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# Capacity and Capability for the Essential Service Package (ESP) Program in Bangladesh: A Review of the PRIME/National Integrated Population and Health Project (NIPHP) Program

**Final Project Review**

**July 2002**

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## PRIME II
## Bangladesh

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# *Acronyms*

| | |
|---|---|
| ACNM | American College of Nurse-Midwives |
| AITAM | Associates in Training and Management |
| ARI | Acute Respiratory Infection |
| BOU | Bangladesh Open University |
| BRAC | Bangladesh Rural Advancement Committee |
| CM | Clinic Manager |
| CMT | Contraceptive Management Training |
| CSI | Child Survival Interventions |
| CWFD | Concerned Women for Family Development |
| DBL | Distance-based Learning |
| DCH | Dhaka Community Hospital |
| FM | Field Manager |
| FP | Family Planning |
| FPCS | Family Planning Clinical Services |
| HPSP | Health and Population Sector Programme |
| ICDDR,B | International Institute for Diarrheal Disease Research, Bangladesh |
| IMCH | Institute for Mother and Child Health |
| IMCI | Integrated Management of Childhood Illnesses |
| MCHTI | Maternal and Child Health Training Institute |
| MIS | Management information systems |
| MSCS | Marie Stopes Clinical Society |
| NGO | Non-Governmental Organization |
| NSDP | NGO Service Delivery Point |
| NIPHP | National Integrated Population and Health Project |
| OGSB | Obstetrics and Gynecology Society of Bangladesh |
| OJT | On-the-Job Training |
| OSPA | Objective Structured Practical Assessment |
| ORH | Other Reproductive Health |
| QIP | Quality Improvement Partnership |
| PD | Project Director |
| PM | Program Manager |

| | |
|---|---|
| PSTC | Population Services and Training Centre |
| PTS | Performing to standard |
| QoC | Quality of Care |
| RSDP | Rural Service Delivery Partnership |
| RDU | Rational Drug Use |
| RTI/STD | Reproductive Tract Infection/Sexually Transmitted Disease |
| SD | Safe Delivery |
| SDPs | Service Delivery Points |
| TAT | Technical Advisory for Training |
| TDS | Training Documentation System |
| TMG | Training Management Group |
| TMIS | Training management information system |
| TRG | Training Resources Group |
| UFHP | Urban Family Health Partnership |
| USAID | United States Agency for International Development |

# *Executive Summary*

PRIME has been working in support of the USAID-funded National Integrated Population and Health Program (NIPHP) since early 1998, when the Mission invited PRIME to assist the bilaterally-funded partnerships to implement the training component of the program. For four years, PRIME has provided training technical assistance to the NIPHP, and has seen good results in terms of sending well-trained paramedics and doctors back to their service sites, and in terms of seeing significant progress in strengthening the training organizations supporting the training program. As this portion of the NIPHP came to an end in June 2002, this Final Project Review summarizes the approaches, inputs, progress, and results of PRIME's contribution to the training component of the program.

From being represented only by national consultants in the early days to having a fully-equipped office with a resident advisor and several professional national staff, PRIME's presence grew with the growing recognition of its value to the program. In September 2000, PRIME was made a full partner in the NIPHP, and given full responsibility for organizing and implementing NIPHP training. It has continued to hold this responsibility until the end of the program.

PRIME's assistance has taken three forms: assistance in the development of training materials, including curricula for the Child Survival Interventions (CSI), Other Reproductive Health (ORH), and Contraceptive Management Training (CMT) courses, developing training and clinical skills among the trainers, and generally strengthening the training organizations. PRIME has worked with 11 training organizations, mostly Non-Governmental Organizations (NGOs), in this process. Most of these are service delivery organizations which have a training unit that has been strengthened by PRIME. One, Institute for Mother and Child Health (IMCH), is a government institution that was established to provide clinical and educational services. One NGO, Associates for Training and Management, was originally established to fill a training niche in the country and has subsequently added its own clinical services.

One of the objectives of PRIME's Bangladesh program was to use both traditional and innovative methods to improve performance of NIPHP service providers (paramedics and doctors). PRIME developed standardized basic training curricula on CSI and ORH to assure that the clinical service providers throughout the NIPHP system receive similar training for service provision. An important innovation introduced by PRIME was follow-up of trainees at their service site to assess the provider's skills and provide supportive supervision. Usually a trainer accompanied by a PRIME staff member would do this follow-up. Follow-up of a sample of the 569 paramedics trained in CSI found that 81% were performing to standard (PTS) at their service site. A similar follow-up of a sample of the 959 ORH trainees found that 100% were PTS.[1]

1 PTS = An 80% score on the standard observation checklist for CSI trainees and a 60% score for ORH trainees. The lower standard of expected performance for the ORH trainees was determined by the Training Management Group in the early stages of the program.

Beyond skills curricula development and follow-up, PRIME worked with the training organizations in developing training and non-training related systems, based on needs assessments conducted by PRIME. The training systems included evaluation of the trainers through peer feedback and supervision, training of trainers, developing on-the-job training (OJT) capability, internships, and installing a training management information system (TMIS).

At the request of Urban Family Health Partnership (UFHP), PRIME also developed a pilot SD course that proved to be quite effective. Doctors and paramedics at three UFHP clinics are now providing SD services that did not previously exist. An evaluation of the SD course found that the trainees (paramedics and doctors) were delivering an average of 18 babies per month.

In August 2001, PRIME conducted a Training Effects Study of performance of CSI and ORH trainees at their service sites. Of the 124 paramedics interviewed at 36 clinics, 113 were trained in CSI, ORH, or both – 15 had received no training and served as a natural control group. The study found that as many as 64.2% of the trained paramedics possessed adequate CSI knowledge as compared to only 24.1% of the untrained paramedics. On the other hand, 96% of the trained paramedics possessed adequate ORH knowledge as against 62.5% of the untrained paramedics. The difference between the knowledge levels of trained and untrained paramedics in both CSI and ORH is statistically significant. It was also found that utilization of clinic services had increased dramatically since the arrival of the trained paramedics, and it is felt that part of that increase was due to the higher quality of services delivered by the trained paramedics.

Non-training system development at the training organizations included development of strategic and business plans, financial management, and marketing of their training capability. Special initiatives were made with select training organizations to strengthen capability in manufacturing and marketing anatomical models for training, and distance-based learning (DBL) for refresher purposes. These are described in detail in the report.

During this review, a final assessment of training organization strengths was conducted by PRIME, using a questionnaire that had been used in annual reviews for the past three years. The assessment questionnaire was filled out during interviews with training organization leaders, and measures progress in a number of institutional areas, including infrastructure, planning, use/development of training materials, quality of training, number/variety of courses offered, Management Information Systems (MIS), and application of evaluation. The findings from the questionnaire were then scored on a standard four-point scale. The results of this assessment show that the training organizations have progressed substantially since the baseline assessment. The average score of the six training organizations still active at the end of NIPHP was 32.3 compared to 17.3 at baseline. This indicates that the training organizations have strengthened themselves along the critical dimensions, by increasing the number of trained trainers, classrooms, and clinical sites; by expanding their training beyond the NIPHP to other donor-funded programs, and incorporating evaluation and MIS activities into their day-to-day activities.

In summary, the training performance of NIPHP under PRIME's leadership has shown significant progress. The 1,528 (CSI/569 plus ORH/959) paramedics and doctors trained have demonstrated their ability to perform to standard at their service sites. PRIME has introduced some innovations in training, including follow-up of trainees at the service site, internships, SD course, OJT, and DBL, all of which strategies can be continued under the new USAID-funded NGO Service Delivery Program (NSDP) bilateral, getting underway in July 2002. The training organizations involved with the program have also been strengthened and show considerable progress in institutionalizing these strengths, as evidenced by the final training organization assessment. Although activity in training has diminished over the past 12 months due to the lack of service delivery partnership funding for training, the training organizations remain eager to renew their efforts and continue to support the new USAID program with high quality training.

# *Introduction*

## Background

In early 1998, PRIME I was invited by USAID/Dhaka to assist the USAID-funded NIPHP in implementing its training objectives within the project. PRIME brought a long history of excellence in training to its role of providing training technical assistance for the training of NGO paramedics and doctors in Essential Service Package (ESP) services. Funded by field support, PRIME worked with the two service delivery partnerships (Urban Family Health Partnership (URHP), and Rural Service Delivery Project (RSDP), and the Quality Improvement Partnership (QIP) to plan and develop training programs in CSI and ORH.

Later in 1998, the Mission asked PRIME to assign a long-term advisor to spearhead the training efforts. While recruitment efforts were underway, a consultant dispatched by PRIME in June worked with local groups on the CSI curriculum. She was followed by a duo of PRIME consultants in fall 1998 who worked on completing the CSI curriculum and beginning work on the ORH curriculum. The PRIME Technical Advisor for Training (TAT), Sharen Blake, CNM, took up residence in Dhaka in late December 1998, and set up the PRIME office in Gulshan, Dhaka. PRIME hired two Bangladeshi training officers and other support staff to fill out the office staff. Technical assistance to the program was provided by staff from the PRIME Regional Office for Asia and the Near East in New Delhi, and by staff at the Chapel Hill headquarters.

PRIME was made a member of the Training Management Group (TMG), composed of representatives of RSDP, UHFP, and QIP, that was responsible for overall planning and coordination of training. As QIP also had direct training responsibilities under the terms of its cooperative agreement, PRIME and QIP worked closely together in planning and organizing the details of individual training activities. PRIME took major responsibility in developing the curricula for ORH and CSI, and in conducting training of trainers for the two courses. PRIME also introduced the concept of following up trainees at their workplace. Follow-up was important to determine how well they were able to practice the skills learned in training, to correct and reinforce the practice of skills, and to identify areas in which training could be improved, based on the problems seen in practice by the trainees. For example, certain content areas could be emphasized more, and/or trainees could be given more practice in certain skills before they left training.

Improving the skills of the trainers was seen as a critical capacity-building initiative. Trainers not only need to know the technical content areas, but they need to be able to convey the skills and knowledge to the trainees in a way that is efficient and effective. Classroom training has its place, but adequate practice in hands-on technical skills is also necessary. Training methods need to be appropriate to the audience. PRIME built interactive methods into the training methodology, and generally used an adult learning approach.

