Participant's Notebook

Lactational Amenorrhea Method

Training Skills Course

USAID
FROM THE AMERICAN PEOPLE

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Institute for Reproductive Health
Georgetown University
4301 Connecticut Ave, NW, Suite 310
Washington, DC 20008

Jhpiego
1615 Thames St.
Baltimore, MD 21231

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LACTATIONAL AMENORRHEA METHOD (LAM) TRAINING SKILLS COURSE: PARTICIPANT'S NOTEBOOK

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INTRODUCTION

COURSE RATIONALE

Worldwide, 50% of pregnancies are unintended. Pregnancies that are spaced too close together decrease the likelihood of healthy newborn, child and maternal outcomes. A postpartum woman may become pregnant, even while she is breastfeeding or before her menstrual period has returned—*if* she is not using contraception, such as the Lactational Amenorrhea Method (LAM).

LAM is a highly effective, temporary method of contraception that is available and accessible to postpartum women who are breastfeeding. Although the scientific evidence supporting LAM is strong, LAM is often undervalued and rarely used, even by women who would be excellent candidates for the method. A major reason for the underutilization of LAM is the lack of awareness of LAM—its advantages/benefits, mechanism of action and correct use—and of LAM counseling skills on the part of family planning service providers. To help address this need, the LAM Training Skills Course will prepare participants to facilitate a LAM Workshop for Family Planning Service Providers.

COURSE GOAL AND OVERVIEW

The goal of this three-day course is to provide the **LAM knowledge/skills** and **training skills** necessary for participants to effectively facilitate a LAM Workshop for Family Planning Service Providers.[1] As summarized below, the first half of the course focuses on knowledge and skills updates; the second half focuses on preparing for and undertaking a practicum, in which participants will have the opportunity to apply the knowledge and practice the skills that they have learned.

Day One:
LAM Technical Update (full day)—Participants gain the knowledge and skills needed to provide LAM counseling—as part of preparing to become facilitators of a LAM Workshop. Topic areas include LAM mechanism of action, LAM criteria, advantages and limitations of LAM, opportunities for integration of LAM with other health care services, appropriate timing for transition from LAM to other modern methods, optimal breastfeeding practices, and LAM counseling. This highly interactive, participatory update allows time for practice of LAM counseling skills in a simulated setting

[1] Because LAM services do not usually "stand alone," but are rather incorporated into other services, this course/content may be integrated with training on antenatal or postpartum care, child care or basic family planning. Additional training may be necessary to update participants' knowledge on modern contraceptive methods, through a contraceptive technology update.

Day Two:
Training Skills Update (morning/half day): Participants focus on the skills needed to effectively lead a LAM Workshop. Topic areas include features of adult learning, effective presentation skills and a variety of training methods. This update allows practice of selected teaching skills.

Preparation for Practicum (afternoon/half day): Participants have the opportunity to prepare for a LAM Workshop, which they will conduct on Day Three. Trainers will assist, mentor and guide participants in their preparation.

Day Three:
Practicum (full day): Participants conduct a LAM Workshop for Family Planning Service Providers. They have the opportunity to discuss their experience and observations at the end of the practicum.

COURSE SYLLABUS

Participant Learning Objectives

LAM Technical Update—By the end of Day One of the course, participants will be able to:
1. Discuss the benefits of healthy timing and spacing of pregnancies (HTSP)
1. Explain the basic mechanism of action and effectiveness of LAM
2. Describe LAM criteria and the importance of each
3. List advantages and limitations of LAM, including counseling for the HIV-positive woman
4. Discuss opportunities for integrating LAM counseling with other services
5. Identify appropriate timing of introduction of key methods of contraception to the breastfeeding mother
6. Discuss optimal breastfeeding practices
7. Identify basic LAM counseling content and approach, including use of key learning tools/job aids
8. Provide LAM counseling
9. Discuss attitudes toward LAM

Training Skills Update—By the end of Day Two of the course, participants will be able to:
1. Discuss the principles of effective teaching and learning
10. Describe the use of effective facilitation skills
11. Describe a variety of teaching methods
12. Discuss the effective use of relevant audio-visual aids
13. Demonstrate LAM training skills
14. Discuss effective on-site supportive supervision
15. Effectively prepare for conducting a LAM Workshop
16. Conduct a LAM Workshop for Family Planning Service Providers

Practicum—By the end of Day Three of the course, participants will be able to:

- Demonstrate effective LAM training skills

TRAINING/LEARNING METHODS

- Illustrated lectures and group discussions
- Case studies and other exercises
- Demonstration of LAM counseling skills through role plays
- Mentoring and coaching participants in conducting a LAM Workshop for Family Planning Service Providers

Participant Selection Criteria

Participants for this course should be family planning service providers and trainers. Ideally, they should be currently active in family planning service provision and in training.

Methods of Evaluation

Participant:

- Participant self-assessment and peer assessment of LAM counseling skills using the LAM Counseling Checklist
- Training skills assessment by peers and trainer using the Training Skills Assessment Checklist

Course:

- Course evaluation (to be completed by the participant)

Course Duration

- Three days

Suggested Course Composition

- Up to 24 participants
- One or two trainers

MODEL LAM UPDATE AGENDA

MODEL LAM UPDATE AGENDA (4.5 HOURS)			
	Activity	Brief Content Description	Time Allotted
1	Welcome	Welcome	10 minutes
2	Opening and Overview	Introductions, participant expectations, course goals and objectives, course materials	15 minutes
3	Pre-Course Knowledge Assessment	Assessment of participants' pre-course knowledge	20 minutes
4	Overview of Course	Introduction to LAM within the context of family planning	5 minutes
5	Presentation/Discussion	Benefits of healthy timing and spacing of pregnancies	10 minutes
6	Presentation/Discussion	Basic mechanism of action and effectiveness of LAM	15 minutes
7	Presentation/Discussion EXERCISE/Case Studies for LAM Criteria	LAM criteria and their importance	30 minutes
8	Presentation/Discussion	"Transition"—an essential component of LAM	5 minutes
9	Brainstorm and Presentation/Discussion	Benefits and limitations of LAM	10 minutes
10	Presentation/Discussion	Use of LAM by the HIV-positive mother	10 minutes
11	Presentation/Discussion	Opportunities for integration of LAM services, including transition	10 minutes
12	EXERCISES/Transition to other Modern Methods of Contraception	Appropriate timing for transition from LAM to other modern methods of contraception	20 minutes
13	Presentation/Discussion	Optimal breastfeeding	10 minutes
14	Presentation/Discussion	Principles of effective counseling	10 minutes
15	Presentation/Discussion EXERCISE/Counseling Demonstration and Practice	Content of LAM counseling Use of key learning tools/job aids Counseling skills development	60 minutes
16	Activity/Discussion	Advocacy—common attitudes toward LAM	15 minutes
17	Post-Course Knowledge Assessment	Assessment of participants' post-course knowledge, summary	20 minutes
18	Wrap-Up	Closing remarks	10 minutes

