka Velezantsi	Senior Nurse, Region C

Supervisors of participants

Mrs V Mayana	Supervisor of B Mackay
Mrs D Mzinyati	Supervisor of L Oben
Mrs Doyi	Supervisor of N Mseti
Mrs Bebelele	Supervisor of T Nquini
Mrs Maraw	Supervisor of P Makalima
I Ntloko	Supervisor of J Ngcongo

Second generation trainees trained by nurse trainers

Mrs Larsen	Trained by K van Heerden
Mrs Burrell	Trained by K van Heerden
Mrs Jacobs	Trained by K van Heerden
Mrs Daniel	Trained by N Cheba

ANNEX B

TERMS OF REFERENCE AND INFORMATION SOURCES FROM 3 END-OF-PROJECT EVALUATIONS IN SOUTH AFRICA

ANNEX B: Summary of terms of reference and information sources of the 3 end-of-project evaluations (*Note that evaluations were conducted for both PHC skills and management training courses. Summaries presented here are limited to PHC comprehensive skills for trainers course*.)

TRAINING PROGRAM EVALUATION REPORTS

Carr, Celeste *et al*	Kogi-Makau, Wambui and Parker, Laurie Noto (ed).	Shelver, Norah.
USAID/South Africa Bridging Training Activities Evaluation Report: PHC Comprehensive Skills Training Management Training, May 1997	*Report of the Background Information Collected, Organized and Presented by PRIME Consultant W Kogi-Makau, in Preparation for the Final Evaluation of the PHC Comprehensive Clinical Skills and PHC Management Skills Training Courses*, Feb 1997	*EQUITY Project Impact Evaluation of PHC Management and Comprehensive Skills Training of Trainers: Eastern Cape Province 1996/97*, December 1997
SUMMARY OF TERMS OF REFERENCE (only those that pertain to PHC skills training program)		
Assess training approaches and processes in planning and implementing training program Determine impact of training activities in achieving USAID/SA strategic objective (health) Examine degree to which PHC comprehensive skills training reflected DOH training policy for PHC training Identify policies that have evolved or are evolving from PHC training experiences Identify strengths and limitations of the PHC comprehensive skills training	Analyze/tabulate data collected during consultancy Make site visits to trainees' work sites to observe and discuss work site applications of skills and knowledge from training program, and collect other information *NB: This report was commissioned by PRIME to collect and provide background data for the EQUITY evaluation by Shelver*	Identify benefits that have occurred from the training activities Document examples of skills, for consideration of application on a wider scale Assess training and impact of training under the EQUITY project (defined as working patterns, skills, motivation, leadership, sharing with co-workers)

INFORMATION SOURCES*

Document review. Site visits and interviews with DOH officials, 7 trainees, 5 facilitators or co-facilitators, 4 mentor-preceptors or work site colleagues, the provincial training program coordinator, and other organizational personnel	Document review. Where possible, collection and tabulation of selected data. Interviews with DOH officials, BASICS and PRIME staff. Site visits and key informant interviews with 5 trainees, other work site colleagues, several supervisors, members of selected communities	Document review. Site visits and interviews with 16 trainees, 6 supervisors of trainees, and other officials and second generation trainees
**Note that there was limited overlap/repetition in the key informants interviewed by the different evaluators. That is, most informants were interviewed by only one of the 3 evaluators. 4 trainees were interviewed by 2 of the evaluators. Only one DOH official was interviewed by all 3 evaluators.*		

ANNEX C

TRAINING COURSE GUIDELINES

PRIMARY HEALTH CARE COMPREHENSIVE TRAINING OF TRAINERS' PROGRAM

GUIDELINES

GUIDELINES FOR THE IMPLEMENTATION OF THE PHC COMPREHENSIVE SKILLS TRAINING OF TRAINERS (TOT) PROGRAM

1996

TABLE OF CONTENTS

ABBREVIATIONS

DBL	Distance Based Learning
PHC	Primary Health Care
RDP	Reconstruction and Development Program
SAQ	Self-Assessment Question(s)
TNA	Training Needs Assessment
TOT	Training of Trainers
WHO	World Health Organization

GUIDELINES FOR THE IMPLEMENTATION OF THE PHC COMPREHENSIVE SKILLS TRAINING OF TRAINERS (TOT) PROGRAM

1. TRAINING APPROACH

The distance-based learning and participatory approach is employed in this training program.

2. WHAT IS DISTANCE BASED LEARNING?

The term distance based learning refers to a learning situation where the learners and the teacher/facilitator are partially or wholly separated from each other in time and space. This physical separation means that distance education learners work on their own most of the time but come into physical contact with their teachers from time to time according to an agreed schedule. The learners in the PHC comprehensive skills TOT program will study on their own most of time but come into contact with facilitators, mentors/preceptors from time to time.

Why use distance based learning in the PHC Comprehensive Skills TOT Program?

Distance based learning is of growing importance especially in post-school and post - professional training, for the following reasons:

It provides greater flexibility than the conventional approach because it is able to respond to the increasing demand for education and training faster and more effectively to meet emerging needs for skills at workplace.

It can be multiplied many times to reach many people scattered over a wide geographical area using the available educational technology.

It has the potential for introducing a systematic strategy of apprenticeship in accordance with the most modern principles of psychology.

It is generally more economical than conventional systems because distance learning materials developed by a small team of expert teacher/ trainers will reach and give quality training to many people, at their own homes and places of work.

It offers people knowledge, skills, additional professional qualification and opportunities for attitude change without withdrawing them from their duties for long periods.

It enables learners to apply the knowledge and skills at their own worksite, it facilitates immediate changes and improve performance.

For these reasons the distance based learning approach is appropriate for the PHC Comprehensive Clinical Skills program because the target group are practising adult professionals who require additional training to meet the emerging community needs without too much disruption in service delivery.

Limitations of Distance Based Learning

Despite its many advantages, distance based learning has its peculiar limitations.
There is no immediate feedback because of physical as well as the intellectual isolation between the learners and the teacher. This can lead to frustration and eventual dropout.

Distance based learning assumes that the learner is well motivated to work on his or her own and this is why it is applied more to adults than to children.
The methods of instruction are new novel to learner's. This very often leads to delayed adjustment to content that may lead to delay in the study of the material.

Competing interests for the learner's time and attention particularly on how to combine family and occupational commitments with their studies.

Limited access to additional specialized experiences. Some learners may not have easy access to experience required for practicing certain skills/techniques due to geographical location.

To overcome these limitations, the distance based learning self-instructional materials are developed in a manner that facilitates participatory learning and immediate application of knowledge, skills and acquired.

3. PHC COMPREHENSIVE CLINICAL SKILLS PROGRAM

The program is offered by the Eastern Cape Provincial Department of Health Universities/Technikons in collaboration with the National Department of Health and support from the USAID funded EQUITY PROJECT

Since the learners are already qualified in their own professional areas of specialization, the purpose of this program is to upgrade, update and bridge any gaps in knowledge, skills and attitudes required in the provision and management of comprehensive PHC services.

4. DURATION

The course consists of 6 modules to be covered in 1 year. Each module will be covered in a block of 4 weeks consisting of 1 to 2 weeks depending on the content intensive face-to-face contact session followed by 4-6 weeks distance based learning component at learner's worksite supported by the coaches receptors/mentors.

5. TARGET GROUP (SERVICE PROVIDERS)

The target group will comprise nurses working in primary health care settings in the 5 regions of Eastern Cape Province, and other provinces.

6. ENTRY REQUIREMENTS

The learners should have been trained as registered nurses and should be working in a primary health care setting as provider manager or supervisor.

7. RESPONSIBILITIES OF THE LEARNERS

Learners (who have been selected for this training by their regions and district) are expected to attend all the face to face sessions and complete the lessons on each module.