PRIME's capacity-building efforts did not stop with simply training trainers in

training methodology. PRIME uses the Performance Improvement Approach (PIA) to address strengthening needs in non-training areas as well. Thus PRIME initiated assessments of each of the training organizations to identify the priority strengthening needs of each. Based on these assessments, PRIME developed general and organization-specific interventions in several areas to develop the whole of the training organization. These interventions included financial management, strategic planning, development of promotional materials, establishment of a TMIS, evaluation of training and feedback systems for trainers, curriculum development, internship programs, development of anatomical models by Associates in Training and Management (AITAM), and DBL by Population Services and Training Centre (PSTC).

In recognition of its efforts supporting the NIPHP, PRIME was made a full partner in the NIPHP in September 2000, and was included in official meetings of the NIPHP partner organizations. At this time, its role was expanded, and it was made the prime training organization in the program. QIP retained training responsibility in the area of long term methods, but PRIME became responsible for all other project-wide training, including doctors and paramedic training in CSI, ORH, and CMT. Consolidation of training functions under one organization reduced some of the earlier problems relating to coordination with QIP, and also reduced the role confusion between QIP and PRIME perceived by the service delivery partnerships, since both PRIME and QIP had had substantially overlapping training roles within the program.

In June 2001, Sharen Blake, PRIME's long term advisor holding the position of Technical Advisor for Training and Chief of Party, left her position to return to the U.S. PRIME recruited another candidate for the position but was told by the Mission that it intended to let the bilateral program lapse in June 2002 and solicit bids for a new consolidated bilateral. As there was too little time left in the life of the NIPHP to place another long term advisor, PRIME began using the services of its Regional Clinical Manager based in New Delhi to provide periodic management and technical support to the project. Dr. Shalini Shah was assigned this duty and made extended visits to Dhaka, approximately every other month, staying 3-4 weeks each time. She did this until the end of the PRIME NIPHP program in June 2002. At that time, the PRIME NIPHP office was closed and staff that were not transitioning to the new bilateral, known as the NGO Services Delivery Program (NSDP), were released from service.

## Goal of the PRIME NIPHP Project

The goal of the PRIME/NIPHP project is to strengthen the capacity of training organizations to provide quality training in the essential service package (ESP) to service providers, and to increase the quality of ESP service delivery in rural and urban communities of Bangladesh.

## Objectives of the End Term Review

- To examine selected PRIME/NIPHP project activities (inputs), processes and accomplishments.

- To assess the extent to which project objectives were met.
- To document difficulties and successes, identify lessons learned and make recommendations for future activities in Bangladesh.
- To determine whether the project was implemented as planned and discuss changes made in the course of implementation.

## Methodology

The evaluation team visited all collaborating Training Organizations (TOs), met with their staff involved in the NIPHP (including management, select trainers and providers) and conducted structured interviews to obtain the qualitative and process information. For the majority of quantitative information, the team relied on the secondary data sources based at the PRIME/Dhaka office, with existing training events databases (TMIS) being the key data source. Other important sources reviewed include: TOs' training records, mentoring documents, mentoring visit records, and special reports on the SD training and DBL activities.

The team also administered the Training Institutionalization Questionnaire, the same instrument utilized for the baseline assessment in January 1999 and for the PRIME/NIPHP Review in March 2000. The results gathered during this review were compared to those of the two previous exercises.

Additional sources, such as monthly reports, quarterly progress reports, semi-annual portfolio review, PMP report, and trip reports supplemented the information required to complete the Final Project Review.

# *Discussions*

## Review of Training Program Components

### *CSI Training for Paramedics*

CSI was the second training course developed under the NIPHP (after CMT), but the first in which PRIME participated when it sent its consultants to Bangladesh to assist the CSI curriculum development process. The third edition of CSI curriculum for paramedics was reviewed and updated in March 2000 jointly by QIP and PRIME. With the start of the new NSDP program, Integrated Management of Childhood Illnesses (IMCI) has been identified as the main approach for child survival intervention. Starting in April 2002, the CSI curriculum in use under NIPHP was reviewed for its compatibility with the IMCI approach and it was determined that three major areas needed to be incorporated: care for the sick child, healthy child, and newborn care. These sections and other minor changes will be incorporated in the curriculum during the next project period.

**Status of paramedics training and follow-up**: From July 1999 to February 2002, 569 paramedics were trained in 40 batches of CSI training. For each batch, by agreement with the TMG, two paramedics were to be followed at their work site using a checklist. Per this criterion, in 40 batches, 80 paramedics should be followed up. However only 52 paramedics (65% of 80) have been followed up and of these 42 paramedics (80.8% of 52) are PTS. No significant differences were observed between the performance skills of paramedics during training and after training at follow-up.

**Table 1: Paramedics' performance in CSI**

| # of batches | # of paramedics trained | Post-test skill performance | # of paramedics followed up | % of paramedics PTS during follow-up |
|---|---|---|---|---|
| 40 | 569 | 81.4 | 52 | 80.8 |

The reasons for not following up all the trainees identified for follow-up include the following:

- Training organizations gave priority to training, not to follow-up.[2]
- Paramedic attrition – a major problem for the NIPHP – has left fewer paramedics on the job, so follow-up is not possible for some of those selected.
- Turnover of trainers also affects follow-up because trainers are not available to conduct the follow-up..
- Trainers are sometimes transferred to other departments, and are unavailable to make follow-up visits.

2 This is partly due to the way reimbursement for the training organizations is structured. When the reimbursement system for training organizations was first established by the NIPHP, there was no provision made for reimbursing costs associated with follow-up visits to trainees.

**Training of Trainers (TOT) for CSI**

During the period July '99 to February '02, PRIME mentored the CSI TOT courses in which trainers from nine training organizations participated. In all, 57 trainers were trained in three batches and six trainers trained in a combined CSI/ORH course. The training organizations stressed the need for TOTs for newly recruited training staff. Trainer turnover rate is very high because of transfers, leave for higher studies, and resignation.

**Table 2: TOT for CSI**

| Type of TOT | Batches | # of trainers trained |
|---|---|---|
| CSI | 3 | 57 |
| Teaching TOT | 1 | 15 (6 CSI+9 ORH) |

**Lessons learned:**

- To counter the turnover of trainers, there is continuous need for TOT of new trainers, so TOT should be conducted on a regular basis.
- Trainers should first go through the clinical TOT - meaning the actual training course - as a participant and then in a structured Teaching TOT to help to develop both clinical and training skills.
- Quality of services can be promoted by assuring that the trainers and trainees both meet the performance standards.
- Trainers/ Trainees pre-course skills assessed by Objective Structured Practical Assessment (OSPA) can help the trainer to give appropriate support to individual needs during the training course.
- Involving training organizations in developing the curriculum, planning and conducting training courses can enhance ownership of the training by the training organization.

### *ORH Training for Paramedics*

ORH was the third content area developed for the NIPHP, after CMT and CSI. It was called "Other Reproductive Health" to distinguish it from the reproductive health care involved in the family planning (FP) training. It basically consisted of maternal health (pre-natal care, post-natal care, breastfeeding) and Reproductive Tract Infection (RTI)/Sexually Transmitted Disease (STD) prevention. The ORH training curriculum for Paramedics was begun in October 1998 and completed in May 1999. PRIME worked with staff from QIP and the training organizations to develop the ORH curriculum.

Five training organizations participated in the training of paramedics for ORH: AITAM, OGSB, IMCH, Concerned Women for Family Development (CWFD), and Marie Stopes Clinical Society (MSCS). An 11-day TOT was conducted for a total of 43 trainers during NIPHP. Because of the high turnover of trainers at IMCH due to transfer within the organization, an additional TOT had to be organized at IMCH. These trainers in turn trained 959 paramedics in ORH. As with all of its training, PRIME mentored both the TOT and the on-going training programs to assure that the

trainers were on track and that the training was proceeding smoothly, and provided feedback to the trainers and to the training organization managers in order to improve their performance.

The trainers trained are listed by organization below. There are 31 trainers in ORH who are still employed by the training organizations.

- Five trainers from one training organization, MSCS, oriented for preceptorship.
- 10 Trainers at three training organization (IMCH, AITAM, and CWFD) received internship on RTI/STD case management. (See OJT discussed below.)
- 74 paramedics followed up for ORH

**Table 3: Status of ORH trainers**

| Name of agency | # of trainers trained | # of trainers at present | # of trainers who have left |
|---|---|---|---|
| AITAM | 7 | 7 | 0 |
| CWFD | 8 | 6 | 2 |
| IMCH | 14 | 9 | 5 |
| MSCS | 6 | 4 | 2 |
| OGBS | 8 | 5 | 3 |
| | **43** | **31** | **12** |

**Results of TOT**

The trainers' average knowledge scores improved from 63% at the time of the pre-test to 92% at the time of the post-test. In other words, the average gain in knowledge scores is 29%. Skills were not assessed at the beginning of training, but at the post-test, the average skill score was 84%. Therefore, ORH training has resulted in trainers improving their knowledge as well as skills.

**Table 4: Results of ORH TOT**

| Name of agency | # of trainers trained | Average pre-test score | Average post-test score | Average skill assessment score |
|---|---|---|---|---|
| AITAM | 6 | 64 | 96 | 83 |
| CWFP | 8 | 53 | 87 | 80 |
| IMCH | 14 | 68 | 90 | 87 |
| MSCS | 6 | 65 | 97 | 82 |
| OGBS | 5 | 63 | 91 | 90 |
| | **43** | **63** | **92** | **84** |

Likewise, the knowledge and skill scores of the trainees also showed substantial improvement from pre-test to post-test. As seen in the table below, the average pre-test score was 53 and the average post-test score was 86. The average post-test score for skills was 84.