PRE-COURSE KNOWLEDGE ASSESSMENT (ANSWER SHEET)

1.	The Lactational Amenorrhea Method (LAM) is 80% to 90% effective when correctly used.	
2.	Breastfeeding and LAM are the same thing.	
3.	LAM cannot be relied on for contraception if the woman has vaginal bleeding after the first two months postpartum.	
4.	If a woman is not breastfeeding, ovulation will occur at 45 days postpartum **on average**, and may occur as early as 21 days postpartum.	
5.	Most health care workers encourage mothers to use LAM because they know that it is an effective modern method of contraception.	
6.	One of the benefits of waiting at least two years after a birth to become pregnant again is that it reduces newborn, infant and child mortality.	
7.	The health care worker does not need to mention transitioning from LAM to another modern method until the fifth or sixth month postpartum.	
8.	The breastfeeding postpartum mother can safely use progestin-only contraceptive pills or an intrauterine contraceptive device (IUD) at six weeks postpartum.	
9.	The HIV-positive mother should not use LAM.	
10.	LAM counseling might appropriately be provided as part of antenatal care, postpartum care, child health care or community health visits.	

LAM UPDATE EXERCISES

IDENTIFYING LAM CRITERIA: CASE STUDIES (ANSWER SHEET)

1. Dafina is the mother of a three-month-old baby. She only/exclusively breastfeeds the baby and has already had menstrual bleeding.

   Q. Can this woman rely on LAM? Why or why not?

17. Mary has a four-month-old baby and her menses have not returned. She feeds her baby only breast milk. Lately, she has been leaving the house for three hours every day to do laundry. While she is gone, the baby stays with his grandmother.

    Q. Can this woman rely on LAM? Why or why not?

    Q. Based on the information provided, is there any reason to suggest that she should start using another method sooner rather than later? What would you recommend?

18. Pilar, mother of a two-week-old baby girl, presents at your clinic. She only/exclusively breastfeeds her baby and has vaginal bleeding.

    Q. Can this woman rely on LAM? Why or why not?

19. Parvene has a two-month-old baby boy. She has not yet had any menstrual bleeding. She breastfeeds the baby and also gives him two or three spoonfuls of sugared water a few times a day—to calm him when he is crying.

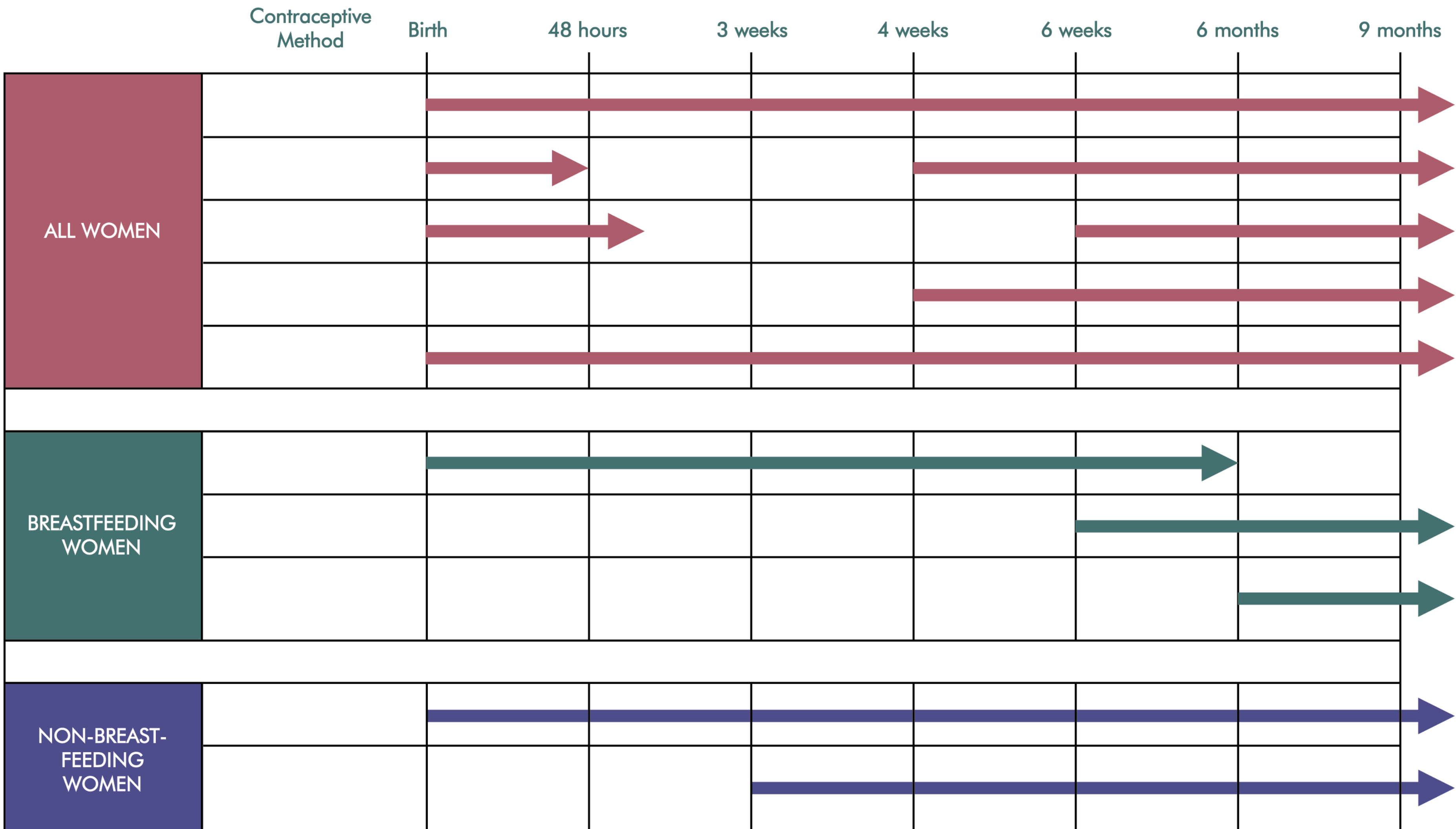
    Q. Can this woman rely on LAM? Why or why not?

20. Sonia comes to you for a check-up at six months postpartum. She is only/exclusively breastfeeding her baby and has not had any menstrual bleeding.

    Q. Can this woman rely on LAM? Why or why not?

TRANSITIONING TO OTHER MODERN METHODS OF CONTRACEPTION

Exercise One—Initiation of Postpartum Contraception—Answer Sheet (blank graph)



Exercise Three: Case Studies for Transition (Answer Sheet)

1. Jane has a four-month-old baby, is only/exclusively breastfeeding and has been using LAM to prevent pregnancy. Her menses returned last week and she is not sure which family planning method would be best for her while she continues breastfeeding. She has been told that hormonal methods are bad for milk production.