8. THE TRAINING SYSTEM

The training package contains 5 self-instructional, distance based learning modules that the learners will study for 3 weeks at the worksite and apply the knowledge, skills and attitudes acquired from these modules in their day to day work with the help of coaches/preceptors/mentors. Prior to the 2-3 weeks self-instructional studies period, the learners will be introduced to the modules by facilitators in an intensive 1-2 weeks face to face residential session. The content of the modules is arranged in a logical sequence that enables, the learner to build on the previous module's content and enhance integration.

a) Intensive 1-2 weeks face to face contact session

This session entails intensive and interactive face to face contact where facilitators will introduce the training package to the learners and the coaches/mentors. The facilitators are expected to explain new, technical, and complex concepts and procedures, map out practical work and set the tone for the self-instructional distance based learning activities at the worksite.

b) Distance Based Learning Component

The Distance Based Learning materials are developed in the form of modules. The materials for each modules are self-contained and written in a highly interactive manner that facilitates learner participation when working through the text. Each module is divided into a series of lessons to be covered during the 3 weeks at the worksite. In order to distribute the workload evenly, learners are advised to cover at least 3-4 lessons per week. The module structure is meant to give the learner the scope of the content to be covered.

To facilitate self-participatory learning, the modules are specially written, using motivational devices such as the objectives, self-assessment questions (SAQs), practical activities, self-tests, summaries and further reading. This method of content presentation is meant to enable learners to interact with the text with ease.

The materials are explained and distributed during the intensive face-to face week.

c) The 3-week PHC TOT clinical application at worksite supported by preceptors/mentors and co-facilitators

In the Distance Based Learning component, the role of the mentor/coaches involves teaching through encouraging coaches techniques specifically demonstrations, giving feedback, clarifying concepts and modeling problem-solving techniques in PHC service clinical and community based case management at the worksite during the 3 weeks of clinical application. Mentors/preceptors are involved in the planning, implementation, assessment and evaluation of the learning experience in the PHC comprehensive clinical skills program. As such they should give learners support as follows:

- Plan for and hold at least one weekly conference with the Learners to discuss the answers and results the learner has come up with after carrying out the "activity" and "self-test" stipulated in the learning materials
- Counsel and assist the learners to plan their study time in order to complete the lessons and apply the learnings
- Be on the lookout for additional, practical learning activities or opportunities for the learner to strengthen skills and subsequently assist the learners to access these additional opportunities e.g. investigating an outbreak of disease
- Act as a clinical resource for the learners by enriching their answers to "activities" and products or outcome of the self tests
- Observe directly the learners skills performance according to set criteria, giving feedback on strengths and areas learners need to work more on
- Jointly with the learner identify what issues and technical questions should be raised with the facilitator tutor/trainer when they visit

In order to perform the above roles effectively, the mentor/preceptor should forge and maintain good interpersonal communication skills and empathize with the learners so as to win their trust and acceptance. This empathizing will ease any anxiety on the part of both the mentor/preceptor and the learners. It will help the 2 to develop a realistic and open relationship during the learning experience. The Primary Health Care Comprehensive Clinical Skills trainers based in districts should function as incutors of service providers.

9. ASSESSMENT

Feedback will be by continuous assessment, written post-tests and an assignment project.

Pre-test

Before commencement of the instruction particularly for the more clinically oriented modules or sub-modules, a pre-test will be administered to assist learners assess their entry knowledge (to as to move from known to unknown.)

a) Continuous Assessment

i) **Practical Activities and Self Tests**

During the course of instruction the learners are expected to do practical activities and self-tests in the modules and discuss their answers/results with the trainers/coaches/mentors / preceptors.

The answers or results to selected self-tests and practical activities will also be reviewed by coaches/trainers/tutors in order to assess the application and mastery of the skills acquired.

ii) **Post-test**

A post-test will be administered after each face to face module and a self checklist filled by the learner after each DBL has been covered.

b) <u>Assignment Project</u>

The learners are expected to carry out an Assignment Project to be submitted for grading 2 weeks after they have completed each module. This Assignment Project will be given to the learners when they come for the intensive face-to-face week. The learner should present the project, depicting how the learner has applied the lessons learnt from each module, in the real situation.

10. WEIGHTING

a. Post-tests will be given for post tests and assignment projects and these will determine the eligibility of the learner to write a final examination.

Pass Mark

The overall pass mark derived from both the module post-tests and the final Assignment Project is set to be 50%.

11. PROGRAM STRUCTURE

The training program contains 5 modules as follows:-

Module 1: Orientation to PHC Approaches for Service Delivery and Management

Sub-module 1.1: Orientation to PHC Concept and Philosophy

Sub-module 1.2: Community participation

Sub-module 1.3 Management of PHC Services

Sub-module 1.4 Interpersonal Communication Skills

Module 2: Training and facilitation, epidemiological research, monitoring and evaluation

Sub-module 2.1: Training facilitation

Sub-module 2.2: Epidemiology and Research

Sub-module 2.3: Monitoring and evaluation of Primary Health Care Services and Training

Module 3: Reproductive Health and Women's Health Interventions

Sub-module 3.1: Sexuality Education and Life Coping Skills.

Sub-module 3.2: Family Planning services

Sub-module 3.3: Mother and Child Health.

Sub-module 3.4: Women's Health Interventions.

Sub-module 3.5: STDs, HIV and AIDS + Counseling.

Sub-module 3.6: Infertility.

Module 4: Child Survival Interventions

Sub-module 4.1: Optimization of Breastfeeding

Sub-module 4.2: Implementation of EPI

Sub-module 4.3: Early detection of growth failure

Sub-module 4.4: Decreasing mortality due to acute respiratory infections (ARIS)

Sub-module 4.5: Decreasing mortality due to diarrhea disease

Sub-module 4.6: Advocating the rights of the child

Sub-module 4.7: Optimizing growth

Sub-module 4.8: Minimizing disability and maximizing potential of handicapped children

Sub-module 4.9: Preventing and managing non-accidental injury

Sub-module 4.10: Minimizing impact of tuberculosis

Sub-module 4.11: Preventing rheumatic heart disease

Sub-module 4.12: Prenatal Health

Module 5: Acute and Chronic Conditions

Sub-module 5.1: Different Cultural Perceptions and disease

Sub-module 5.2: Ear, Nose and Throat conditions (ENT) & Ophthalmology

Sub-module 5.3: Gastro-Intestinal Tract

Sub-module 5.4: Genito-Urinary Tract. OCH & TB

Sub-module 5.5: Musculo-Skeletal Problems

Sub-module 5.6: Cardiopulmonary

Sub-module 5.7: Endocrinology

Sub-module 5.8: Skin Diseases

Sub-module 5.9 Mental Health & Neurology

Sub-module 5.10: Geriatric Care

Sub-module 5.11: Occupational Health

12. CERTIFICATE

When the learner has successfully completed the course and has compiled with the exam requirements she or he will be awarded a Diploma. The learner will be awarded a certificate at the end of the training provided she or he completes the program and complies with the

requirements and the assessment results are satisfactory according to stipulated expectations of the program.

13. (COST IMPLICATIONS) Course Costs

Discuss with the provider/ECDOH and MSH.