**Table 5: Results of ORH trainees**

| Name of agency | # of batches of paramedics trained | # of paramedics trained | Average pre-test score | Average post-test score | Average skill assessment score |
|---|---|---|---|---|---|
| AITAM | 9 | 130 | 49.0 | 78 | 72 |
| CWFP | 16 | 225 | 519 | 86 | 86 |
| IMCH | 4 | 56 | 45 | 85 | 86 |
| MSCS | 17 | 218 | 63 | 91 | 83 |
| OGBS | 24 | 330 | 52 | 87 | 87 |
| Total | **70** | **959** | **53** | **86** | **84** |

Note: Performance to Standard (PTS) >=60

**ORH Trainee Follow-up**

Per standard practice, two paramedics from each batch were to be followed up within 4-6 weeks of the completion of training. The paramedics were randomly selected and informed about the date of follow-up during the training. One of the trainers, accompanied by PRIME staff, conducted the follow-up at the work site of the paramedic.

Although the total number of paramedics to be followed up should have been 140, only 74 (52%) paramedics were followed up. None of the five training organizations completed follow-up as per the scheduled time. As noted above for the CSI training, the main reasons for this were that the training organizations saw their priority as training, not follow-up, and there was no earmarked funding for this purpose

Of the 74 paramedics followed up, all were PTS, which is a high percentage. The follow-up results suggest that the trainees have retained the skills gained at the time of training.

**Table 6: Status and results of ORH trainees and follow-up**

| Name of agency | # of batches of paramedics trained | # of paramedics trained | # of paramedics needed to be followed up | # of trainees followed and PTS* |
|---|---|---|---|---|
| AITAM | 9 | 130 | 18 | 16 |
| CWFP | 16 | 225 | 32 | 16 |
| IMCH | 4 | 56 | 8 | 7 |
| MSCS | 17 | 218 | 34 | 10 |
| OGBS | 24 | 330 | 48 | 25 |
| Total | **70** | **959** | **140** | **74** |

*PTS = performing to standard, according to the standardized checklist

### *Internship program*

One of the more innovative aspects of PRIME's assistance to the NIPHP was its development of an internship program as an adjunct to the ORH training. Guided preceptor training programs are almost unheard of in Bangladesh. PRIME decided to develop this program when it saw that a number of the participants in the ORH TOT needed to acquire additional clinical skills in RTI/STD care at the end of their training. Realizing that it is often not sufficient to simply place one person next to another and expect skills to be transferred, PRIME developed a structured internship program for ten would-be trainers in ORH, beginning first with an orientation of the

preceptors and then a five-day internship under their supervision.

The goal of the internship program was to assist the new trainers to practice their newly learned skills under supervision, thereby increasing their clinical expertise and their effectiveness as trainers. The internship was conducted at MSCS for ten trainers. The preceptor/preceptee ratio was one to one or one to two.

The first step was to hold a three-hour orientation for the preceptors or master trainers on the method of conducting the preceptorship. This was intended to lay the groundwork for future internship programs and can be adapted for OJT. The purpose of this three-hour session was to orient the trainers of the selected training organizations regarding the concept of preceptorship and prepare them as effective preceptors of clinical training, including the final evaluation of the preceptee.

The second phase was the five-day clinical internship at MSCS for the preceptees to get more experience at clinical practice in order to increase their clinical competencies and confidence in performing the skills. Specifically, they needed to develop a comprehensive management plan for care of an RTI/STD client, based on correct findings and valid rationale, and confidently implement the plan. A daily plan was developed between the preceptee and preceptor. At the end of each day, the preceptee made a plan for the next day with the assistance of the precepter. At the end of the internship, all of the preceptees were qualified as trainers in ORH.

### *Family Planning Clinical Service (FPCS) Training for Paramedics (formerly know as CMT[3])*

The FPCS training course is the basic FP course for paramedics, and was the first training offered to paramedics under the NIPHP. QIP organized this course from the beginning, and it was only after PRIME was given full responsibility for training in the NIPHP in September 2000, that the responsibility for the course was passed to PRIME. Even then, QIP continued to roll-out the FPCS training for several more months, while PRIME re-organized itself to manage the CSI and ORH courses. The FPCS training course was only offered by AITAM since AITAM alone had government approval for conducting the course. Although it was originally a 17-day course, it was reduced to a 12-day course for the NIPHP, excluding the child health and reproductive component.

In the workplan for the final year, PRIME in collaboration with AITAM has initiated a review of the existing FPCS curriculum for the paramedics. PRIME and AITAM prepared a draft curriculum outline and sent it to UFHP and RSDP for feedback. This became the basis for reviewing the detailed lesson plans and training materials of the existing curriculum in an effort to standardize the CMT curriculum.

The curriculum had three components:

- **Facilitator's Guide –**PRIME edited this Guide for language only. There is still scope for improving the methodology of the training sessions and improving the materials.

3 Contraceptive Management Training

- **Course Director's Manual -** PRIME compiled all the contents of this manual from different sources. Copies of the Course Director's Manual were given to AITAM to begin using.
- **Trainees' Manual –** the technical content of this manual was updated by PRIME in April 2002, based on the latest technical standards and service delivery protocols for FP. Corrections were made on the hard copy of the final version of this manual. AITAM will incorporate these changes in the soft copy, and will make necessary formatting changes to the manual.

**Further assistance to AITAM –** It was decided that AITAM would do the final formatting for all three manuals. As there is no further training for NIPHP paramedics, these documents will not be published and distributed. AITAM will have them reviewed by the Ministry of Health and Family Welfare and print them as required for their present government requirements. Further use of these manuals for NGO service providers will be considered by the NSDP.

### *Refresher Training in CSI and ORH for Paramedics*

After most of the paramedics had finished their initial basic training in CMT, ORH and CSI, PRIME staff and others following up the trainees reported that many of the paramedics needed refresher training. Thus, a draft Refresher Training strategy was developed for the paramedics working under NIPHP in April 2000. The objective of this activity was to refresh the skills and knowledge of the paramedics.

#### Curriculum Development Process

PRIME involved different stakeholders - including the training organizations - in the overall decision-making process and subsequent development/preparation of the refresher training curricula packages. Representatives from training organizations were involved in all steps of the curriculum development process. In order to upgrade their capacity in curriculum development, PRIME provided the training organizations with technical assistance during the process of developing the curricula.

A curriculum development working group was formed with representatives from QIP, PRIME, UFHP, RSDP and training organizations. PRIME led the working group and provided technical assistance to develop the performance-based refresher training curriculum packages.

The curriculum development process started with the analysis of the job descriptions of the target paramedics. The lists of the major tasks identified from the job descriptions guided the curriculum development working group members to determine the gap in the knowledge and skills, making the refresher curricula more performance-oriented.

Based on the list of the major tasks (which also used as a checklist for determining the gap in paramedics' performance) a PNA tool was also developed to gather information from the supervisors/managers of the paramedics. Information was collected to identify the training needs from the UFHP representative, from the trainee follow-up reports, through performance

observation of the paramedics and discussion with the managers in two RSDP and two UFHP clinics. All these findings were documented and a summary report of the TNA was written.

The findings of the TNA were prioritized and most of the gaps were addressed in the six-day refresher training curriculum. It was decided that the rest would be addressed through the DBL initiative with PSTC. (See the DBL section below.)

The existing and newly developed standards and service delivery protocols were used to determine the content for topics to be covered to meet the learning objectives of the training course.

The curriculum was pre-tested with a group of 15 RSDP paramedics at OGSB. Every session was reviewed using the session evaluation formats. The pre-test refresher training course was mentored and the assessment findings were discussed with the curriculum working group members and the curriculum was refined accordingly. Sufficient copies were produced and distributed to all partners and training organizations.

**Orientation of Trainers**

PRIME organized a two-day orientation for the trainers of training organizations. Twenty-eight (28) trainers from seven training organizations participated in the orientation and were certified to conduct the refresher training course. In addition, another two-day orientation was organized on the spot for individual training organizations especially in organizing and setting up of the OSPA spots. These were given to OGSB, CWFD and AITAM, which were the only training organizations used for the refresher training. The findings from the mentoring visit trip reports showed that all trainers possess competent training and management skills to run the refresher training.

**Status of Refresher Training and Follow-up**

From May 2000 to December 2001, 88 paramedics were trained in six batches. The original plan was to provide training to 300 paramedics, but this could not be done because the service delivery partnerships lacked funds during the last year of the NIPHP. Six paramedics were followed up at their worksites and all of them were PTS.

**Lessons learned**

- Involving the training organizations in curriculum development enhances their feeling of ownership of the training and increases the managerial capability in organizing quality training.
- Frequent changes of the curriculum development team members affect the continuity of curriculum development and the members don't develop an equal level of skills in all steps of curriculum development.
- Payment for follow-up visits should be made separately once the follow-up is completed. This will increase the number of follow up visits.

### *Doctors' Training (integrated curriculum: CSI, ORH, FP, RDU[4], IP[5])*

PRIME II reviewed the existing combined Doctor's curriculum on CSI and ORH prepared by QIP and developed a revised version of the integrated curriculum (CSI, ORH, FP, RDU, IP) for doctors in the year 2001.

**Steps of development process:**

*Step 1:*

- Reviewed job description and prepared a list of task/sub-tasks to be addressed
- Mentored one whole training course and evaluated each session using session review form
- Interviewed the program people (trainee, trainer)
- Reviewed existing documents

*Step 2:*

- Identified the learning objectives
- Developed outline of revised curriculum (objectives, duration, contents, training method, training materials, assessment procedure etc.)

*Step 3:*

- Prepared session plans and materials
- Developed assessment tools

*Step 4:*

- Oriented the trainers (about 13 trainers of CSI and ORH)
- Pre-tested the curricula

*Step 5:*

- Revised and printed curriculum package

**Status of Doctors Training and Follow-up**

Between July 1999 and February 2002, 265 doctors were trained in 19 batches. Of these, 20 of the 38 designated doctors were followed-up (58%) at their work site, and of these, 17 doctors (85% of 20) were judged PTS.

**Table 7: Doctors trained and PTS**

| # of batches | # of doctors trained | # of doctors followed up | % of doctors PTS during follow-up |
|---|---|---|---|
| 19 | 265 | 20 | 85 |

The reasons for low follow-up were similar to those for the paramedics:

- Training organizations give priority to training, not to follow-up. (See Footnote

4 Rational Drug Use
5 Infection Prevention

1, page xi.)

- Trainees leave their job after training, so follow-up is not possible.
- Turnover of trainers affects follow-up.