   Q. Can this woman continue to rely on LAM? Why or why not?

   Q. Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

2. For the last six months (since delivery), Mrs. Smith has been only/exclusively breastfeeding her baby. She believes that breastfeeding will continue to protect her from pregnancy until her menstrual bleeding returns.

   Q. Can this woman continue to rely on LAM? Why or why not?

   Q. Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

3. Celia had her baby two weeks ago and has been using LAM. She is returning to work and will no longer be only/exclusively breastfeeding the baby.

   Q. Can this woman continue to rely on LAM? Why or why not?

   Q. Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

4. Stephanie is the mother of three children; her youngest is three months old. She believes that she has been using LAM to space her pregnancies, but she began to give the baby a daily bottle of formula when he was two months old. She has not yet had any menstrual bleeding. Stephanie plans to continue breastfeeding but seems confused about LAM. She is not sure how much longer she will be protected from pregnancy.

   Q. Can this woman continue to rely on LAM? Why or why not?

   Q. Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

5. While counseling Sophie after delivery about initiating LAM, you learn that she lives far away from the clinic. She is concerned that she may not be able to return soon enough when one of the criteria can no longer be met. What should she do?

   Q. Can this woman continue to rely on LAM? Why or why not?

   Q. Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

LAM COUNSELING PRACTICE SCENARIOS

Client Profile #1:

You are six weeks postpartum with your second baby. Your first baby is 20 months old. During an antenatal care visit, your midwife told you about LAM and you decided you wanted to use this method. You have been only/exclusively breastfeeding your infant and your postpartum bleeding has stopped. You would like to give the baby some herbal tea but are not sure whether you should. You have no plans for work outside the home. You have not used any contraception method previously.

Provider Profile #1:

You are the midwife at the family planning clinic in the district health center. This is the first time this patient has attended a family planning clinic. Her husband is not present.

Observer Considerations:

While following along with the LAM Counseling Checklist, note whether the provider:

- Follows the interaction outlined in the LAM Counseling Guide; covers all points in the guide (important because the client is a candidate for LAM)
- Has the client refer to the LAM Client Education Card
- Emphasizes the concept of transition and reviews locally available methods that she might use following LAM (important this client has never before used contraception)
- Uses any (additional) client education material available
- Invites the woman to take the card home with her

Client Profile #2:

You are three months postpartum and have come to the family planning clinic because you are afraid that you might get pregnant. You and your husband have become sexually active again. You are only/exclusively breastfeeding your baby, although you have been giving the baby a liquid antibiotic twice each day for a week because the baby has been ill. You have not had any bleeding since your postpartum bleeding stopped. You do not work outside of the home and are usually there.

Provider Profile #2:

You are the midwife at the family planning clinic in the district health center. This is the first time this patient has attended a family planning clinic. Her husband is also present.

Observer Considerations:

While following along with the LAM Counseling Checklist, note whether the provider:

- Follows the interaction outlined in the LAM Counseling Guide, including the husband in the counseling; covers all points in the guide (important because the client is a candidate for LAM)
- Has client(s) refer to the LAM Client Education Card
- Confirms that the woman meets LAM criteria: the baby gets nothing by mouth except for breast milk and medicine; the woman has not had any vaginal bleeding during the past month.
- Explains that the woman should only/exclusively breastfeed until the baby is six months of age, emphasizing that liquid medicine will not exclude her from using LAM
- Introduces the concept of transition and reviews locally available methods that she might use following LAM
- Uses any (additional) client education material available
- Invites the couple to take the card home with them

Client Profile #3:

You are two months postpartum and have come to the family planning clinic because you do not want to become pregnant. You are breastfeeding your baby, but also give the baby a bottle once a day because you work outside of the home. You and your husband plan to begin having sex again this week. This is your first baby and you have never used contraception before.

Provider Profile #3:

You are the midwife at the family planning clinic in the district health center. This is the first time this patient has attended a family planning clinic. Her husband is present but waiting outside.

Observer Considerations:

While following along with the LAM Counseling Checklist, note whether the provider:

- Clearly recognizes that the client is not a candidate for LAM because she is not only/exclusively breastfeeding her baby (is separated from her baby during the day, gives one full feeding other than breast milk every day)
- If the client permits, invites the husband to join the counseling session
- Talks to the client/couple about return to fertility and the benefits of healthy timing and spacing of pregnancies

- Reviews locally available methods of contraception that are compatible with breastfeeding, and provides the chosen method
- Encourages the woman to continue breastfeeding as much as possible
- Uses any client education material available

Client Profile #4:

You are being discharged today from the hospital after giving birth two days ago. Your milk has not "come in" yet. You told the midwife who delivered you that you want to breastfeed and that you do not want to become pregnant for at least one year. However, you have heard bad things about IUDs and do not want to use one. The midwife advised you to go by the family planning clinic, which is located in the same building, on your way home today. Your mother-in-law and husband are with you, as is your baby.

Provider Profile #4:

You are the nurse at the family planning clinic in the district hospital. The midwife from the delivery ward has called to tell you that a recently delivered woman is coming over and she may be interested in using LAM. You do not have another client at the moment and so are able to take this postpartum woman as soon as she arrives at your clinic.

Observer Considerations:

While following along with the LAM Counseling Checklist, note whether the provider:

- If the client permits, invites the husband and mother-in-law to join the counseling session
- Follows the interaction outlined in the LAM Counseling Guide; covers all points in the guide (important because the client is a candidate for LAM)
- Has the client(s) refer to the LAM Client Education Card
- Talks to them about return to fertility and the benefits of healthy timing and spacing of pregnancies, as well as the benefits of using LAM
- Ensures that the husband and mother-in-law understand that they have an important role in supporting the mother (e.g., giving her help at home) so that she can breastfeed successfully
- Uses any (additional) client education material available
- Invites them to take the card home with them

Client Profile #5:

You are one week postpartum and are using LAM, adhering to all three criteria. The doctor where you delivered told you that if you had any problems using LAM, you should go to the family planning clinic. Your mother-in-law has been saying that the baby needs a bottle because she believes he is not getting enough milk.

Provider Profile #5:

You are the nurse at the family planning clinic in the district health center. This is the first time this patient has attended a family planning clinic. Her mother-in-law is with her.