14. DISTANCE BASED LEARNING MODULE STRUCTURE/FORMAT

To facilitate learning, the Distance Based Learning Modules will assume the following structure:

a) Module Structure

Each module will have:

- Cover page
- Title page
- Contents list (module outline)
- General introduction
- Module objectives
- Series of lessons
- Self checklist
- Evaluation Plan/Tools

Note: Because of the varied nature of the content of each module, further reading texts will be listed at the end of each sub-module.

b) Lesson Structure

Each lesson will have:

- Title
- Introduction
- Specific Objectives
- Series of sub-topics and sub-sub-topics
- Summary
- Practical activities and self test

c) Treatment of content in the module

The modules have been written in specially selected distance based learning self-instruction design, language and style using:

- Prose
- Bullets where information is listed
- Learner friendly conversational style
- Visualization i.e. use of illustrations where relevant
- Active learning devices such as self assessment questions, summaries etc.
- Icons (symbols) to sign post learners to important aspects of the text

d) The following icons (symbols) are used in the module:

This tells you there are **objectives** in the module

This tells you there is a **self-assessment (SAQ**) or in-text question to answer or think about in the text

This tells you to **take note** of or to remember an important point

This tells you there is a **self test** for you to do

This tells you there is a **checklist**

This tells you there is an **activity** for you to do

This tells you that these are the key areas we have learnt **(summary)**

This tells you there is **further reading** for you to do

e. Activity:

Each time you come to an activity, carry it out and then discuss your answers or product with the mentor/preceptor to enrich your answers. The activity offers you a chance to apply the concepts you learn immediately and helps you master the

knowledge. It also helps you to test out how the concepts and information apply to your setting.

The co-facilitator is expected to review with you and the mentor/preceptor how you handled some of the activities in each lesson, the technical issues you have. The interaction is meant to enrich your learning and further help you master the knowledge and also to monitor your progress.

f. Self-Test.

The self-test is presented in the form of an activity or actual knowledge, test or skills check-list. The outcome of a self-test-no matter how it is presented - is a major self-assessment tool for your skills development. The self-test in these self-study materials is meant to give you chances to apply learning and practice process (or manual) skills. It represents the practical experience normally found in the traditional approach of tests with training health workers. Discuss the outcomes of self mentor and co-facilitator when they visit. Keep good information or records of these practical experiences.

g. Further Reading

This list represents a bare minimum of references. It is expected that you will endeavor to read as much as possible from additional self-discovered references in order to widen your scope on the subject matter.

ANNEX D

SAMPLE OF A DISTANCE-BASED LEARNING SUB-MODULE

Lesson 2 - The Communication Process

Introduction

In this lesson we will define the term communication and discuss how the communication process takes place. We shall also discuss the factors that affect the interpersonal communication process and explain how as communicators, we can overcome communication barriers.

Lesson Objectives

At the end of this lesson, you should be able to:

1. Define the term communication

2. Explain the factors that influence the interpersonal communication process

3. Describe types of communication and how they take place

4. Discuss barriers to communication and how you can overcome them to enhance effective communication

What Is Communication?

The communication process involves one individual or many people sending a message to other people with the intention of receiving feedback. Effective communication is a 2-way process that should stimulate feedback as shown in the elements of the communication process shown below.

Sender	→	message	→	receiver	→	medium (channel)	→	Feedback
(who says)	→	(what?)	→	(To who?)	→	(Through which medium)	→	(With what effect?)

The sender who is also the source of the message begins the communication process. The receiver ultimately becomes a sender too because he/she is required to acknowledge the message by giving feedback. The message may be anything ranging from, "what is your problem", to giving instruction on how to perform a complicated surgical heart operation. The channel is the means or medium by (or through which the message is conveyed between 2 (or more) parties. Examples of channels include telephone lines, faces, voices, written materials, radio, television and many others.

Self-Assessment Question (SAQ)

What type of messages do you send to the individuals or families you serve and which channels do you use?

What Is Interpersonal Communication?

Interpersonal communication is a 2-way interaction process that involves sender, message, receiver, medium (means of communication) and the effect of the message or feedback

received from the receiver of the message. Communication occurs verbally, using words; visually through symbols or pictures; and through actions such as showing, pointing, gesturing, demonstrations, facial expressions and bodily positions.

Types of Communication

Written, verbal communication and Public speaking skills

The ability to communicate through language sets the human species above all others. To be an effective communicator, we are required to learn and practice certain communication skills. Using the skills listed below will improve the effectiveness of your communication skills.

- Use simple, clear precise language
- Avoid jargon, slang, acronyms and abbreviations
- Use technical terms that are familiar to your audience
- Use illustrations freely, but make sure that your audience can interpret them correctly
- Avoid monologues
- Be gender sensitive
- Speak up (do not talk to the wall)
- Vary your pitch and be distinct
- Keep water handy (you may need it)
- Monitor your voice speed (do not speak too rapidly or too slowly)
- Establish eye contact
- Involve your audience (do not talk down to your audience)
- Use appropriate gestures and visual aids to strengthen your message
- Use analogies, examples and verbal illustrations to create mental pictures

Activity 1

Imagine that there is frequent rape of women and children in the community that you serve. Other than the psychological torture that this act has on the victims, there is also the danger of unwanted pregnancies and spreading of STD and HIV/AIDS among all affected. Using the above communication skills, prepare and conduct a health education session on the consequences of rape to the individual, family and community at large.

Non-verbal communication

Very often, we communicate with gestures, facial expressions and our bodies. This is referred to in the communication process as body language. Body language is important in the instructional setting. You communicate different messages when using either positive or negative body positions.

Positive Postures	**Negative Postures**
• open posture	• arms crossed
• arms outspread	• hands in pockets
• body leaning forward	• chin in hand
• hands at side	• fists clenched
• open palms	• hands hidden
• relaxed appearance	• legs tightly crossed
• nodding the head	• tense appearance

Body language is used to express different type of feelings. For example your audience is showing willingness to listen, approval, deep thought when they part their hair, smile

frequently or lean their bodies forwards. Similarly they are showing signs of frustration, disapproval or rejection when they pound their clenched fists on the tables.

Self Assessment Question (SAQ)

What are some of the body language gestures used in the community you serve and what do they mean?

Factors enhancing effective communication

We communicate in order to be read, or heard and understood. If we are to establish commonness of purpose with our audience during the communication process we must observe certain factors.

Clarity

The language you use must be clear to your audience and pegged to their reading ability. In order to enhance the understanding of the message being passed across:

- Use familiar words as much as possible
- Avoid passive verbs and use active verbs
- Make abstract verbs concrete by giving relevant examples that are familiar to the target group
- Explain new and complex concepts and technical terms
- Make sure that all the words are used correctly
- Tailor your message to the identified competencies of the target group

Paraphrasing

Paraphrasing is simply restating what the other person has said in your own words. The process of paraphrasing is very much like catching a ball and throwing one back -- except the ball you throw back is your own and perhaps a bit different from the original ball. Nonetheless, it is still a ball. You can throw back the other person's ideas by using such beginning phrases as:

"You are saying ...."
"In other words ...."
"I gather that ...."
"If I understood what you are saying ...."

The best way to paraphrase is to listen very intently to what the other person is saying. If while the other person is talking we worry about what we are going to say next or are making mental evaluations and critical comments, we are not likely to hear enough of the message to paraphrase it accurately.

It is helpful to paraphrase fairly often, so that you develop a habit of doing so. You can even interrupt people to do so, since people generally don't mind interruptions that communicate understanding. For example, "Pardon me but let me see if I understand what you are saying ...."

Example 1: Participant:

"It seems the basic problem is that some of the people don't know how to use the management information system".

Trainer: "In other words, you see the problem as lack of know-how".

Example 2: Participant:

"I think the most important thing is to tell the staff member clearly and directly how he is contributing to the problem".

Trainer: "So you are saying it's important to tell the staff member directly what kind of impact he is having on the problem".

Asking Questions

Any communication process calls for a question and answer form of presentation. The question and answer technique generates useful and provocative questions or comments. This technique yields questions and issues that the audience or learners wish to have clarified or expanded.

Questions can be asked as closed-ended or open-ended questions. Closed-ended questions often result in yes/no answers and inhibit discussion. They are often answered with one word. For example.

Trainer: "Do you think that recommendation will work?"

Participant: "No".