**Trainer's Training Skills**

IMCH is the only training organization that conducted doctors' training in the last two years. To assess trainers' training skills, PRIME mentored the training course, giving special attention to the new trainers. The findings from the mentoring visit trip reports for the last year reflected that all trainers possess competent training skills.

## *Orientation OJT Training for Project Directors (PDs) and Project Managers (PMs) of UFHP*

### Introduction

Orientation OJT was designed to address the problem that UFHP had approximately 100-125 paramedics working in their clinics who had not had training (CSI or ORH or both) under the NIPHP. Since most of the PDs and PMs (who were doctors) had had CSI/ORH/FP training and were updated on clinical content, it was thought that they could train their clinic staff of three to five paramedics in an OJT format. The purpose of this workshop was to train PDs and PMs of NGOs to plan and conduct orientation OJT of paramedics. Each PD/PM has four to ten clinics under his supervision.

The PRIME Dhaka team designed and delivered a six day Trainers' Training (TOT) program, focusing on developing and strengthening training skills in designing, planning and managing orientation OJT, knowledge of participatory adult learning principles and use of participatory training methods and materials.

#### *Preparation and Development of the TOT Course*

PRIME/Dhaka coordinated the efforts of developing, organizing, conducting and assessing the TOT course with support from other staff in the Regional Office and Chapel Hill. UFHP and guest resource persons from training organizations and other agencies also participated.

The TOT outline was designed based on the future roles of PDs and PMs in the orientation program and the list of areas to be covered during the TOT provided by UFHP. One field visit was also conducted to observe orientation facilities at an NGO level and discuss the role of Project Managers as future trainers in the overall plan, design, organization and assessment of on the job orientation courses for paramedics.

The whole PRIME team, including two from the PRIME Health and Population Sector Programme (HPSP) project (who participated in leading the training) had several meetings during the development process for effective coordination and linkage between sessions.

#### *Status of OJT Follow up*

The PDs or Project Managers participated in the six-day TOT in two batches, one in

December 2001 and another one in February 2002. In total, 27 participants from 26 NGOs attended the course.

**Lessons learned**

- The concept of OJT was very much appreciated by the PDs and PMs, but they suggested including other members of the NGO team like clinic managers (CMs) to form a bigger OJT team at the NGO level.
- Mentoring of few more OJT courses at NGO level was not possible since most of the schedules for holding the OJTs were tentative and some administrative and financial issues needed to be in place before implementation of the OJT. So during the last three months only a few OJT training sessions were conducted at NGO level. Exact figures are not available at the central level.

***Distance-Based Learning (DBL)***

Based on the findings of a training needs assessment, a draft Refresher training strategy in CSI, ORH, and CMT was developed for the Paramedics working under NIPHP in April 2000. As discussed above, a six-day CSI/ORH Refresher training course was developed for approximately 300 paramedics. However, it was felt that an additional refresher strategy was needed to supplement the six-day refresher course.

Thus, a pilot DBL refresher program was planned to supplement the refresher training. It was decided to use the PSTC's monthly *Projanmo* magazine as the vehicle for delivering the distance learning messages. The DBL pilot program was implemented during October 2001 to April 2002 within selected service sites of the urban and rural service delivery partnerships (RSDP). The initiative had three components: 1) Strengthening the capacity of PSTC to develop distance learning materials, 2) Dissemination of DBL lessons to paramedics through *Projanmo* magazine, and 3) Use of monthly clinic meetings to facilitate discussion, questions and provide practice opportunities based on the self-study lessons.

A series of seven self-study lessons were published during the pilot on the following topics:

1. Introduction to self-directed learning
2. Counseling for informed choice
3. Improving Acute Respiratory Infection (ARI) case management skills
4. Post-natal care
5. Side effects and complications of injectable contraception
6. Managing with insufficient breast milk
7. Missed opportunities

These were circulated by PSTC among the managers and paramedics in the selected clinic sites. An assessment was made to determine the usefulness of this series by

comparing knowledge on the selected topics before and after introducing the DBL series. Changes in skills of the UFHP providers were measured. Recommendations were made for the improvements of the program and its continuation.

A self-study lesson development team consisted of ten representatives drawn from PSTC, UFHP, RSDP, QIP, and OGSB. PRIME/CH drafted the introductory lesson on DBL, and the self-study lesson development team prepared the next six self-study lessons. In February 2001, PRIME hired a local consultant from Bangladesh Open University (BOU) to design and organize a six day-long workshop to develop the self-study lesson. The team drafted six DBL lessons in English. The PRIME in-country office, regional office, and Chapel Hill office staff assisted the consultant during designing the workshop and the in-country staff assisted in implementing it.

Approximately 100 paramedics were included in this pilot program, nearly equally drawn from both UFHP and RSDP clinics. A total of nine UFHP clinic sites with 52 paramedics and 12 RSDP clinics with 48 paramedics were selected for this pilot phase.

The original plan was to orient CMs and RSDP Field Managers (FMs) in Dhaka, so that they would understand the DBL program and the expectation that they would review the lesson with their paramedics each month at their regular staff meetings. However, the CMs and FMs were not available for this orientation session, and it was decided to orient the managers during baseline data collection. Accordingly, the CMs, RFMs and paramedics at these target sites were oriented during the baseline data collection by the data collection team. A facilitator's guide prepared by PRIME/Bangladesh was also provided to the Managers (CMs and RFMs) during this orientation explaining the DBL procedure and how they would facilitate each specific DBL lesson to the paramedics.

At the same time, the first lesson in *Projanmo* magazine containing the introductory lesson was disseminated by the PSTC among the managers and paramedics.

From October, 2001 copies of the first introductory DBL lesson through *Projonma* were sent to paramedics and their Managers at the targeted NGO clinics. Every month, from November 2001 through April 2002, one of the six main DBL lessons was sent to the managers and paramedics.

PSTC and PRIME jointly conducted the first monitoring visits during the period between January-March 2002, covering all 21 selected clinics. A second monitoring visit was conducted at two UFHP and two RSDP clinics during April.

Distribution of the *Projonma* magazine proved to be a problem. The Bangladesh postal service delivered to some sites and courier services were used for others. No one method (postal or courier service) was successful in all cases, and there were many instances of missed issues, although by the end of the pilot most people had received all of the issues.

### *Learner Support System*

In the initial monitoring visits, it was found that most of the managers had not read or followed the guidelines for conducting discussion meetings with the paramedics. In

some places, the guidelines were missing. The importance of the manager's role was re-emphasized to them and they were re-supplied with guidelines. By the time of the second monitoring visit, the managers stated that the facilitator's guide was sufficient to understand their role in DBL program and provided guidance for facilitating the meetings on specific DBL lessons. Many of them said they used the discussion guidelines during the meetings and made the discussion participatory. In a few cases, the managers didn't use the specific guidelines for discussing the lessons.

Most of the managers were found enthusiastic about the pilot DBL program and participated fully, but many of them suggested involving their program supervisors in this DBL program to build their ownership instead of monitoring separately by PRIME and PSTC.

The final post-test was conducted during the last week of May and the first week of June, 2002. Ninety-six (96) paramedics were followed up. The initial results show that the paramedics participating in this pilot showed slight gains in **knowledge** and significant gains in the **skill** level for management of mothers with insufficient breast milk and for post-natal care (a difference of +26.5% and +34.9% respectively over baseline).

It is recommended that the deficiencies of the pilot be corrected and that this initiative be expanded under the NSDP. For example, in a future iteration, the CMs need better advance orientation to the DBL program and they need to incorporate its use into their routine monitoring and supervision activities with the paramedics. The system for distributing the newsletters also needs to be made more reliable. Still this pilot seems to have generated considerable interest among other providers – who want to read the material - and other donors, who are considering a DBL program of their own.

## Training Effects Study

### *Background*

By June 2001, CSI and ORH training activities had been underway for more than three years and about 1,300 paramedics had been trained in both CSI and ORH courses. The post-test and follow-up scores indicated improvements in both the knowledge and skills of trained paramedics. However, to assess whether such high knowledge and skill levels correspond with overall improved provider performance at the service site, including enhanced quality of care and client use of services, PRIME conducted a study in August 2001 to assess the effects of paramedics' training on their performance and client use of services.[6]

The main objectives of the study were:

- To determine whether training in CSI and ORH services has resulted in improved Quality of Care (QoC) and overall performance of trained paramedics.
- To assess whether the expanded availability of services has effectively resulted in increased use.

6 For more detailed information on this study, please see Technical Report # 38.

- To elicit client and community perceptions of services offered by paramedics in relation to their needs.

### *Study Design*

The study was a cross-sectional assessment of provider performance at service delivery points (SDPs), or the clinic level. In addition, the review of clinic records for CSI and ORH services included data on services provided before and after training. Out of 285 clinics where trained paramedics have returned to deliver services, a sample of 36 clinics (slightly more than 10%) was selected. As the proportion of UFHP and RSDP clinics is almost the same, 18 clinics were selected from UFHP as well as RSDP area. Of the 124 paramedics interviewed, 86 (69.3%) were trained in both CSI and ORH, nine (7.2) were trained only in CSI, 14 (11.3%) were trained only in ORH and the remaining 15 (12.1%) were neither trained in CSI nor ORH and were thus considered "untrained." These untrained paramedics in the sampled clinics served as a natural 'control' group.

The paramedics at the clinic sites were observed while they were providing services to clients, and assessed, using a checklist, for their ability to perform ORH and CSI services according to the established standards. Exit interviews were held with clients to determine their satisfaction with the services, the clinic facilities, and open hours. The clinic inventory was reviewed to see if all the essential supplies and equipment were present. Finally, focus group discussions were held with community members to gain their perceptions of the quality of services provided at the clinic.