Observer Considerations:

While following along with the LAM Counseling Checklist, note whether the provider:

- Ensures that the client and her mother-in-law feel welcome; asks the mother-in-law why she thinks the baby is not getting enough milk
- Reassures the client and mother-in-law that unless the baby is losing weight or not urinating, he is getting enough milk
- Explains the benefits of only/exclusive breastfeeding for the health of the baby
- Talks to them about return to fertility and the benefits of healthy timing and spacing of pregnancies, as well as the benefits of using LAM
- Follows the interaction outlined in the LAM Counseling Guide, covering all points
- Has the client(s) refer to the LAM Client Education Card
- Reinforces the three LAM criteria, emphasizing and fully explaining the criterion of only/exclusively breastfeeding
- Continues addressing any concerns of the client or the mother-in-law
- Uses any (additional) client education material available
- Invites them to take the card home with them

TRAINING SKILLS UPDATE AGENDA

MODEL TRAINING SKILLS UPDATE AGENDA			
	BRIEF CONTENT DESCRIPTION	TRAINING/LEARNING METHODS	TIME ALLOTTED
1	Welcome, course goals and objectives	Welcome and Overview	10 minutes
2	Key features of effective training in the context of adult learning	Activity Presentation/Discussion	20 minutes
3	Use of effective presentation skills	Brainstorm Presentation/Discussion	15 minutes
4	Use of a variety of training methods	Presentation/Discussion	15 minutes
5	Effective use of audio-visual aids	Presentation/discussion	15 minutes
6	Practical skills development	EXERCISE/Training Skills Practice Presentations and Assessment	120 minutes
7	Supportive on-site supervision	Discussion/Presentation and Brainstorm	15 minutes
8	Closing remarks	Wrap-Up	10 minutes

TRAINING SKILLS ASSESSMENT CHECKLIST

(To be used for self-assessment, peer assessment, and supervisor's assessment)

Name of person being assessed: ______________________________

Instructions: Please rate the performance of the participant–facilitator on a 1 to 5 scale:

4—Strongly agree **3—Agree** **2—Disagree** **1—Strongly disagree**

THE TRAINER	RATING	COMMENTS/SUGGESTIONS
1. Treats participants with respect		
2. Makes participants feel welcome		
3. Is organized with necessary materials		
4. Encourages interaction with all participants		
5. Clearly states objective of training session		
6. Uses a variety of teaching techniques		
7. Moves around room		
8. Maintains eye contact with participants		
9. Uses words/expressions that are easy to understand		
10. Displays enthusiasm about the topic		
11. Asks both simple and challenging questions		
12. Effectively leads discussion		

THE TRAINER	RATING	COMMENTS/SUGGESTIONS
13. Effectively leads small group work, if applicable		
14. Effectively leads brainstorming, if applicable		
15. Effectively uses audio-visual aids		
16. Provides feedback to participants on their performance		
17. Arranges appropriate space for any role plays or simulations		
18. Arranges for, or conducts, skills assessment		

TRAINING SKILLS REFERENCE

A positive learning environment maximizes the effectiveness of various learning activities, helping participants achieve the course/workshop goals and objectives more effectively and efficiently. To create such an environment, trainers should understand the learning process and be skilled in using a variety of appropriate teaching and assessment methods. Careful consideration should also be given to the availability of various resources, scheduling and other logistics. This section of the Participant's Notebook provides information and practical tips for conducting an effective clinical skills course/workshop.

KEY FEATURES OF ADULT LEARNING

Effective training builds on adult learning principles. Health care workers who attend training courses or workshops to acquire new knowledge, skills and attitudes share the characteristics described below:

- Require learning to be **relevant**. The trainer should offer participants learning experiences that relate directly to their job responsibilities. At the beginning of the course/workshop, the learning goals and objectives should be stated clearly and linked clearly to their current or future job performance.
- Are **highly motivated**. If they believe learning is relevant and will enable them to become effective health care providers, they will bring high levels of motivation and interest to learning. Motivation can be increased and channeled by the trainer who adheres to the learning goals and objectives provided.
- Prefer that **new learning build on what they already know** or have experienced.
- Need **participation and active involvement** in the learning process. Few individuals prefer just to sit back and listen. The effective trainer will design learning experiences that actively engage participants in the training process. Examples of how the trainer may involve participants include:
    - Questioning participants and providing feedback
    - Encouraging participants to draw from their own knowledge and experiences
    - Enabling participants to practice applying new knowledge and skills in a simulated environment
- Desire a **variety** of learning experiences. To keep the participants' interest, the trainer should use a variety of learning methods, including:
    - Audiovisual aids
    - Illustrated lectures/presentations

  - Demonstrations
  - Brainstorming
  - Small group activities
  - Group discussions
  - Role plays and case studies
  - Practice in simulated situations
- Desire **positive feedback**. Participants need to know how they are doing, particularly in light of the objectives and expectations of the workshop. Learning experiences should be designed to progress from the known to the unknown, as well as from simple to more complex activities. This progression yields positive learning experiences and ample opportunity for the trainer to provide positive feedback to participants. To develop/maintain a strong pattern of positive feedback, the trainer should:
  - Give verbal praise to a participant who is doing well, either in front of others or in private
  - Provide positive/constructive responses to participants' answers during questioning
  - Note any evidence of progress—let the participants know that they are moving toward achieving the learning objectives
- Have **personal concerns**. The trainer must recognize that many participants fear failure and embarrassment in front of their colleagues. Participants often have concerns about their ability to:
  - Fit in with the other participants
  - Get along with the trainer
  - Understand the content of the training
  - Perform the skills being taught
  - Need an **atmosphere of safety**. The trainer should open the workshop with an introductory activity that will help participants feel at ease. By communicating an atmosphere acceptance, participants will be less likely to judge one another or themselves.
- Need to be **treated as individuals**, each of whom has a unique background, experience and learning needs. To help demonstrate recognition of participants' individuality, the trainer should:
  - Use participants' names as often as possible
  - Engage all participants, collectively and individually, as often as possible
  - Treat participants with respect
  - Allow participants to share information with others during classroom and clinical instruction

- Must **maintain their self-esteem**. Participants need to maintain high self-esteem to deal with the demands of the workshop. It is essential that the trainer show respect for the participants, no matter what practices and beliefs they hold to be correct, and continually support and challenge them. This requires that the trainer:
  - Reinforce those practices and beliefs embodied in the workshop content
  - Provide corrective feedback when needed, in a way that the participants can accept and use it with confidence and satisfaction
  - Provide teaching/training that adds to, rather than subtracts from, their sense of competence and self-esteem
- Have **high expectations** for themselves and the participants. People tend to set high expectations both for the trainers/trainers and for themselves. Always strive for excellence.
- Have **personal needs** that must be taken into consideration. All participants have personal needs. Taking timely breaks and providing the best possible ventilation, proper lighting, and an environment as free from distraction as possible can help to reduce tension and contribute to a positive learning atmosphere.