The open-ended question requires elaboration e.g. "Tell me what you like about that recommendation", seeks information. How? What? Why? are words that begin open-ended questions.

Trainer: "What did you like about that recommendation?"

Participant: "I think it is a good strategy for resolving the issue, one that can be implemented without using a lot of resources."

Trainer: "What kinds of goals did the group set?"

Participant: "They set a wide range of goals. The first was ..."

In what context would you use the questioning technique during the communication process?

By answering questions people get a broader understanding of the problem and avoid jumping to premature conclusions.

Activity 2

1. A 15- year-old school girl who is 2 months pregnant comes to see you for advise. She is an orphan and still wants to go on with her education. She fears that she has no one to look after the baby if she carries the pregnancy to full term.

    - How do you see what is going on?
    - How does the problem affect you?
    - What is likely to happen if the problem is not addressed and resolved?
    - What are the likely causes of the problem?
    - What seems to be the real and root cause of the problem?
    - What are the benefits of solving it?

<u>Summarizing</u>

This communication skill is a deliberate effort on the part of the communicator to pull together the main points in a write-up and/or discussion.

The purpose of summarizing is to:

- Pull important ideas, facts, or data together.
- Establish a basis for further discussion or to make a transition,
- Review progress
- Check for clarity; check for agreement.

By using summarizing in a conversation, you can encourage people to be more reflective about their positions as they listen for accuracy and emphasis.

Summarizing requires you to listen carefully, in order to organize and present information systematically. Summarized information ensures that everyone in the discussion is clear about what transpired in the just-completed portion of learning exercise and/or discussion.
For example, as a trainer you may summarize to ensure that participants remember what has been said or to emphasize key points made during a group discussion. In these instances summarizing is very useful. Some starter phrases to help you begin a summary are:

* "There seem to some key ideas expressed here . . . "
* "If I understand you, you felt this way about the situation"
* "I think we agree on this decision . . . what we are saying is that we intend to . . . . "

Example 1: Assume that someone named Joan has talked for 3 or 4 minutes, and you summarize as follows:

Let me see if I have it straight, Joan. First, you say the work is boring, not carefully scheduled and finally, you are concerned about the number of hours people are expected to work, correct?

Example 2: In another example, the discussion has gone on for several minutes and you summarize as follows:

In talking about this issue, we have come up with 3 main points . . . .

Listening

Listening is a facilitation technique that if well used can tell us a lot about learners needs, reactions about the content and the entire experience. Listening is described as passive and active.

Self Assessment Question

What is the difference between passive and active listening?

Passive listening occurs when we quietly absorb the statements and questions of the speaker. This type of listening is very effective in therapeutic situations where the speaker needs someone to talk to. The listener enhances listening by throwing in passive responses such as "oh?" or "I see."

On the other hand **active listening** is stimulating and encourages a 2-way communication process. In a learning or counseling situation, active listening gets the speaker involved in the learning or counseling process and encourages problem solving.

According to *Delivery of Effective Training by TW Goad (1982),* the steps in active listening are:

1. The sender sends a coded message
2. The receiver receives the message.
3. The receiver decodes the message
4. The receiver feeds back what the message is -- nothing more or less
   -- with no evaluations

The sender (now a receiver too) either agrees with the receiver's interpretation or, if not, starts the message over again.

Self Assessment Question

What do the terms encode and decode mean?

A number of good things can happen if you use active listening appropriately.

- It shows the learners (or whoever is communicating to you) that you want to hear what they have to say
- It relieves you of the position of having all the answers and acknowledges that learners have something to say, too
- It allows you to get closer to the learners through open, honest communication

- It recognizes the feeling part of communication between people; if negative feelings exist, they can be brought out and dealt with
- It helps to overcome resistance on the part of the learners
- It improves the chances for people who are silent and/or dependent to become involved in the learning process
- It keeps the problem where it belongs-- with the learner -- and provides a forum for it to be resolved immediately
- It encourages the sender to keep communication going, because it does not evaluate or steer the communication away from the sender's original intent

Active listening requires avoiding the behaviors listed below:

- Ordering, directing, commanding
- Warning, admonishing, threatening
- Exhorting, moralizing, preaching
- Advising, giving solutions or suggestions
- Lecturing, teaching, giving logical arguments
- Judging, criticizing, disagreeing, blaming
- Praising, agreeing
- Name calling, ridiculing, shaming
- Interpreting, analyzing, diagnosing
- Reassuring, sympathizing, consoling, supporting
- Probing, questioning, interrogating
- Withdrawing, distracting, humoring, diverting

Feedback

Feedback is the other form of enhancing communication.

Self Assessment Question

What is feedback?

Giving feedback is a way of helping another person to understand the impact of his or her behavior on other people. It can be positive or negative. Feedback is effective when the following criteria are used.

- Make specific statements; support general statements with specific examples
- Use descriptive rather than judgmental language; it reduces the need for the person receiving feedback to respond defensively
- Be direct clear and to the point
- It must take account of the needs of the receiver and the giver of feedback
- It must be well planned
- It should seek information on clear and specific areas
- It must be brief. Major points must be paraphrased by asking clarifying questions.

Take Note

We are all happy when we receive positive feedback about our performance. This is because there is much that goes on every day that is positive. This is not to say that we should ignore negative feedback or develop communication patterns in which we only give positive feedback. Both positive and negative feedback must be given in a manner that focuses on areas that the person receiving feedback can change or improve on rather than on personality.

Barriers to Effective Communication

Establishing commonness in communication does not come on its own. This is because there are many barriers that make it difficult for us as communicators to reach our goal.

Self Assessment Question (SAQ)

What are the most common barriers to communication?

1. Age Difference: The age difference between the sender and the receiver can constitute a barrier. A common language needs to be found between the sender and the receiver

2. Economic Gap: The economic gap between 2 different income groups is another barrier. For example a health worker who is employed and earning a salary is not communicating when he or she tells a poor unemployed person who is suffering from pneumonia that the cause of the infection is exposure to cold weather

3. Language barrier: Barriers can exist in the case where the sender uses technical and complicated or even ambiguous language with a group of people who have no prior knowledge of that subject area. The illustration below shows the confusion ambiguous language can cause

ILLUSTRATION

Activity 3

a. What message is the instructor passing to the apprentice?

b. What message does the apprentice get and what happens thereafter?

c. How would this message be communicated clearly?

4. Knowledge about the audience: Knowing your audience is one way of overcoming communication barriers. You must know the background, interests and needs of the target group so as to plan an effective learning experience for them

5. Appropriateness: The message we pass must be timely, meaningful and applicable to the situation

6. The audience must overcome its own barriers: Communication is a 2-way process. Both the communicator and the receiver must establish a common ground in order to create a dialogue

7. Cultural diversity: Differences in cultural backgrounds create a barrier to communication particularly in the interpretation of non-verbal communication signals that may carry different meanings

8. Different educational and professional backgrounds: These can create a barrier because of different orientation between the receiver and the sender of the message

9. Lack of empathy: As communicators we must learn to empathize with our audience. Showing sensitivity to feelings of your audience brings them closer to you

Self test

Answer the following questions and discuss your answers with the mentor/coach.

1. How does lack of effective interpersonal communication skills affect the health care services that you provide to individuals, families and the community that you serve?

2. How would you enhance verbal and non verbal communication skills when interacting with the community members?

Summary

So far, we have said that interpersonal communication is establishing commonness between the sender and the receiver of a message. We have also said that in order to overcome communication barriers, we as communicators must use effective communication skills such as clarity, paraphrasing and listening.

Further reading

Goad T.W. (1982): *Delivery Effective Training*, University Associates Inc. San Diego California chapter 7 and 8.

Fred Abatt and Rosemary McMalhon: *Teaching Health Care Workers: A Practical Guide* 2nd Ed. 1993 - chapter 12.