**Findings**

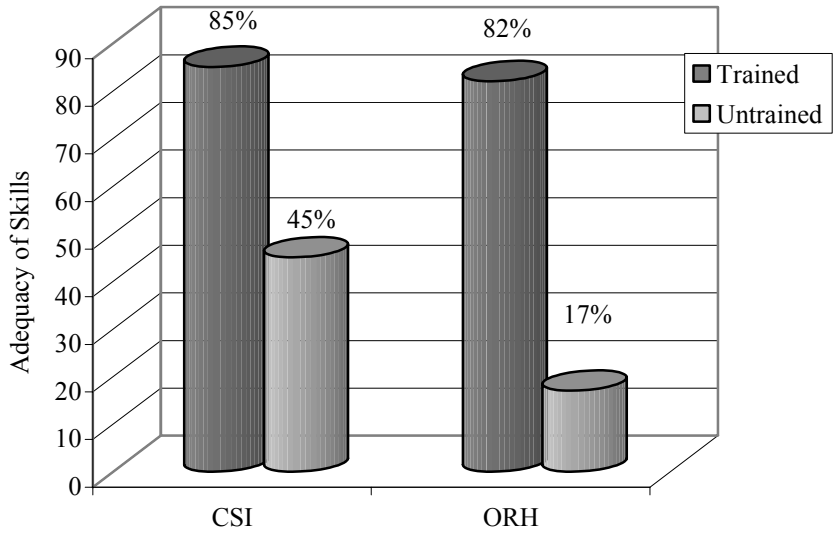
As many as 64.2% of the trained paramedics possessed adequate CSI knowledge as compared to only 24.1% untrained paramedics. For the purpose of this study, a paramedic was considered to possess adequate knowledge in CSI if she scores at least 80% in the CSI knowledge questionnaire. On the other hand, 96% of the trained paramedics possessed adequate ORH knowledge as against 62.5% of the untrained paramedics. A paramedic is considered to possess adequate ORH knowledge when he scores at least 60% in ORH knowledge questionnaire[7]. The difference between the knowledge levels of trained and untrained paramedics in both CSI and ORH is statistically significant.

The post-training knowledge scores of the trained paramedics were compared with the knowledge scores from an interview schedule containing the same questions. As might be expected the knowledge scores were significantly lower 22 months after CSI training and 17 months after ORH training.

In terms of skills, 85 % of the trained paramedics as compared to 45% of the untrained paramedics demonstrated adequate CSI service skills. For ORH, 82% of the trained paramedics as compared to only 17% of the untrained paramedics demonstrated adequate ORH service skills. These were also statistically significant results. (See Figure 1 below).

7 The minimum levels to define "performing to standard" were set by the TMG early in the NIPHP, and probably need to be re-examined in the NSDP.

**Figure 1: CSI and ORH service skill scores comparing trained paramedics to untrained paramedics**




In the exit interviews, clients responded to questions whether they had confidentiality/privacy, whether the providers listened to clients' problems and whether the providers advised clients to make a return visit for follow-up. The same percentage of clients (95.5%) responded positively about all three items related to paramedics' behavior, stating that these were handled well or very well. About 90% of the clients rated waiting arrangements (seating arrangements, place, etc.) at clinics as "good" or "very good." Nearly 99% of the clients thought that the clinic hours were "good" or "very good." The high ratings raise the issue of courtesy bias, however, and one wonders if the questionnaire could have been constructed differently to collect more differentiated responses.

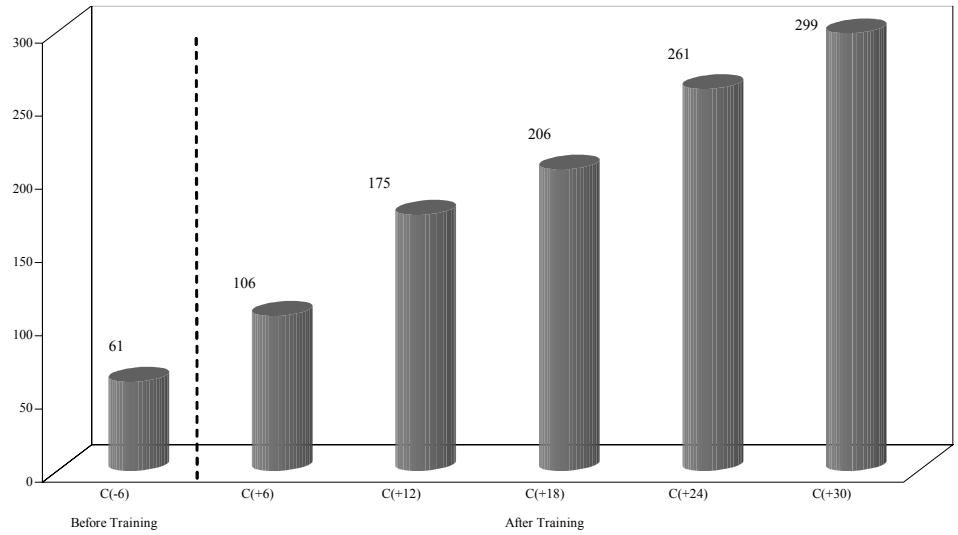
The biggest improvement that the clients would like to see (37%) was the addition of obstetric services. This was noted in connection with the SD training program that is being piloted and that is described below.

Through the use of the facility inventories, it was found that only in two clinics, all essential items for providing the three services - general, CSI and ORH, were available. In 31 clinics, 75%-99% of essential items were available and in the remaining three clinics, 51-74% of essential items were available at the time of data collection. The inventories revealed that in 28 clinics (77.7%) of the 36, all essential items to provide general clinical services were available. At the same time, seven clinics (19.4%) had all essential items to provide CSI clinical services, and only five clinics (13.8%) had all essential items to provide ORH clinical services. This shows that there is still considerable room for improvement in keeping the clinics stocked with essential supplies.

Clinic records were reviewed to assess the average number of clients visiting a clinic per month before the first paramedic in the clinic was trained in either CSI or ORH. The records revealed that there has been a marked increase in the average number of clients attending clinics after paramedics' training (Figure 2).

On an average, 61 clients per month were visiting a clinic six months before the first paramedic was trained. Six months after the training, the average number of clients visiting each clinic per month went up to 106. After 12 months of training, the average number of clients visiting each clinic was 175 per month. The findings indicated that there has been a steady increase in the average number of clients after the training. Though the trend is consistently positive, the lack of similar clinic data from a control group that did not receive the intervention makes it impossible to ascertain the **net** growth in the number of clients due to the intervention. Thus the increase could be due to a number of factors including enhanced performance due to training.

**Figure 2: Average number of clients visiting each clinic monthly for CSI and ORH services before and after training**




In the focus groups with community members, participants mentioned that they were satisfied with the quality of services provided at clinics since they are treated equally irrespective of their economic status. They were also satisfied with the convenient location and clinic hours. The participants mentioned that confidentiality is maintained with clients. These comments support the responses of clients in the client exit interview.

In summary, the study findings reflect that provider performance has improved as a result of training as the knowledge and skills of trained paramedics are significantly greater than that of untrained providers. Clinic utilization of services has also increased after paramedic training and training may have a very important influence in increasing the number of clients at the clinic. The study report recommends that the service delivery partnerships consider initiating obstetric services at the NGO clinics.

## Safe Delivery (SD) Training

### *Background*

SD training was developed by PRIME at the request of the service delivery

partnerships, particularly the UHFP. The SD training course was designed for service providers (doctors, nurses) working in rural and urban static and satellite clinics. It is a competency-based training course emphasizing the technical skills, knowledge, and attitudes required for providing competent, high quality, essential SD services. It employs a performance-based training approach that not only focuses on the tasks, skills and knowledge required to perform a given job, but also includes the supervision, logistics and material support needed to perform that job.

PRIME/Dhaka staff assessed a number of potential clinical training sites prior to the start of the program to determine the best sources of classroom and clinical training. PRIME decided that the two most appropriate centers to participate were OGSB and the Maternal and Child Health Training Institute (MCHTI). OGSB was the primary site for clinical training, but MCHTI was used as well. Five trainers came from OGSB and three from MCHTI. The program was implemented primarily by trainers from OGSB. The trainers were trained by PRIME in SD skills during a clinical TOT in January-February 2001.

The training curriculum and clinical guidelines were adapted by PRIME staff and an American College of Nurse-Midwives (ACNM) consultant from the Healthy Mother/ Healthy Newborn Manual and selected Life Saving Skills modules. The draft curriculum was pre-tested during the clinical TOT. The TOT included clinical content, tools and training process (planning, conduction and evaluation) to be used in the training.

Before the training began, PRIME took steps to train all the staff (i.e., doctors and nurses) at OGSB and MCHTI in the content of the NIPHP training. This was done so that the staff could model for the trainees the same techniques and approaches to patient care that would be used by the trainees themselves. It was believed that the trainees needed to see the new approaches in action so that they understood that the training they were receiving was the mainstream, accepted standard for SD care. This orientation and training of trainers lasted two weeks.

OGSB and MCHTI jointly conducted the Safe Delivery training course for 32 service providers, in four batches, from March to October 2000. Participants were from six clinical sites of UFHP-supported NGOs. The duration of training course was 22 days. PRIME staff and consultants mentored the activities of OGSB and MCHTI trainers as well as participants' performance and provided technical assistance throughout the course and followed-up SD trainees at their work sites.

The training was designed to involve classroom training as well as considerable hands-on practice. Each trainee was expected to practice delivery on a minimum number of delivers before she graduated. Before "graduation" from the training program, each trainee had to pass a performance examination. Those who did not pass were required to stay a few days longer in training to receive additional instruction and practice. PRIME felt it essential that no one be passed who was not fully competent in the desired skills.

The initiative was done as a pilot test that would be evaluated and then rolled out to other centers, if it was successful and if the service delivery partners still had an

interest in the program.

### *Evaluation of Safe Delivery Program Pilot*

The SD training review was carried out by the PRIME-NIPHP team, ROANE consultant, and selected NGO site staff in May-June 2002. The key purpose of the review was to assess the project achievements and establish if the capacity of OGSB/MCHTI had been established to provide quality training in SD. Apart from this, the review addressed whether the trained service providers were able to perform to standard and provide quality care to delivery clients. The routine training monitoring and trainee mentoring activities were reviewed for effectiveness in addressing issues. The review also looked at other training issues that might need modification if the pilot is to be replicated. The review looked at the NGO clinics which were used in the pilot and assessed whether they had been adequately strengthened to manage and conduct SD services. A client perspective was sought to know the usefulness and perception of the quality of care provided by the trained service providers. Finally the review addressed the lessons learned from the pilot and what improvements can be incorporated if the service has to be replicated and scaled up in all the NGO clinics.