CREATING A POSITIVE LEARNING ENVIRONMENT

Adopting an Effective Learning Approach

To help ensure that clinical skills training is effective, the learning environment should:

- Incorporate an educational philosophy that:
  - Encourages the development of **problem-solving and critical thinking** and
  - Emphasizes behaviors that **respect and respond to a patient's/client's rights and perceived needs;**
  - Include **relevant educational materials** that reflect an adult learning approach;
  - Involve trainers who are adequately prepared to use **competency-based learning methods** and clinically competent to teach and serve as role models for participants;
  - Involve competent clinical preceptors and supervisors who are able to use **competency-based assessment tools**;
- Arrange for practical learning experiences to develop the **essential skills** needed for clinical/counseling situations; and
- Include evaluation methods that assess knowledge, skills and attitudes.

> **Note:** The main principles of the **learning approach** used in this course are discussed in greater detail in **Appendix One**.

Preparation of Classroom Facilities

Classrooms should be available for interactive presentations (e.g., illustrated lectures) and group activities. Seating in classrooms should be comfortable, with adequate lighting and ventilation. At a minimum, a writing surface should be provided for each participant; a chalkboard and/or flipchart chalk and/or felt pens, and an overhead projector should be available in each classroom. If possible and applicable, classrooms should be within easy access of the clinical sites used for the program.

Preparation of a Simulated Practice Environment

A simulated practice environment provides participants with a safe environment where they can work together in small groups to practice skills—with other participants playing the role of clients. If a room dedicated to simulated practice is not available, a classroom or room at a clinical practice site should be set up for this purpose. The simulated practice environment must have the necessary supplies and equipment for the desired practice sessions.

A Note about Clinical Skills Practice and Assessment in the LAM Workshop

Because the LAM Workshop is only 2½ hours in length, there will not be sufficient time for participants to acquire competency in a clinical setting. Some practical skills may be acquired through observation of the counseling demonstration and practice in the classroom. However, the majority of skills development, and all of skills assessment, will occur in the participants' own clinical sites following completion of the workshop. Trainers and supervisors will visit participants in their clinical sites and, using the same checklist used in the workshop, observe clinical service provision. Prior to this visit, the participant will prepare by using the checklist for self-assessment and peer assessment.

Successful Participant–Trainer Ratio

The ratio of participants to trainers has a direct impact on the quality of learning and the ability of participants to gain the knowledge and skills required. Ratios that have lead to success in other programs are:

- **Classroom:** One trainer for a maximum of 30 students
- **Small group learning or discussion:** One trainer for 15–18 students (a single trainer may oversee the work of two to three small groups, which together have a maximum of 15–18 students)
- **Simulated practice:** One trainer to 8–12 students who are working on models or in a simulated setting

ESSENTIAL TRAINING SKILLS

Using Effective Presentation Skills

To ensure a successful learning experience, it is also important to use effective presentation skills. Establishing and maintaining a positive learning climate during training depend on how the clinical trainer delivers information because s/he sets the tone for the workshop. In any learning activity, **how** something is said may be just as important as **what** is said. Some common techniques for effective presentations are listed below:

- **Follow a plan**, which should include the session objectives, introduction, body, activity, audiovisual reminders and summary.
- **Communicate in a way that is easy to understand.** Many participants will be unfamiliar with the terms, jargon and acronyms of a new subject. The trainer should use familiar words and expressions, explain new language and attempt to relate to the participants during the presentation.
- **Maintain eye contact with participants.** Use eye contact to "read" faces. This is an excellent technique for establishing rapport and getting feedback on how well participants understand the content.
- **Project your voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone and inflection to maintain participants' attention. Avoid using a monotone voice, which is guaranteed to put participants to sleep!
- **Avoid the use of slang or repetitive words, phrases or gestures** that may become distracting with extended or repeated use.
- **Display enthusiasm about the topic and its importance.** Smile, move with energy and interact with participants. The trainer's enthusiasm and excitement are contagious and directly affect the morale of the participants.
- **Move around the room.** Moving around the room helps to ensure that the trainer is close to each participant at some time during the session. Participants are encouraged to interact when the clinical trainer moves toward them and maintains eye contact.
- **Use appropriate audiovisual aids** during the presentation to reinforce key content or help simplify complex concepts.

Note: Tips for using audiovisual aids are presented in greater detail in Appendix Two.

- Be sure to ask both **simple and more challenging questions**.
- **Provide positive feedback** to participants during the presentation.
- **Use participants' names as often as possible.** This will foster a positive learning climate and help keep participants focused on the presenter.

- Display a **positive use of humor** related to the topic (e.g., humorous stories, cartoons on transparency or flipchart, cartoons for which participants are asked to create captions).
- **Provide smooth transitions between topics.** Within a given presentation, a number of separate, yet related topics may be discussed. When shifts between topics are abrupt, participants may become confused and lose sight of how the different topics fit together in the bigger picture. Before moving on to the next topic, therefore, the trainer can ensure that the transition from one topic to the next is smooth by:
  - Providing a brief summary
  - Asking a series of questions
  - Relating content to practice
  - Using an application exercise (case study, role play, etc.)
- **Be an effective role model.** The trainer should be a positive role model in appearance (appropriate dress) and attitude (enthusiasm for the workshop), and by beginning and ending the session at the scheduled times.

Conducting Learning Activities (Effective Learning Methods)

Every presentation (teaching session) should begin with an **introduction** to capture participant interest and prepare the participant for learning. After the introduction, the trainer may deliver content using an **illustrated lecture, demonstration**, **small group activity** or **other learning activity**. Throughout the presentation, **questioning** techniques can be used to encourage interaction and maintain participant interest. Finally, the trainer should conclude the presentation with a **summary** of the key points or steps.

Delivering Interactive Presentations

Introducing Presentations

The first few minutes of any presentation are critical. Participants may be thinking about other matters, wonder what the session will be like or have little interest in the topic. The **introduction** should:

- Capture the interest of the entire group and prepare participants for the information that follows
- Make participants aware of the trainer's expectations
- Help foster a positive learning climate

The trainer can select from a number of techniques to provide variety and ensure that participants are not bored. Many introductory techniques are available, including:

- **Reviewing the session objectives.** Introducing the topic with a simple restatement of the objectives reinforces the participants' awareness of what is expected of them.