Lesson 3 - Service Providers, clients, patients, families and the community as adult learners

Introduction

In module one, we identified that PHC approach aims at empowering the individuals and the community to take responsibility for their health. We also learnt that adults, community members and individual themselves have a wealth of knowledge that the health worker must take into account wherever they come into contact with them during health promoting activities. We also learnt that health workers as adults too have a wealth of experience they bring to their work situations. In learning situations therefore we should always encourage their active participation to learn what is important for their work needs. Health workers provider role also involves a learner and teacher/educator role. The learner role comes about in that learning is a life long process given the many changes brought about by technological advances in health.

The teacher/educator role arises from the requirement to share information on health scientific facts about disease and health problems in order to empower individuals and community and enable them make informed choices and change their health behaviors.

In this lesson we shall define the concept of Adult Learning and the differences between children versus adult learning. We shall discuss how our assumptions regarding how adults learn influence the way we view how health education and training should be managed.

Lesson Objectives

At the end of this lesson you should be able to:

1. Explain how assumptions regarding adults' learning influences planning and conducting their learning/training

2. Apply the principles on how adult learn best in planning and conducting learning and education sessions for PHC clients ad providers

Self Assessment Question (SAQ)

Who are adults and what are their characteristics?

The Adult Learning Process

In the adult learning process, one person (mentor /coach / trainer) provides the opportunity and environment for another person (adult learner) to acquire knowledge and skills and change attitudes as opposed to traditional teaching in which the teacher/the professor imparts knowledge to learners without giving them the opportunity to make a choice in what is most important for them and to participate actively in acquiring the new information or skills.

Self Assessment Question (SAQ)

How do adults learn best?

While there are different theories on Adult Education, research indicates that effective adult learning occurs when the learner is **actively** engaged in the learning process. In addition, the needs of adults should be considered and relevancy of what they learn to their own goals must be borne in mind.

Next time you are planning a health education session for a client, a community group or conducting training activity of health care workers, you should consider and follow the principles that have been established about how adults learn. Once you understand these assumptions, you will find that there is no need to give long lectures on facts. The knowledge could instead be drawn from the individual's past and experience or questioning with the facilitator filling up gaps.

Seven assumptions of how adults learn best

Take Note

- Adults must want to learn
- Adults learn only what they feel they need to learn
- Adults learn by doing (by experiencing)
- Adults learn by solving practical problems
- Adults learn through the application of past experiences
- Adults learn best in an informal environment
- Adults learn best through a variety of training methods

Let us look at these assumptions and see how they can apply to training other health workers, clients or community groups learning in your own primary health care setting.

Adults must want to learn

Adults are motivated to learn when they have or develop needs and interest for learning. Therefore learners' needs and interests are the appropriate starting points for reorganizing adult learning activities. You must remember that the learner is asking himself or herself questions such as: will learning this material make the job easier? Will it improve skills and perhaps result in a better paying job. In the case of a client or community, questions include: will the change of the behavior result in being free of disease? Will it result in the rest of my children and relatives escaping sickness and death from tuberculosis? Will it result in my getting and using a contraceptive method that will meet my family planning goal and that will not result in side effects or complications? As a facilitator/service provider you can give them evidence to the questions they are asking?

Adults learn only what they feel they need to learn

Adults learning emphasis is on life and work related situations and what is of immediate need, not theoretical subjects. If an adult must learn more, then you must convince him / her that

learning the more advances or theoretical subject will result directly to making the work easier or improve their career or health status.

Adults learn by doing

As a PHC worker, you are also a trainer as well as a learner. You must remember that adult learners get easily bored by textbooks and long lectures and speeches. You should therefore base the training/education on opportunities for the learner to actively participate in the learning. This means practicing, seeing and doing. Practice and doing ensures that they apply their new skills or knowledge immediately.

Adults learn by solving practical problems

Provide adult learners with real - world problems and challenges. You should avoid giving adult learners imaginary examples that only support theories and are not real. When you present to them their real world, then learning takes place naturally and effectively since they have to solve real practical problems.

Adults learn through the application of past experiences

Experience is the richest source of learning. When working with adult learners regardless whether they are health worker trainees, patients or clients, or the community, you should first bear in mind that the new knowledge you are introducing must be related to, and integrated with, existing or old knowledge. The big challenge for you is to help the learner see how new and old are similar or different and why the new knowledge (or way of doing things) is important. You must show how the past leads to the new and different (perhaps improved) ways of doing things. If you do not integrate past knowledge and the new, it is likely the learner will listen and revert to the old way of doing things.

Adults learn best in an informal environment

When working with adults, you must avoid unpleasant school memories such as grading, assigned seats and strict rules. It is better that you seat your group in a way that ensures all can actively participate, and provide a means whereby all learners can measure their own progress during the session. Correct use of humor and informal discussion helps break the formality of a training session.

Adults Learn Best Through A Variety of Training Methods

When you combine a variety of learning methods and aids, it is more likely to result to higher level of learning. It is therefore wise to combine methods that use listening, visualizing and working with hands or active discussion for learning to take place.

Activity 1

1. Take a few minutes to think of the differences between how children learn as compared to adults. List your points down

   _____

   _____

   _____

2. Refer to handout on Adult Training versus Teaching Children (Andragogy versus Pedagogy) and compare your responses

COMPARING PEDAGOGY TO ANDRAGOGY

	PEDAGOGY (Formal/Children)	**ANDRAGOGY** (Non-formal Adult)
LEARNER'S ROLE	- Follow instructions - Passive reception - Receive information - Little responsibility for learning process	- Offer ideas based on experience - Interdependent - Active participation - Responsible for learning process
MOTIVATION FOR LEARNING	- External: Forces of society (family, religion, tradition etc.) - Learner does not see immediate benefit	- From within oneself - Learner sees immediate application
CHOICE OF CONTENT	- Teacher-controlled - Learner has little or no choice	- Centered on life or workplace problems expressed by the learner
METHOD FOCUS	- Gain facts, information	- Sharing and building on knowledge and experiences
PROCESS OF LEARNING	- The teacher is the source of information therefore he /she gives them information in view of his/her experience and expertise as their teacher	-The teacher/trainer acknowledges/takes into consideration the learner's experience and actively uses as the point of the departure to unfold the new

Self Assessment Questions (SAQ)

1. Which column do you place the way you give health promotion/education to clients and the community?

2. What changes do you propose to make in planning and conducting future client health education?

Summary

Adults learn because they choose to learn and they learn best if they are involved in the learning process. In this lesson we have looked at the differences in learning preferences between children and adults. We have also identified the importance of treating our clients, including the community as adults. Learn from them, build on what they already know and do, and provide new information to fill in their knowledge gaps or give scientific factual data. The lesson has clarified that one way to communicate a caring, respectful attitude is by treating adult clients as respectable, knowledgeable individuals with specific goal oriental interests and not as children.

Self Test

1. What are the most important things you will remember to do when you plan and conduct your next training for adults who are working in the PHC setting

2. Prepare a lesson for a group of at least 6-10 women attending the clinic where you work. Deliver the session. Ensure that the lesson adheres to the assumptions on adult learning in terms of the objectives, the learning methods, and the evaluation

3. Give your mentor or colleague the guide for evaluation to assist give you feedback on your performance after your own self-assessment

Further Reading

1. Fred Abbat and R McMahon*: Teaching Health Care Workers*, 2nd ed. 1993

2. Abbat F, *Teaching for Better Learning, A guide for teachers of Primary Health Care Staff,* 2nd ed. WHO 1992

Lesson 4 - Developing Positive Caring Attitudes and Ethos at Workplace

Introduction

In this lesson, we shall discuss how we can develop and maintain caring attitude at our places of work. We shall also discuss what counseling is about, the counseling process and its role in our day-to-day work. Finally we shall review the interviewing process as a commonly used method of collecting information from individuals and how the service provider can convey a caring attitude.