## Methodology

The review methodology was an end of pilot (post-test) review which consisted of the following:

- Desk review of all the training and monitoring data
- First follow-up of 32 trainees from the five NGO sites
- Review of the UFHP SD review report
- Review of the training organization (OGSB) which carried out the training
- Second follow-up of trainees from Khulna, Chittagong and Dinajpur
- Interview with PD of NGO or CM
- Client Interview
- Review of service records since training

## Findings of Safe Delivery Training Review

### *Institutional Findings*

The review found that the OGSB has demonstrated strong institutional and professional commitment and excellent capability to conduct SD training to other NGOs. It has sufficient infrastructure (two classrooms and residential facilities) and an appropriate clinical training site at the MCHTI hospital. The training team is able to plan and manage competency-based training in SD. The same team also follows the trainees in their routine post-training monitoring activities and administers OJT coaching or invites a provider for additional three to five days of clinical practice within the OGSB facilities. On the negative side is the observation that the staff are overworked, especially when they are asked to carry out training responsibilities on

top of their service delivery duties.

The OGSB team has recently developed SD training curriculum for community midwives for a WHO project (a copy has been shared with PRIME) for use in the upcoming training, which is a significant accomplishment in institutional development of this TA.

OGSB is governed by a board of directors, and the operational issues are handled by a charismatic leader, OGSB Director (and now also President), Prof. A.B. Bhuiyan. His total commitment to providing state-of-art SD training for providers and SD services for the people of Bangladesh has galvanized enthusiastic support of his staff (providers/trainers) and produced excellent results. There is concern, however, that not enough decision-making and management authority has been passed to others of his staff and that the long-term prospects for the organization are thus resident in one person.

OGSB has an operational computerized Training Documentation System (TDS) and TMIS, as imparted via PRIME assistance. A full-time OGSB administrative staff member updates the TDS/TMIS regularly following the training and monitoring events. While they are capable of producing basic reports and graphs, those are still fairly basic, mainly limited to "computerized trainee lists" featuring their pre- and post-data and doesn't go beyond that.

### *Trainee Performance in Safe Delivery*

Safe delivery trainees were followed-up at three different sites, Dinajpur, Chittagong, and Khulna, where they were observed providing services and scored according to a standardized checklist for performance to standard. The results show that the clinics are attending a range of 17-22 childbirths/month. The clinic in Dinajpur showed the best results, with all four of the providers still employed by the clinic and PTS. The average deliveries per month is 22, and the antenatal visits average 40 per month. At Chittagong, the supervising doctor has left and two of the three paramedics are on sick or maternity leave. The average number of deliveries in Chittagong is 17/month and antenatal visits are 779/month. At Khulna, all five providers (one doctor and four paramedics) were found to be PTS. They are attending an average of 17 deliveries/month and see an average of 26 antenatal visits/month.

Generally, the SD program seems to have gone well. The clinics are providing SD services that they did not previously provide. The services seem well-accepted by the community, and, in fact, the community seems interested in availing the services more and more in the future. The providers at one of the clinics need continuing support due to the absence of the doctor supervisor, and paramedic absences from the clinic that have interfered with opportunities for practice. PRIME recommends that this program continue and expand to train additional providers at new clinics under the NSDP.

Institutional capacity in SD training has been strengthened at OGSB, and the potential exists to de-centralize this training outside of Dhaka.

## Institutional Strengthening Component

The training organizations participating in the NIPHP were selected by the TMG from proposals that were submitted by a large number of organizations that wanted to participate. Initially, ten training organizations were selected in this process:

1. Associates in Training and Management (AITAM)
2. Concerned Women for Family Development (CWFD)
3. Institute of Mother and Child Health (IMCH)
4. Marie Stopes Clinical Society (MSCS)
5. Obstetrics and Gynecology Society of Bangladesh (OGSB)
6. Radda MCH-FP Centre
7. Gonoshastha Kendra
8. Dhaka Community Hospital (DCH)
9. Bangladesh Rural Advancement Committee (BRAC)
10. International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B)

At the beginning, six of these were used for CSI training and five for ORH training, but later on four of them led both training programs[8]. AITAM was the only organization certified by the GOB to train in CMT, so it alone has provided that service under the NIPHP. It also trains in CSI and ORH.

IMCH is a governmental institution, but all the others are NGOs. Most of the "training organizations," e.g., CWFD, MSCS, BRAC, DCH, Radda, ICDDR,B, OGSB, are units of organizations that were originally established to provide clinical services. The training unit was established later by the organization for staff development purposes, and sometimes for training participants from other NGOs. Typically, the training unit grew over the life of NIPHP, as more and more resources were put into that part of the institution, and became a much more important piece of the organizations' package of services.

IMCH is a governmental institute (soon to become an autonomous institute, according to the Director), that has dual goals of providing clinical services and also providing state-of-the-art training and educational services. Uniquely, AITAM was started with the express purpose of filling a training niche. Although it initially depended, though letters of agreement, upon other clinics for its clinical practicum, it now has its own new building in which it provides clinical services.

Over the life-span of NIPHP, Gonoshastha Kendra, DCH, and ICDDR,B dropped out because of lack of interest and/or lack of requests for training. BRAC dropped out in 2001 because it declined to sign the Mexico City Policy. At the end of NIPHP, six training organizations (nos. 1-6 above) were still involved in training for CMT, CSI, and ORH.

8 One organization was used for both at the beginning, but later on AITAM, CWFD, IMCH, and OGSB all trained in both CSI and ORH.

However, during the last year of NIPHP bilateral, the service delivery partnerships experienced a financial crisis. They did not have enough money to continue training at the level required by the program. Therefore, they conserved their resources, and funded only a limited amount of training during the last year of NIPHP. This meant that training fell off dramatically during the last year. MSCS, for example, has not done NIPHP training since June 2002, and no training in CSI and ORH has taken place anywhere in NIPHP since February 2002.

From the beginning, PRIME has been committed to building long-term sustainability of training capacity within the training organizations involved with the program. This has meant not only developing the capacity to train, using the approaches accepted as the most effective – but also building the capacity to develop and manage their own training programs and to generate the diversified funding base necessary to survive as an institution.

## Training-related Interventions

1. **Enhancing the curriculum development capability of trainers**. Trainers from the training organizations were actively involved in the process of developing the curricula and training materials. This had the dual result of giving them skills in developing curricula as well as an understanding of the training approaches. It also gave them a sense of ownership of the training. Involving trainers in development of curricula was an important ingredient of the PRIME strategy for capacity building. The Final Project Review assessment found that many of the training organizations were developing their own curricula for non-NIPHP training, and using the format and tools introduced by PRIME.
2. **Installing trainer feedback mechanisms**, including trainee evaluation of trainers, peer feedback, and monitoring of training by training organization supervisors and PRIME staff. At the end of each training program, trainees would fill out questionnaires that gave feedback on how the training was conducted and managed. PRIME encouraged the establishment of peer feedback systems in which trainers would give each other feedback. In addition, PRIME staff would monitor the training programs – especially when they were first getting underway – and give feedback to the trainers, suggest modifications to the way material was presented, and improvements in training management.
3. **Inculcating awareness of the importance of follow-up and the expectation that trainers will follow-up trainees**. At the instigation of PRIME, the TMG agreed early in the program that 10% of trainees would be followed-up at their service site after the program. Generally, this was done within three months after training, and meant that two persons were to be followed up from each training batch, since the average batch size was about 15 persons. Typically a PRIME staff member, along with one of the trainers would visit the trainee at his/her site and observe the provision of services, using a standard observation checklist. The results of the observation checklist showed that 81% of the paramedics were performing up to standard in CSI and 100% in ORH in the skills they had learned during training.[9]

9 Data from the PRIME II TMIS.

The follow-up visit was also an opportunity for the PRIME staff and trainers to reinforce the skills taught during training, and to correct procedures that were not done correctly. It was also an opportunity for the trainers to become aware of the conditions in which the paramedic had to work and the instruments, supplies, and other materials that supported her work. In many cases, it was discovered that crucial supplies, e.g., fetoscopes, immunizations, were not available in the clinic. When this was discovered, the PRIME team reported back to the service delivery partnership, so that the deficiency could be rectified. Finally, the follow-up visit was useful in giving the trainers a sense of what had worked well during training and what had not worked well. It gave a sense of what material and approach during training needed to be changed in order to convey the information more effectively. So the follow-up visit was not only useful to the trainee, but also to the trainer, in terms of being able to improve the training program.

4. **Strengthening trainer skills in training methodology**. This was a routine feature of all new training programs. When turnover of trainers brought in new trainers who had not been trained, PRIME organized batches of these new trainers for TOTs. A special regional training was held in 1999 in Nainital, India, for Bangladeshi and Indian trainers involved in PRIME-sponsored training to reinforce and strengthen skills in training methodology. Of the 20 trainers attending, approximately ten trainers, one from each of the training organizations with which PRIME was working in Bangladesh, participated in this workshop. The purpose of this weeklong workshop was to give the trainers a better appreciation of sound adult learning methodologies, and to prepare them with the skills to organize and lead high quality training programs. Two PRIME/TRG facilitators led this workshop.

   The workshop was so successful that some of the trainers wrote in their post-training evaluation that it was a life-changing experience for them. They were so enthusiastic about the new approaches that they held a roll-out workshop in these same methodologies for staff of their own training organizations within three months after returning to Dhaka.

5. **Strengthening and standardizing clinical skills of the trainers**, so that all the trainers within the organization and across all the training organizations would be teaching the same clinical approaches. PRIME discovered early that many of the trainers were using clinical approaches that were either out-dated or incorrect. There was also inconsistency in clinical approaches to the same service even within the same organization. Therefore, a key feature of PRIME's approach in Bangladesh was to make sure that all the trainers were standardized in the clinical approach that PRIME wanted to project in the program. In order to do this, PRIME required all the trainers to participate as a trainee in the training program before they received training as trainers. This ave the trainers the opportunity to see the role of trainer being modeled by others, so that they would see first-hand how they were expected to train later.

## Non-training Interventions

In addition, on the basis of needs assessments and the expressed desire of the training organizations, PRIME implemented the strengthening of non-training features of the

organization.