- **Asking a series of questions about the topic.** The effective trainer will recognize when participants have prior knowledge concerning the workshop content and encourage their contributions. The trainer can: ask a few key questions; allow participants to respond and discuss answers/comments; and then move into the body of the presentation.
- **Relating the topic to previously covered content.** When a number of sessions are required to cover a subject, relate each session to previously covered content. This ensures that participants understand the continuity of the sessions and how each relates to the overall topic. When possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.
- **Sharing a personal experience.** There are times when the clinical trainer can share a personal experience to create interest, emphasize a point or make a topic more job-related. Participants enjoy hearing these stories as long as they relate to the topic and are used only when appropriate.
- **Relating the topic to real-life experiences.** This technique not only captures the participants' attention, but also facilitates learning because people learn best by "anchoring" new information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.
- **Using a case study, clinical simulation or other problem-solving activity.** Problem-solving activities focus participants' attention on a specific situation related to the training topic. Also, working in small groups generally increases interest in the topic.
- **Using a videotape or other audiovisual aid.** Use of appropriate audiovisuals can be stimulating as well as generate interest in a topic.
- **Giving a classroom demonstration.** Most clinical training courses/workshops involve equipment, instruments and techniques that lend themselves to demonstrations, which generally increase participant interest.
- **Using a game, role play or simulation.** Such activities generate tremendous interest through direct participant involvement and are therefore particularly useful for introducing topics.
- **Relating the topic to future work experiences.** Participants' interest in a topic will increase when they see a relationship between the learning experience and their work. The clinical trainer can capitalize on this by relating objectives, content and activities of the workshop to real-life work situations.

Using Questioning Techniques

Questions can be used at anytime to:

- Introduce a topic
- Increase the effectiveness of the illustrated lecture/presentation
- Stimulate discussion
- Encourage brainstorming

- **It is important to use a** variety of questioning techniques **to maintain interest and avoid a repetitive style. Three key techniques are described below:**
  - **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some participants may dominate while others may not participate.
  - **Target the question to a specific participant by using her/his name prior to asking the question.** The participant is aware that a question is coming, can concentrate on the question and respond accordingly. The disadvantage is that once a specific participant is targeted, other participants may stop paying close attention.
  - **State the question, pause and then direct the question to a specific participant.** All participants must listen to the question in the event that they are asked to respond. The primary disadvantage is that the participant receiving the question may be caught off guard and have to ask the trainer to repeat the question.

The key in asking questions is to avoid a pattern. The skilled trainer uses all three of the above techniques to provide variety and maintain the participants' attention. Other techniques follow:

- **Use participants' names** during questioning. This is a powerful motivator and also helps ensure that all participants are involved.
- **When a participant's response is correct**, repeat the response. This provides positive reinforcement to the participant, ensures that the rest of the group heard the response and keeps participants engaged in the topic. Positive reinforcement may also take the form of praising, displaying a participant's work, having a participant act as an assistant or using positive facial expressions, nods and other nonverbal actions.
- **When a participant's response is partially correct**, acknowledge and reward the correct portion and then address the incorrect portion—or redirect a related question to that participant or the other participants to give them a chance to correct it.
- **When a participant's response is incorrect**, respond in a noncritical and constructive manner and restate the question to help lead the participant(s) to the correct response.
- **When a participant makes no attempt to respond**, follow the above-described procedure or redirect the question to another participant. Come back to the first participant after receiving the desired response and involve her/him in the discussion.
- **When participants ask questions**, determine an appropriate response by drawing upon knowledge and personal experience and weighing the individual's needs against those of the group. If the question addresses a topic that is relevant but has not been previously discussed, the trainer can either:
  - Answer the question and move on; or
  - Respond with another question, thereby beginning a discussion about the topic.

Summarizing Presentations

A **summary** is used to reinforce the content of a presentation and provide a review of its main points. The summary should:

- Be brief
- Draw together the main points
- Involve the participants

Many summary techniques are available to the trainer:

- **Asking the participants for questions** gives them an opportunity to clarify their understanding of the instructional content. This may result in a lively discussion focusing on content areas that seem to be the most troublesome.
- **Asking the participants questions** that focus on major points of the presentation helps them summarize what they have learned.
- **Administering a practice exercise or test** gives participants an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for a discussion by asking for correct answers and explaining why each answer is correct.
- **Using a game to review main points** provides some variety, when time permits. One popular game is to divide participants into two teams, give each team time to develop review questions and then allow each team to ask questions of the other team. The clinical trainer serves as moderator by judging the acceptability of questions, clarifying answers and keeping a record of team scores. This game can be highly motivational and serve as an excellent summary at the same time.

Facilitating Group Discussions

The **group discussion** is a learning method in which most of the ideas, thoughts, questions and answers are developed by the participants. Typically, the trainer guides the participants as the discussion develops, facilitating rather than leading it.

Group discussion is useful:

- At the conclusion of a presentation
- After viewing a videotape
- Following a clinical demonstration or skills practice session
- After reviewing a case study or clinical simulation
- After a role play
- Any other time when participants have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when participants have limited knowledge or experience with the topic often will result in little or no interaction and thus an ineffective

discussion. When participants are familiar with the topic, the ensuing discussion is likely to **arouse participant interest, stimulate thinking and encourage active participation**. This interaction affords the trainer an opportunity to:

- Provide positive feedback
- Stress key points
- Develop critical thinking skills
- Create/maintain a positive learning climate

The trainer must consider a number of factors, as summarized below, when choosing to use a group discussion as a learning strategy:

- Discussions involving **more than 15 to 20 participants may be difficult to facilitate** and may not give each participant an opportunity to participate.
- Discussion requires **more time than an illustrated lecture** because of extensive interaction among the participants.
- **A poorly directed discussion may move off target** and never reach the objectives established by the facilitator.
- **If control is not maintained, a few participants may dominate** the discussion while others lose interest.

> In addition to a group discussion that focuses on the session objectives, there are **two other types of discussions** that may be used in a training situation:
>
> - **General discussion** that addresses participants' questions about a learning event (e.g., benefits of LAM)
> - **Panel discussion** in which a moderator conducts a question-and-answer session between panel members and participants

Follow these key points to ensure successful group discussion:

- **Arrange seating to encourage interaction** (e.g., tables and chairs set up in a U-shape or a square or circle so that participants face one another).
- **State the topic** as part of the introduction.
- **Shift the conversation** from the trainer to the participants.
- **Act as a referee** and intercede only when necessary.
  Example: "It is obvious that Alain and Ilka are taking two sides in this discussion. Alain, let me see if I can clarify your position. You seem to feel that...."

- **Summarize the key points** of the discussion periodically.
  Example: "Let's stop here for a minute and summarize the main points of our discussion."
- **Ensure that the discussion stays on the topic.**
- Use the contributions of each participant and provide positive reinforcement.
  Example: "That is an excellent point, Rosminah. Thank you for sharing that with the group."
- **Minimize arguments** among participants.
- **Encourage all participants to get involved.**
- **Ensure that no single participant dominates** the discussion.
- **Conclude the discussion with a summary** of the main ideas. The trainer must relate the summary to the objective(s) presented during the introduction.

Facilitating a Brainstorming Session

Brainstorming is a learning strategy that **stimulates thought and creativity** and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts or alternative solutions that focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that participants have some background knowledge or experience related to the topic.