Lesson Objectives

At the end of this lesson, you should be able to:

1. Analyze the concept of caring ethos as it applies to health care providers

2. Demonstrate behaviors that convey caring attitudes in health care provision situations

3. Demonstrate the ability to improve the sense of caring and compassion among the health team members at the work place

Self Assessment Question (SAQ)

1. Health workers at clinic have "very bad attitudes" to their work: What might the community members be meaning by such a statement?

2. The nurse displayed "very good attitude" list to her what work family member meant by this statement?

You may have heard some health workers described by Consumers of health services and fellow health workers as being "very bad" or having "very good attitude" to their work. These statements are made to describe how one talked or performed a duty. For example some service providers may be frequent late comers to the places of work. Some delay provision of health services by keeping clients waiting as they (health workers) engage in unnecessary personal conversation or personal duties. Such health workers are manifesting uncaring attitudes towards their clients and work mates and negative attitudes towards their work..

Take Note

Attitudes are described as the driving forces that determine how we behave and perform our duties.

Caring Attitudes

However if for example service providers start serving clients on time regularly and the day they are late they explain what happened before they start, the clients may rate them as caring and having a positive attitude towards their work.

Caring Ethos

Self-Assessment Question (SAQ)

What is ethos?

Ethos is a Greek word that means a custom or character. Thus we can refer to the distinguishing character, moral nature or the guiding beliefs of a person, group or institution as ethos. When health workers, nurses or clinic staff explain to the clients about health services procedures and why they are necessary and seek the client's reactions while operating procedure standard we say they care. Similarly, when, we extend a helping hand to sick and exhausted clients and show them where to sit in comfort, if they must wait, when we sit with a bereaved family after breaking sad news of death or worsening condition of their loved one, we are manifesting caring. As health workers in that health facility if we do that giving equal care to our clients regardless of their social, economic or ethnic status and the public recognizes those attributes, we are manifesting caring ethos. That becomes a positive distinguishing character of the gap of service providers and the particular health facility. However, if the health workers develop the tendency to discuss the illness or private information about those we are in confidence by virtue of our professional role - and the public comes to know, they can be regarded us as having uncaring unethical ethos. Caring ethos can be developed. Every member of the health team has a responsibility for developing

and maintaining caring as a foundation of the helping profession. PHC service providers should become known through this characteristic.

Self-Assessment Question (SAQ)

How would you develop and apply caring ethos at your workplace?

You can develop caring ethos by initiating and applying socially acceptable work norms relationship and communication including:

- Promptness in the delivery of health services
- Displaying customer friendly behavior compassion and consideration for clients' concerns
- Extending preventive and promotive care to the community through encouraging and counseling
- Ensuring our technical competencies are updated and upgraded in order to assure safety
- Initiating cooperation and information sharing with other workers in the community geared towards accessing information for health promotion and disease prevention to the community

Activity 1

1. What are the current issues that manifest lack of and/or loss of caring ethos in:

    a. PHC service providers?
    b. Members of the community?
    c. PHC Trainers and educators?

2. What interventions should health workers in partnership with the community make in order to change the situation? Prepare a session on appropriate interventions for discussion in a health team meeting

As PHC workers we must establish, convey and maintain a consistent attitude of caring that distinguishes members of our professions whenever we work with different communities, persons from other sectors of development and patients or clients.

However, caring ethos are not confined to our work place only. They apply in all situations where we are interacting with other human beings who by virtue of their human rights must be regarded with respect, care and concern. As health professionals we are also required to give counseling services to our clients, workmates and members of the community. Good counseling techniques convey caring and respect. The next lesson will address counseling.

Self Test

1. How would you develop, convey and maintain a consistent and caring attitude that distinguishes you from other professionals?
2. Hold a short sharing session with other staff members at the clinic to tell them what you have learned about caring and discuss how each can contribute to raising the caring attitude at your clinic

Further Reading

Fred Abatt and Rosemary McMahon: *Teaching Health Care Workers: A Practical Guide*, 2nd Ed. 1993,
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Lesson 5 - Counseling

In this lesson we shall examine counseling as an important care skill and care services for primary health care delivery. We shall review the information giving counseling continuum and apply counseling skills, and the counseling process.

Lesson Objectives

At the end of this lesson, you should be able to:

1. Differentiate between counseling and advising

2. Explain key aspects of counseling: purposes, skills, the counseling process, qualities of a good counselor

3. Apply counseling skills in the delivery of a variety of PHC services

Self-Assessment Question (SAQ)

Why is counseling an important core skill for every PHC service provider or trainer?

In the course of health care delivery, we come across many situations that demand counseling services. For this reason, every provider of health care services must have the requisite knowledge and counseling skills and be prepared to counsel clients over and above the complaints or conditions that clients or families present with.

What is counseling?

a. Counseling is a person-to-person communication in which the counselor assists the client to examine a personal situation, a concern, issue or problem to make a free decision and act on it

b. The counselor or provider assists by establishing a helping relationship with the client that involves open dialogue between the 2 and by providing adequate information to enable the client to make a free and informed choice about the course of action that is best for him or her in resolving a problem

c. Effective counseling requires that we as providers/counselors us to empathize with our clients by putting ourselves in their situations

Self Assessment Question (SAQ)

What does ''free and informed choice" mean?

Availing the client free and informed choice is an important goal in counseling because the clients must be given adequate and accurate information about what is known of the issue at hand including successful experiences with similar issues in the past so that the client can make voluntary decisions relevant to their situations on what to do without coercion, constraints or other forms of pressure.

Take Note

Counseling is not advising or educating. In advising, the providers/counselor takes on more responsibility for the decisions. In counseling the client is encouraged to seek the information they need and take responsibility for the decision.

Essential Counseling Skills

It is important for counselors to employ effective communication skills such as:

1. Active listening and non-verbal communication skills

Tips for active listening

a. Meet the clients in a comfortable and private place
b. Accept the client and treat them as individual
c. Listen to what the client says and the way in which they say it. Pay attention to their voice, choice of words and facial expressions
d. Maintain eye contact without staring in a rude manner
e. Lean forward when listening. Nod your head
f. Make comments such as “uh huh”, “go on”, “yes...,” I see”
g. Try to feel empathy for the client
h. Encourage the client to participate actively in the 2-way interaction by allowing time for the client to talk and ask questions
i. Listen carefully to the client instead of thinking about what you are going to say next
j. Use the skill of paraphrasing (repeating in your own words what the client has just said) to make sure that you have understood the client. Example “what I

hear you say is ....." This gives the client an opportunity to correct or confirm your perception)

2. Paraphrasing in order to reflect a client's content

3. Empathizing in order to identify with and reflect on a client's feelings

4. Validating in order to confirm to a client that his/her expressed feelings are valid under the circumstances

5. Clarifying in order to check if the counselor understands the client

6. Summarizing in order to clarify topics and issues discussed

7. Asking questions in order to find out what the client wants.
Questions can be open ended or closed and can be used to elicit factual information or feelings of the client. The questions we ask must focus on the current situation; assess feelings of the client and how he/she tried to resolve the problem. Open ended questions are preferred because they keep the dialogue open. Such questions begin with what how, in which way,
when, where..... Questions that tend to give "Yes" or "No" answers should be limited as they are likely to close the discussion before the issues are fully explored

Purposes of counseling in health care

The purposes of counseling in PHC are many. They include:

- To help people make voluntary, informed decisions to use various preventive, promoting, rehabilitative and curative health services

- To help individuals or families solve their own health related problems, issues, concerns in ways that are successful
- To encourage individuals and families to continue using the various PHC services
- To encourage individuals, couples and families to adopt healthy behaviors and practices
- To create awareness about a potential or actual health need perceived by the provider even though the client is unaware of it
- To promote empowerment of individuals and family in health matters as one way of applying the PHC philosophy

Steps of the counseling process

1. Putting the clients at ease

You can make your clients feel at ease by greeting them on arrival, giving a friendly smile, asking them about their family or work and by making them comfortable on a chair. You can increase the client's feeling of ease by creating an environment that assures them of privacy and confidentiality.