1. **Strategic Planning, Marketing, and Business Plan development**. Two PRIME/TRG staff members led a workshop in 2000 for leaders of the training organizations. The purpose of this workshop was to explain the value of strategic planning and lead the participants through an exercise of generating their own vision of the future of their organization and developing their own draft strategic plan. The workshop also included sessions on developing a related business plan that was intended to guide their thinking about how they would get from "now" to the future. Part of the business plan included marketing their training services to donors and to other NGOs. The facilitators guided the participants in drafting an organizational brochure, which advertised their services and provided the costs of each training program. In the Final Project Review assessment that forms a part of this report, it was learned that several of the training organizations, in particular CWFD and MSCS, had developed very attractive brochures for their training organizations.
2. **Installing TMIS systems**, so that the training organizations can keep track of names of trainees and their organizations, trainee pre- and post-training test scores, and follow-up results. PRIME provided each of the training organizations with TMIS software and trained staff of the training organization in how to use the software. The final assessment of the training organizations showed that almost all of them are using the PRIME-provided software – or their own – and are using the TMIS for management and reporting purposes.
3. **Development of anatomical training models**. AITAM had developed some crude pelvic anatomical training models and were interested in improving them and marketing them as an additional source of income. PRIME, through its partner PATH, consulted with AITAM and made some suggestions for improving the construction of the model. PRIME/PATH also made recommendations for marketing the models on AITAM's web page and linking with other web pages, for maximum exposure.
4. **Development of distance learning capability**. During its first two years in Bangladesh, PRIME worked with Gonoshastha Kendra on a distance learning newsletter that was sent to all of its own staff in the field. This effort was not particularly successful, however, as its distribution was limited to one organization's staff, and the commitment of Gonoshastha Kendra to the distance learning approach was not sufficient. In 2000, the Mission recommended that PRIME continue the effort, but work instead with PSTC, which was producing a newsletter that was distributed to all the paramedics in the NIPHP program. PRIME thus embarked on a new distance learning program with PSTC that is described above in this report.

## Institutional Assessment of Training Organizations

PRIME determined early that it would measure the progress of its institutional training efforts. To do this, a questionnaire was devised that has been administered each year since 1999 during PRIME's annual review. The questionnaire assesses progress in the following areas:

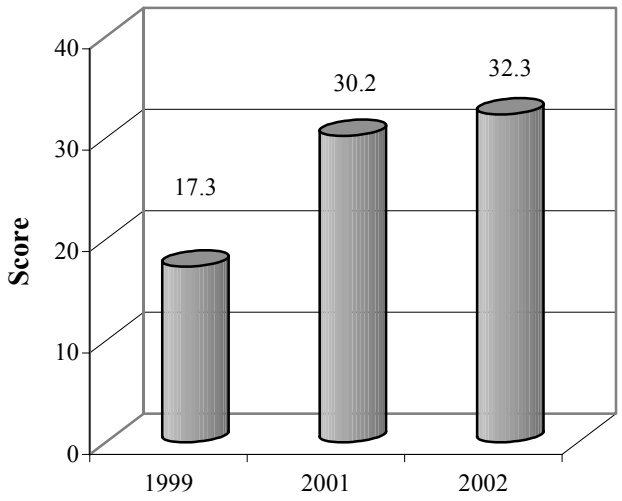
1. Infrastructure, including classrooms and clinical facilities for training

2. Evidence of responsive planning, including use of training needs assessments
3. Use/development of training materials
4. Quality of training, in terms of the number of trainers receiving TOT and use of standardized materials
5. Number of courses offered and number/variety of professional cadres trained
6. Use of MIS for training management
7. Application of evaluation

The review done for this Final Project Review is the fourth such inventory and measurement of the training organizations. For the assessment, a PRIME team visited each training organization and completed the standard questionnaire (Appendix 2) in interviews with the leadership of the training organization. After completing the questionnaire, PRIME gave a score on a four-point scale to the seven dimensions of institutional development, according to a standardized scoring sheet (Appendix 3).

The results of the assessment questionnaire are seen in Appendix 1, which compares the baseline scores with the scores in 2002. Considerable progress in institution strengthening is seen over the four years that PRIME worked with these organizations. The average of the baseline scores in 1999 for the six organizations currently involved in NIPHP was 17.3. In 2001, they had improved significantly to an average of 30.2. The year 2002 saw an incremental increase to 32.3. (See Figure 3.)

**Figure 3: NIPHP institutional assessment: Institutional strengthening scores**




What this means is that the training organizations have progressed substantially since PRIME first began working with them in 1998. Part of this is due to a reimbursement scale negotiated in the early stages of the NIPHP, which reimburses the training

organizations for the costs of providing training. Many of the training organizations were able to accumulate resources from that reimbursement which allowed them to raise their trainers' salaries, purchase additional materials, and build additional classroom and hostel space for these residential programs.

# ***Results*** *(including Recommendations)*

1. PRIME established a country office that was capable of providing technical assistance and support to the NIPHP training program.

   **Recommendation**

   A country office should always be established in order to implement complex country activities.

2. PRIME involved training organizations in the development of NIPHP training curricula and thereby increased their skills in curriculum development.

   **Recommendation**

   Training organization staff should be involved in the development of new curricula in order to increase their understanding if and familiarity with the curriculum content and training approaches.

3. At the end of training of trainers courses, the trainers were competent clinically to teach the course.

   **Recommendation**

   Trainers should meet the established clinical proficiency standards before being considered competent to train others.

4. Paramedics trained in both CSI and ORH were found to be performing to standard both during follow-up visits and during the Training Effects Study.

**Recommendation**

PRIME should continue to pass along information to the service delivery organizations regarding clinic needs for supplies, equipment, and facility upgrades. Paramedic follow-up checklists should be reviewed to consider raising expectations of paramedic performance.

5. A relatively low percentage of trainers followed up trainees at their worksites.

**Recommendation**

Mechanisms should be developed to improve motivation f trainers to follow-up trainees.

6. The Safe Delivery Project Pilot successfully introduced safe delivery services to a select group of NGO clinics .

**Recommendation**

Safe delivery services should be expanded to a larger number of NGO clinics under the NSDP.

7. Distance-based Learning was shown to be a viable option for enhancing

knowledge and to a lesser extent, skills of paramedics.

**Recommendation**

Logistics of dissemination and leadership by clinic managers are important issues that need to be improved upon in the next go around.

8. Training organizations benefited from both training and non-training interventions of PRIME II, and showed considerable improvement in their capacity as training organizations, over the four year period.

**Recommendation**

Training organizations should be strengthened in both training and non-training areas, in order to build their capacity to provider high quality sustainable training services.

# *Conclusions*

PRIME II was able to make a difference in the quality of the training of the NIPHP, through its adherence to the systematic principles for assuring quality. PRIME II also assisted the training organizations to strengthen their capacity to deliver high quality training services. Future training programs in Bangladesh would be wise to build upon the systematic approach employed by PRIME in managing training for the NIPHP program.

# *Appendix 1:*

# *Training Organization Assessment*

June 20, 2002

| Indicators | AITAM | | RADDA, MCH-FP Center | | CWFD | | ICHM | | Marie Stopes Clinic | | PSTC | | OGSB | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BL | FPR | BL | FPR | BL | FPR | BL | FPR | BL | FPR | BL | FPR | BL | FPR |
| **Type of training** | CSI & ORH | | CSI | | CSI & ORH | | CSI & ORH | | ORH | | DBL, CSI & ORH | | CSI, ORH & SD | |
| **Infrastructure** | | | | | | | | | | | | | | |
| ▪ # of equipped classroom sites | 2 | 3 | 2 | 2 | 2 | 2 | 3 | 3 | 1 | 2 | 2 | 2 | 1 | 2 |
| ▪ # of equipped clinical sites | 1 | 3 | 3 | 3 | 2 | 3 | 2 | 3 | 1 | 3 | 2 | 3 | 2 | 2 |
| ▪ Case load sufficient for skill practice | 1 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 0 | 3 | 1 | 3 | 3 | 3 |
| **Evidence of Responsive Planning** | 1 | 2 | 1 | 3 | 1 | 3 | 1 | 2 | 3 | 3 | 1 | 3 | 1 | 2 |
| **Use/Development of Training Materials** | 3 | 3 | 1 | 3 | - | 3 | 2 | 3 | 1 | 2 | 1 | 3 | 2 | 3 |

BL = Base Line, FPR= Final Project Review

CSI = Child Survival Intervention, ORH = Other Reproductive Health, DBL = Distance-based Learning, SD = Safe delivery

| Indicators | AITAM | | RADDA, MCH-FP Center | | CWFD | | ICHM | | Marie Stopes Clinic | | PSTC | | OGSB | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BL | FPR | BL | FPR | BL | FPR | BL | FPR | BL | FPR | BL | FPR | BL | FPR |
| **Type of training** | CSI & ORH | | CSI | | CSI & ORH | | CSI & ORH | | ORH | | DBL | | CSI & ORH | |
| **Quality of Training** | | | | | | | | | | | | | | |
| ▪ # TOT received trainers available | | 3 | | 3 | 0 | 3 | 0 | 3 | 0 | 3 | 1 | 3 | 0 | 3 |
| ▪ Trainers use standardized curriculum, teaching aids and models | 1 | 3 | 1 | 3 | 0 | 3 | 0 | 2 | 0 | 2 | 2 | - | 0 | 2 |
| **Number of Courses Offered** | | | | | | | | | | | | | | |
| ▪ Number/variety of training courses offered | 3 | 3 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 2* | 1 | 1 | 3 | 3 |
| ▪ Number/variety of professional categories trained | 3 | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 2 | 2* | 0 | 1 | 3 | 3 |
| **MIS for Training** | | | | | | | | | | | | | | |
| ▪ System for tracking training events | 0 | 3 | 0 | 3 | 0 | 3 | 0 | 2 | 0 | 2 | 1 | 2 | 0 | 2 |
| **Application of Evaluation** | | | | | | | | | | | | | | |
| ▪ Evaluation of training event | 3 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 2 | 3 | 2 | 2 | 2 | 3 |
| ▪ Training follow-up routine and results used to improve training | 0 | 3 | 1 | 3 | 1 | 2 | 0 | 2 | 1 | 3 | 1 | 1 | 1 | 2 |
| **Total Score** | 18 | 34 | 18 | 34 | 16 | 34 | 20 | 32 | 14 | 30 | 15 | 22 | 18 | 30 |