The following guidelines will facilitate the use of brainstorming:

- **Establish ground rules.**
  Example: "During this brainstorming session, we will be following two basic rules: (1) all ideas will be accepted and Aisha will write them on the flipchart; and (2) at no time—during brainstorming—will we discuss or criticize any idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not."
- **Announce the topic or problem.**
  Example: "During the next few minutes, we will be brainstorming and will follow our usual rules. Our topic today is 'How to help women transition from LAM to another modern method of contraception.' I would like each of you to think of at least one way to help a woman transition to another method. Maria will write your suggestions on the board so that we can discuss them later. Who would like to be first? Yes, Ilka."
- **Maintain a written record** of the ideas and suggestions by listing them in clear view of all participants, such as on a flipchart. This will prevent repetition and keep participants focused on the topic. In addition, this written record is useful when it is time to discuss each item.
- **Involve the participants and provide positive feedback** in order to encourage more input.
- **Review written ideas and suggestions periodically** to stimulate additional ideas.

- Conclude brainstorming by reviewing all of the suggestions and **identifying/clarifying those that are acceptable.**

Facilitating Small Group Activities

There are many times during a workshop when the participants will be divided into several **small groups**, which usually consist of four to six participants. Examples of small group activities include:

- **Reacting to a case study**, which may be presented in writing or orally by the trainer , or introduced through a videotape or slides
- **Preparing a role play** within the small group and presenting it to the entire group as a whole
- **Responding to a clinical situation/scenario**, such as in a **clinical simulation**, which has been presented by the clinical trainer or another participant
- **Practicing a skill** that has been demonstrated by the trainer

Small group activities offer many **advantages** including:

- Providing participants an opportunity to **learn from each other**
- **Involving** all participants
- Creating a sense of **teamwork** among members as they get to know each other
- Providing for a **variety of viewpoints**

Appropriate activities for small groups include problem-solving activities, case studies, clinical simulations and role plays, and should:

- Be **challenging, interesting and relevant**;
- Require only a **short time to complete**; and
- Be **appropriate for the background** of the participants.

Logistics of Small Group Activities

The **room(s) used for small group activities** should be large enough to allow different arrangements of tables, chairs and teaching aids (models, equipment) so that individual groups can work without disturbing one another. The clinical trainer should be able to move easily about the room to visit each group. If available, consider using smaller rooms near the primary workshop room where small groups can go to work on their problem-solving activity, case studies, clinical simulations or role plays, without disturbing the other groups. Note that it is difficult to conduct more than one clinical simulation/practice session at the same time in the same room/area.

If the workshop includes several small group activities, it is important that participants are not in the same group every time. Different ways the trainer can **create small groups** include:

- Assigning participants to groups
- Asking participants to count off "1, 2, 3, etc." and having all the "1s" meet together, all the "2s" meet together and so on.
- Allowing participants to form their own groups
- Having participants to draw slips of paper (on which are written group names or numbers)

Each small group may be working on the same activity or each group may be taking on a different problem, case study, clinical simulation or role play. Either way, the success of a small group sessions depends on **a clear process**, as described below.

Instructions to the groups may be presented visually—on a handout, flipchart or transparency—or verbally by the trainer. Instructions for small group activities typically include:

- A clear process description, outlining exactly what the participants should do
- Time limit[2]
- A situation or problem to discuss, resolve or role play
- Participant roles (if a role play)
- Questions for a group discussion (afterward)

Once the groups have completed their activity, the trainer will bring them together as a large group again for a **group discussion** about the activity. This discussion might involve:

- Reports from each group
- Responses to questions
- Role plays developed in each group and presented by participants in the small groups
- Recommendations from each group
- Impressions of the experience (if a clinical simulation)

It is important that the clinical trainer provide an effective **summary** discussion following small group activities. This provides closure and ensures that participants understand the point of the activity.

Conducting an Effective Clinical Demonstration

When new skills are introduced—such as those involved in LAM/postpartum family planning (PPFP) counseling—a variety of methods can be used to demonstrate the skills:

[2] Regardless of the type of activity, there is usually a time limit. When this is the case, inform groups when there are 5 minutes left and when their time is up.

- Show **slides** or a **videotape** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
- Perform **role plays** in which a participant or surrogate client simulates a client and responds/reacts much as a real client would.
- Demonstrate the procedure with **clients** in the clinical setting (clinic or hospital).

Whatever methods are used to demonstrate the procedure, the clinical trainer should set up the activities using the "**whole-part-whole**" approach. For LAM/PPFP counseling:

- Demonstrate the **whole counseling session** from beginning to end to give the participant a visual image of the entire procedure or activity.
- **Isolate or break down the session** into parts (FP history and choice, screening for LAM criteria, counseling on transition methods, counseling on optimal breastfeeding behaviors, etc.) and allow practice and discussion of the individual parts of the session.
- Demonstrate the **whole session** again and then allow participants to practice counseling from beginning to end.

When planning and giving a demonstration, the clinical trainer should use the following guidelines:

- Before beginning, **state the objectives** of the demonstration and point out what the participants should do (interrupt with questions, observe carefully, etc.).
- Make sure that **everyone can see** the client and service provider involved in the demonstration.
- **Never** demonstrate the skill or activity incorrectly.
- Demonstrate the session in as **realistic** a manner as possible.
- Include **all steps** of the procedure in the **proper sequence** according to the approved checklist
- During the demonstration, **explain to participants what is being done**, if necessary.
- **Ask questions** of participants to keep them involved.
  Example: "What should I do next?" "What would happen if…?"
- **Encourage** questions and suggestions.
- **Use client education materials properly** and make sure participants clearly see how they are used.

ASSESSING COMPETENCIES

A variety of assessment methods, which complement both the learning approach and the learning methods described in the previous sections, are included in the learning resource package. Each assessment method is described below.

Case Studies

Case studies serve as an important learning method, as described previously. In addition, they provide an opportunity for the trainer to assess the development of clinical decision-making skills, using the case study answer keys as a guide. Assessment can be conducted on an individual basis or in small groups.

Role Plays

Role plays also serve as both a learning method and a method of assessment. Using the role play answer keys as a guide, the trainer can assess participants' understanding and development of appropriate interpersonal communication skills. Opportunities will arise during role plays for the trainer to assess the skills of the participants involved, whereas the discussions following role plays will enable the trainer to assess the attitudes and values of participants in the context of their role as health care providers.

Clinical Simulations

As with case studies and role plays, clinical simulations serve both as a learning method and a method of assessment. Throughout the simulations, the trainer has the opportunity to assess clinical decision-making and counseling skills, as well as knowledge, relevant to a specific topic.