2. Promoting client's interest to seek solutions to problems (Motivating clients)

"Motivation" is the force that causes us to act in one way rather than another. "Motives" form the inner drive that propels us to make a decision. You can promote your client's inner drive and interest through discussions on their goal regarding a certain issue. You should apply good interpersonal communication to help establish rapport and climate for openness and caring relationship.

When clients are not motivated to seek solutions to their problems, they will not open up to you.

The Counseling Process

An Individual's needs, concerns or problems are influenced by many factors including physical/physiological, environmental, socio-economic. As such, needs and problems differ from one time in life to another. As a counselor, it is important for you to apply counseling skills according to the motivation and changing behavior of each client. You should start your counseling process by finding out and evaluating what the client wants most to achieve.

Self-Assessment Question (SAQ)

What are the advantages of putting a client at ease?

3. Exploration

At this stage, you and the client begin to explore the problem. You may help your client to focus the problem through asking questions that are probing and prompting and then you paraphrase, clarify and summarize the problem as you understand it for confirmation or correction of the understanding.

Take Note

This makes the client feel welcome, accepted and regarded as an individual and that you care for them.

4. Listening and Learning

In counseling the client is the best resource as a counselor, is you have information that can help the clients but in order to do so, you need to know what information the client already has, his/her medical and social history, knowledge, beliefs and perceptions about the problem at hand and this reinforces the fact that counseling is a 2-way process.

When you meet your client for counseling sessions, you must listen actively in order to grasp what his/her problem is and then help them to determine the most appropriate intervention strategy.

5. Giving Careful Explanations

Careful explanation involves being sensitive to the client and how well he/she understands the information provided. It also means that you offer scientifically sound options and facts so that clients can make voluntary but informed choices about the next course of action. Therefore it is your job as a counselor to repeat important information in the language clients understand well. More than once during the session you can encourage the client to restate the information in their own words so that you can repeat anything that was missed or misunderstood.

You can give explanations using the different techniques suggested below:

- Giving information or offering suggestions
- Offering information that you think is necessary or which the client asks for
- Challenging the client for example, by helping them identify what role they played in contributing to the problem
- Helping the client to express emotion

- Acting as a catalyst to enable the client to bring out their problems, concerns, feelings and emotions as they perceive it
- Validating and encouraging the client positively

6. Client Follow-up and Record Keeping

As a counselor, it is important for you to conduct a follow-up of your clients to assess the progress they are making. Therefore you need to keep careful records of your clients. These will give you information on the improvement the clients are making and make future counseling easier.

Activity 2

Reflect back in your life and identify at least 2 counseling sessions in which you were the client. Remember one good experience and one a disaster.

In each situation, give 5 reasons that made each situation either a success or a disaster.

Take Note

For more information on the application of communication skills, read Lesson 1 of sub-module 2.1.

Characteristics of a good counselor

Counseling should employ certain conditional principles that are embodied in social ethics.

A good counselor is:

1.	Committed:	Takes their tasks seriously, which communicates to clients that they are well regarded and have a right to counseling
2.	Warm:	Shows warmth and responds positively to the needs of the clients
3.	Self-assured:	Is well disciplined to maintain his/her social and moral integrity
4.	Truthful:	Truthfulness is necessary as it enables the client to make informed choices and to give informed consent. A good counselor has a moral responsibility to provide accurate information
5.	Knowledgeable:	Is well trained and informed about counseling skills including respect for voluntarism by leaving clients alone to make decisions freely
6.	Efficient*:*	Is able to work well under pressure, with minimum supervision and is well committed to the disciplined tasks of helping others
7.	Unbiased/ Impartial	Is non-judgmental and respects values of others. A good counselor displays respect for the client's regardless of social-economic, ethnic, marital status, age, gender, educational level, religion, or language

8.	Discrete:	Maintains confidentiality and does not disclose information entrusted to him or her without the client's consent. A good counselor conducts counseling in a comfortable setting that ensures privacy
9.	Empathetic:	Identifies himself/herself with the feelings of the clients
10.	Genuine:	Is consistent in what he/she says

Activity 3

1. Given the current, socio-cultural, physical and political environment in which you work, how would you apply the principles of counseling?
2. What difficulties would you face if any, in applying each of the characteristics of a good counselor at your place of work? Give your answer in reference to your workmates and clients

Self Test

1. Apply the counseling skills learned during the intensive period and in this DBL lesson to counsel an individual client at your clinic who has:
   a) tuberculosis and is on treatment
   b) a child suffering from malnutrition
   c) a high risk of contracting STDs and/or HIV/AIDS
2. In each case, note by writing the major aspects, knowledge and skills of counseling that you found most useful
3. Discuss these with your mentor or a peer

Further Reading

Fred Abatt and Rosemary McMahon: *Teaching Health Care Workers: A Practical Guide*, 2nd Ed. 1993,

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ANNEX E

CURRICULUM DESCRIPTION

ANNEX E. Curriculum Description

The PHC Comprehensive Skills Training Program was designed to prepare the trainees to: 1) develop capacity building in PHC comprehensive components of management to include service, data management, human and material resources; 2) influence PHC services by improving the knowledge and skills of service providers, particularly those posted in rural and other hard to reach areas; 3) increase availability of integrated and comprehensive PHC service; and 4) improve the quality of the service through development of training capability and capacity in the province.

Module 1: Orientation to PHC Approaches for Service Delivery and Management

Sub-module 1.1: Orientation to PHC concept and philosophy
Sub-module 1.2: Community participation
Sub-module 1.3: Management of PHC services
Sub-module 1.4: Interpersonal communication skills

In this module the learner was introduced to the concept and philosophy of Primary Health Care. The aim was to give the learner an orientation in the meaning, evolution, principles, and strategies of primary health care and how these may apply in South Africa. The module objectives were that, at the end of this module, the learner should be able to 1) apply concepts and principles of primary health care in organizing integrated and comprehensive services for the community served; 2) empower the community to participate in PHC related activities; 3) demonstrate ability to work with different community development workers from areas such as nutrition, education, and agriculture in the promotion of primary health care services; 4) apply sound management techniques in the implementation and execution of comprehensive, customer-friendly PHC services; 5) communicate effectively with individual clients and the community on health-related issues; and 6) demonstrate a caring attitude when interacting with the PHC community, individuals, families, and work mates.

Module 2: Training and Facilitation, Epidemiological Research, Monitoring and Evaluation

Sub-module 2.1: Training facilitation
Sub-module 2.2: Epidemiology and research
Sub-module 2.3: Monitoring and evaluation of PHC services and training

The goal of Module 2 was to give the learner knowledge and skills on major aspects of training and facilitation, applied epidemiology, and research, evaluation, and monitoring that are relevant to the learner's work in PHC service provision, management, and training. In this module the learner was introduced to the concept of adult learning and its application in education for health workers from the PHC perspective. The orientation towards participatory

training methods that the learner received in Module 1 were strengthened through an experiential learning process and the use of facilitation techniques to promote adult learning principles. The learner was also introduced to simple epidemiological and research methods that are applicable in PHC settings. Finally, the learner was introduced to key aspects of monitoring and evaluation.