BL = Base Line, FPR= Final Project Review

CSI = Child Survival Intervention, ORH = Other Reproductive Health, DBL = Distance-based Learning, SD = Safe delivery

(-) Data not available, Score has not been added in total score for the activity for which data is not available

## Project Monitoring and Evaluation Matrix

The Matrix presented below represents the progress against the PRIME/NIPHP objectives and indicators, as submitted in the PRIME/NIPHP Technical Assistance Proposal for the period October 2001-June 2002.

| **Project Objectives** | **Monitoring** (Inputs, Processes, Outputs) | **Evaluation** (Effect/Impact Indicators and Results) | | |
|---|---|---|---|---|
| | **Indicators and Activities/Methods** | **Indicator** | **Methods/Instruments** | **Results** |
| **Goal:** *To strengthen the capacity of training organizations to provide quality training in ESP to services providers and to increase qulaity of Essential Services Package in rural and urban communities of Bangladesh* | | | | |
| **Objective 1:** Increase capability of 493 paramedics and 73 supervisors to provide quality ESP services | • **80% of the paramedics trained in CSI, ORH, FPCS and SD scored at least 80% in the post-test** | • **80% of the followed up paramedics perform to standard (PMP#1)** | **Follow-up reports, Training Effects Study** | **>80% of paramedics PTS in ORH and CSI** |
| | • **6 DBL lessons sent to 100 paramedics through *Projonma* magazine** | • **Effectiveness of DBL as a method for refresher training of paramedics** | **DBL Evaluation Report** | **+4-10% increases in knowledge; 26-35% increase in skills** |
| | • **Up to 26 training courses on CSI, ORH and FPCS courses mentored** | • **80% of followed up newly trained clinic doctors perform to standard (PMP#1)** | | |
| | | • **Institution (PSTC) with capacity to develop and evaluate FP/RH curricula (PMP#10)** | **Institutional assessment report; publication of *Projonmo* magazine** | |
| | • **6 on-the job orientations mentored** | | **Mentoring reports** | |
| | • **28 PDs/PMs trained as trainers in orientation** | | **TOT report** | • **27 PDs/PMs trained** |

| Project Objectives | Monitoring (Inputs, Processes, Outputs) | Evaluation (Effect/Impact Indicators and Results) | | |
|---|---|---|---|---|
| | **Indicators and Activities/Methods** | **Indicator** | **Methods/Instruments** | **Results** |
| | **OJT** | | | |
| | • **15 trainers trained in CSI and ORH skills** | | | • **57 trainers trained in CSI from July 1999**<br>• **39 trainers trained in ORH** |
| | • **Up to 45 clinic doctors trained in integrated and clinic management course?????** | | | |
| | • **Integrated curriculum for doctors** | | **Copy of curriculum** | • **Curriculum developed** |
| **Objective 2:** Increase the capacity, capability and potential for sustainability of eight training organizations to implement performance-based training in ESP | • **Upgraded TDS developed in eight training organizations** | • **TDS used for planning and self-assessments** | • **Training organization assessment reports** | • **Upgraded TDS being used in the five current training organizations** |
| | • **PNA conducted for 3-4 organizations and interventions plan developed** | • **PNA gaps addressed** | **Copy of PNA report** | • **PNA conducted and interventions designed** |

| Project Objectives | Monitoring (Inputs, Processes, Outputs) | Evaluation (Effect/Impact Indicators and Results) | | |
|---|---|---|---|---|
| | **Indicators and Activities/Methods** | **Indicator** | **Methods/Instruments** | **Results** |
| | • **IMCI integrated into CSI curriculum; ORH curriculum updated** | • **Integrated CSI/IMCI and ORH curricula exist** | **Copy of curricula** | • **Necessary revisions to CSI curriculum identified; revision to occur in the new project. ORH curriculum not updated** |

# *Appendix 2:*
# *Training Institutionalization Questionnaire*

Date: _____

Training center name: _____

Address: _____

Person interviewed: _____

## I. Infrastructure

### A. Staff Position (Training Staff)

| S. No | Name and designation | Qualification (Doctor, Nurses & FMV) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

- Number of **New Staff** in last 12 months? _____
- Number of **trained staff who left** in last 12 months? _____
- Total training staff: full time _____ part time _____
- Total training staff who have received NIPHP TOT:
- CSI _____ ORH _____ Counselling: _____ TOT methodology _____

**B. Facilities Available: (in the training institute)** ***-Directory update***

1. Number of Classrooms? _____
2. Hostel facilities:
   - Do you have your own hostel or do you hire rooms?
   - Is it adequate for participants?
3. Library facilities (books, journals, publications, training modules):
   1. In English or Bangla?
   - Used by trainers?
   - Used by trainees?
4. Do you have adequate audio visual aids?
5. Clinical sites
   - Number of clinical training sites managed by training institute _____
   - Number of clinical training sites used not managed by training institute _____

**C. Funding**

1. What are the sources of funding and funds sanctioned during 1998 – or the last year for which you have complete data? (Please give in percentages of total.)
   a. Institutional grant _____
   b. Agencies endowment _____
   c. GOB _____
   d. Course fees _____

**(If there is a difference from the previous year, ask for an explanation of the changes.*)***

2. Last year did you have a mechanism to track training costs as separate cost center? Do you have one now? Yes ____ No ____ in process ____
3. [Optional: How much did you earn from course fees in last 12 months?]

## II. Evidence of Responsive Planning

In preparing for a new training group how do you determine the need the trainees have for specific content?

What mechanisms do you use to assess the performance of your staff?

Do your trainers practice peer review?
Yes ____ No ____

If so, do you have a review checklist to do this?
Yes ____ No ____ May we have a copy?

Does staff know the mission of the organization and how they do or do not contribute to this mission?
Yes ____ No ____ How is that determined?

Have you developed a strategic plan or business plan?

Do you have – or are you developing – a brochure?
What is the status?

## III. Adequacy of Training Materials

A. Do you want additional assistance from PRIME in developing curriculum/training materials?

B. Do you want additional materials in Bangla?

C. Are you using Bangla materials?

## IV. Quality of Training

*[will be provided from follow-up training/mentoring findings]*

## V. TDS/TMIS for Training

A. What was the system for tracking the training events in 1998?

B. Are you implementing the new TDS/TMIS program provided by PRIME?

C. How are you using the TDS system?

## VI. Application of Evalutation

- Is input from trainers used to feedback to PRIME and QIP to revise the course?
  Yes ____ No ____ If yes, please give example:

- Are you using evaluation methods in any of your non-NIPHP training?
  How are you using them?

## VII. Institutional Support

A. Does your training unit have other strengthening needs in which PRIME can assist?
If so, what are these specifically, e.g.,:

- Infection prevention
- Clinical skill development
- Training methodology
- Basic TOT
- Continuing education
- Supportive supervision
- Analysis and implementation of follow-up findings
- Recruitment / Training / Retraining of trainers

Comments by interviewer:

Name of Interviewer: _____

# *Appendix 3:*
# *Criteria for Scoring*

PRIME assisted training organizations to develop their capability for performance-based training. For the purpose of comparison with baseline scores, dimension number 4 (quality of training), 6 (MIS for training) and 7 (Application of evaluation) should be considered. Improvements will also be seen in other dimensions as a by-product of dimensions 4, 6 and 7.

The following criteria has been used to score the 7 dimensions and 12 indicators (mentioned in the scoring sheet) to assess the status of the training organizations at the time of the ETR. The same criteria were used to score the training organizations at the time of the baseline survey.

| Indicator # 1: Infrastructure | Score |
|---|---|
| **Number of equipped classroom(s)** | |
| One | 1 |
| Two-three | 2 |
| More than three | 3 |
| **Number of equipped clinical sites** | |
| One/collaboration with other agency | 1 |
| Two-three | 2 |
| More than three | 3 |
| **Case load for skill practice** | |
| Less than 15 cases/day | 1 |
| 15-30 cases/day | 2 |
| More than 30 cases/day | 3 |

Based on the assumption that a training group has 15 trainees and each trainee should get at least 1 client for skill development practice.

| Indicator # 2: Evidence of responsive planning | Score |
|---|---|
| **Training needs assessment (TNA)** | |
| Conduct informal TNA | 1 |
| Conduct formal TNA | 2 |
| Formal TNA results used for training curriculum | 3 |

| Indicator # 3: Training material | Score |
|---|---|
| **Use/development of training material** | |
| Not using training material in Bangla | 0 |
| Adapt/use available material in Bangla | 1 |
| Develop training material in Bangla | 2 |
| Develop taining material/use available in Bangla | 3 |

| Indicator # 4: Quality of training | Score |
|---|---|
| **Performance based training TOT** | |
| No trainer in CSI/ORH | 0 |
| One trainer in CSI/ORH | 1 |
| Two trainers in CSI/ORH | 2 |
| Three or more trainers in CSI/ORH | 3 |
| **Skills of trainers** | |
| No checklist used | 0 |
| Needs improvement | 1 |
| Satisfactory | 2 |
| Competent | 3 |

The skills of the trainers have been assessed by PRIME staff based on the standardized checklist.

| Indicator # 5: Quantitative output | Score |
|---|---|
| **Number /variety of courses** | |
| Child health/Other Reproductive Health | 1 |
| TOT child health/Other Reproductive Health | 2 |
| TOT for child health and Other Reproductive Health | 3 |
| **Number/variety of professionals categories trained** | |
| Train community workers only | 1 |
| Train paramedics only | 2 |
| Train paramedics + supervisors | 3 |

| Indicator # 6: MIS for training | Score |
|---|---|
| No system for tracking training events | 0 |
| System for tracking training events exists | 1 |
| Computerized system exists | 2 |
| System for tracking training events used | 3 |

| Indicator # 7: Application of evaluation | Score |
|---|---|
| **Trainers evaluate training event** | |
| Informal system | 1 |
| Formal system including pre-post | 2 |
| Formal system and feedback for improving training | 3 |
| **Training follow-up** | |
| No system exists for follow-up | 0 |
| Follow-up system exists for internal staff | 1 |
| Follow-up system exists for trainees | 2 |
| Results of follow-up used for improving training | 3 |