The module objectives were that the learner should be able to 1) apply the concept and principles of adult learning as they apply to the training process and to the education of community and health workers; 2) demonstrate skills in the facilitation of training; 3) demonstrate knowledge of scientifically sound methods of applied epidemiology and research; 4) using a participatory approach, apply knowledge of these methods to describe and assess the scope of causes and consequences of health-related problems in the community where she or he work; 5) describe the terms *monitoring* and *evaluation* and their application to service delivery and training; 6) demonstrate knowledge and skills about evaluating PHC services and training in order to improve planning and performance; and 7) define the terms *efficiency*, *effectiveness*, and *impact evaluation* for PHC services and training.

Module 3: Reproductive Health and Women's Health Interventions

Sub-module 3.1: Sexuality education and life coping skills
Sub-module 3.2: Family planning
Sub-module 3.3: Mother and child health
Sub-module 3.4: Women's health interventions
Sub-module 3.5: STDs, HIV and AIDS
Sub-module 3.6: Infertility

The goal of this module was to improve the quality and access to key women's health and reproductive health care as an integral component of PHC through the training of trainers and service providers. The objectives of the module were that the learner should be able to 1) apply knowledge about sexuality and the factors influencing adolescence reproductive health in the provision of quality information and services for adolescents, youth, and women as a whole; 2) explain the following concepts: reproductive health, safe motherhood care, women's health interventions, sexuality and sexual health, maximizing access to and quality of care; 3) interpret important demographic health data and trends and use them jointly with the community in the planning, delivery, and evaluation of priority reproductive health/PHC services; 4) using available community resources, apply knowledge about the concepts of safe motherhood care and reproductive health to establish or strengthen services for the underserved groups in the community; 5) use the syndromic management approach to screen, treat, and manage STDs; 6) demonstrate skills in the following areas: counseling for informed choice, counseling youth on sexuality issues and counseling individuals and families on STD and HIV prevention, educating communities on how to care at home for persons suffering from AIDS, enlisting community participation in health promoting activities related to pregnancy, child health, violence against women and girls, maternal nutrition, adolescent care,

and STD/HIV prevention; and 7) to integrate family planning as an integral part of a comprehensive package of maternal care, child care, and women's health.

Module 4: Child Survival Interventions

Sub-module 4.1: Optimization of breastfeeding
Sub-module 4.2: Implementation of EPI
Sub-module 4.3: Early detection of growth failure
Sub-module 4.4: Improving pre-natal care
Sub-module 4.5: Decreasing mortality due to acute
Sub-module 4.6: Decreasing mortality due to diarrhoeal disease
Sub-module 4.7: Advocating the rights of the child
Sub-module 4.8: Optimizing growth
Sub-module 4.9: Minimizing disability and maximizing potential of handicapped children
Sub-module 4.10: Preventing and managing non-accidental injury
Sub-module 4.11: Minimizing impact of tuberculosis
Sub-module 4.12: Preventing rheumatic heart disease

Module 5: Acute and Chronic Conditions

Sub-module 5.1: Ear, nose and throat conditions
Sub-module 5.2: Ophthalmology
Sub-module 5.3: Respiratory tract
Sub-module 5.4: Gastro-Intestinal tract
Sub-module 5.5: Genito-Urinary tract
Sub-module 5.6: Neurological and psychiatric conditions
Sub-module 5.7: Musculo-skeletal problems
Sub-module 5.8: Skin diseases
Sub-module 5.9: Endocrinology
Sub-module 5.10: Geriatric care
Sub-module 5.11: Occupational health

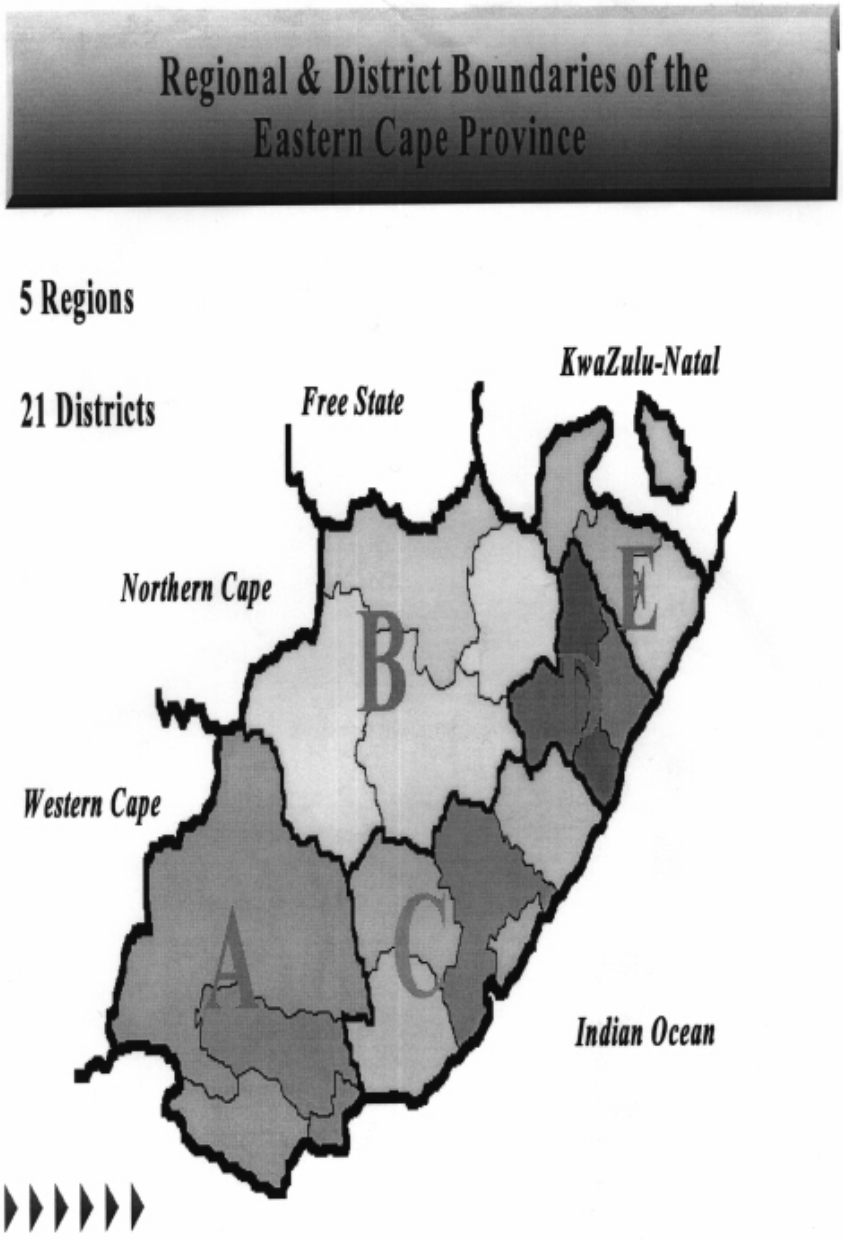
Module 6: Assorted Materials from Earlier Modules (Modules 1, 2, And 3)

Sub-module 6.1: Organizational management
Sub-module 6.2: Change management
Sub-module 6.3: Human and time resources and clinic management
Sub-module 6.4: Stock control
Sub-module 6.5: Management of funds
Sub-module 6.6: Conflict management and negotiation
Sub-module 6.7: Training needs assessment and task analysis
Sub-module 6.8: Data use and evaluation of services

Sub-module 6.9: Applied epidemiology
Sub-module 6.10: STD management
Sub-module 6.11: Management of post-abortion complication and provision of abortion services
Sub-module 6.12: Interpreting Pap smear reports and follow-up
Sub-module 6.12 Review DBL for Module 3

ANNEX F

MAP OF EASTERN CAPE PROVINCE


Regional & District Boundaries of the
Eastern Cape Province
5 Regions
21 Districts
KwaZulu-Natal
Free State
Northern Cape
Western Cape
A
B
C
D
E
Indian Ocean

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