Written Knowledge Assessments

The learning resource package includes a multiple-choice test, or knowledge assessment, intended to assess factual recall at the end of the workshop. The items on the questionnaire relate to the learning objectives for the module/topic area; each questionnaire has an answer sheet for participants and an answer key for trainers. A score of 85% or more correct answers indicates knowledge-based mastery of the content presented. Participants who score less than 85% on their first attempt should be given individual guidance to help them learn the required information before completing the test again. Time constraints may dictate that re-testing occur during the follow-up visit of the trainer or supervisor to the participant's clinical practice site.

Note: More information about **supportive on-site supervision** is presented in **Appendix Three**.

Skill Assessments with Simulated or Real Patients/Clients

Skill assessments with models and patients/clients are conducted using skills **checklists**. Using checklists in competency-based training:

- Ensures that participants have mastered the skills required,
- Ensures that all participants' skills are measured according to the same standard, and
- Forms the basis for follow-up observations and evaluations.

When using checklists, it is important that the scoring is completed correctly, as follows:

✓: Performs the step or task according to the standard procedure or guidelines

Blank: Unable to perform the step or task according to the standard procedure or guidelines

Not relevant: Step, task or skill that not relevant to this particular client or situation

Participants should be able to perform all of the steps/tasks for a particular skill, before the trainer assesses skill competency, in a simulated setting, using the relevant checklist. Supervised practice should then be undertaken at a clinical site before the trainer assesses skill competency with patients/clients, using the same checklist.

Participants' progression in the development of new skills occurs in three observable phases:
Skill Acquisition: Knows the steps and their sequence (if necessary) to perform the required skill or activity but needs assistance
Skill Competency: Knows the steps and their sequence (if necessary) and can perform the required skill or activity
Skill Proficiency: Knows the steps and their sequence (if necessary) and effectively performs the required skill or activity

APPENDIX 1: THE LEARNING APPROACH

Mastery Learning

The mastery learning approach assumes that all participants can master (learn) the required knowledge, attitudes or skills, provided there is sufficient time and appropriate learning methods are used. The goal of mastery learning is that 100 percent of the participants "master" the knowledge and skills on which the training is based. Mastery learning is used extensively in inservice training where the number of participants, who may be practicing clinicians, is often low. While the principles of mastery learning can be applied in preservice education, the larger number of students/participants presents some challenges.

Although some participants are able to acquire new knowledge or new skills immediately, others may require additional time or alternative learning methods before they are able to demonstrate mastery. Not only do people vary in their abilities to absorb new material, but individuals learn best in different ways—through written, spoken or visual means. Effective learning strategies, such as mastery learning, take these differences into account and use a variety of teaching methods.

The mastery learning approach also enables the participant to have a self-directed learning experience. This is achieved by having the trainer serve as facilitator and by changing the concept of testing and how test results are used. Moreover, the philosophy underlying the mastery learning approach is one of continual assessment of learning where the trainer regularly informs participants of their progress in learning new information and skills.

With the mastery learning approach, assessment of learning is:

- **Competency-based**, which means assessment is keyed to the learning objectives and emphasizes acquiring the essential skills and attitudinal concepts needed to perform a job, not just to acquiring new knowledge.
- **Dynamic**, because it enables participants to review continual feedback on how successful they are in meeting the workshop objectives.
- **Less stressful**, because from the outset participants, both individually and as a group, know what they are expected to learn, know where to find the information and have ample opportunity for discussion with the trainer.

Mastery learning is based on principles of adult learning. This means that learning is participatory, relevant and practical. It builds on what the participant already knows or has experienced and provides opportunities for practicing skills. Other key features of mastery learning are that it:

- Uses behavior modeling,
- Is competency-based, and
- Incorporates humanistic learning techniques.

Behavior Modeling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modeling to be successful, however, the trainer must clearly demonstrate the skill or activity so that participants have a clear picture of the performance expected of them.

Behavior modeling, or observational learning, takes place in three stages.

- In the first stage, **skill acquisition**, the participant sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the participant attempts to perform the procedure, usually with supervision.
- Next, the participant practices until **skill competency** is achieved and s/he feels confident performing the procedure.
- The final stage, **skill proficiency**, occurs with repeated practice over time. Proficiency is not usually attained, especially on complex skills, during preservice education, as new participants require many repetitions of a skill to gain proficiency.

Competency-Based Training

Competency-based training (CBT) is **learning by doing**. It focuses on the specific knowledge, attitudes and skills needed to carry out the procedure or activity. How the participant performs (i.e., a combination of knowledge, attitudes and, most important, skills) is emphasized rather than just the information learned. Competency in the new skill or activity is assessed objectively by evaluating overall performance.

To accomplish CBT successfully, the clinical skill or activity to be taught must be broken down into its essential steps. Each step is then analyzed to determine the most efficient and safe way to perform and learn it. The process is called **standardization**. A checklist makes learning the necessary steps or tasks easier and evaluating the participant's performance more objective.

An essential component of CBT is coaching, in which the classroom or clinical trainer **first explains a skill or activity and then demonstrates it** using an anatomic model or other training aid, such as videotape. Once the procedure has been demonstrated and discussed, the trainer then observes and interacts with participants to guide them in learning the skill or activity, monitoring their progress and helping them overcome problems.

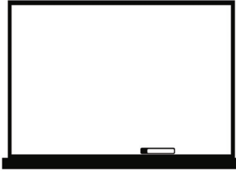
The coaching process ensures that the participant receives feedback regarding performance:

- **Before practice**: The trainer and participants meet briefly before each practice session to review the skill/activity, including the steps/tasks that will be emphasized during the session.
- **During practice**: The trainer observes, coaches and provides feedback to the participant as s/he performs the steps/tasks outlined in the learning guide.

- **After practice**: Immediately after practice, the trainer uses the learning guide to discuss the strengths of the participant's performance and also offer specific suggestions for improvement.

APPENDIX 2: TIPS FOR USING AUDIOVISUAL AIDS

Writing Boards



The writing board is the most commonly used visual aid. It can display information written with chalk (chalkboard or blackboard) or special pens (whiteboard). You can use a writing board for announcements, informal discussions, brainstorming sessions and note taking. A writing board is also an excellent tool for illustrating subjects like anatomy and physiology and for outlining procedures.

Some **possible uses** of a writing board:

- Document ideas during discussions or brainstorming exercises.
- Draw a sketch of anatomy or a physiological response.
- Note points you wish to emphasize.
- Diagram a sequence of activities for working through the process of making a clinical decision.

The **advantages** of using a writing board:

- Writing boards are available in most classrooms and do not require electricity.
- They are inexpensive and easy to use.
- They are excellent for brainstorming, problem-solving, making sketches, diagrams, charts, and lists, and for other participatory activities.

The following are some **disadvantages** of using a writing board:

- The board cannot hold a large amount of material.
- Writing on the board is time-consuming.
- It is difficult to write on the board and talk to participants at the same time.
- In large classrooms, it is difficult to write large enough so that participants in the back of the room can easily read what is written.
- There is no permanent record of the information presented.

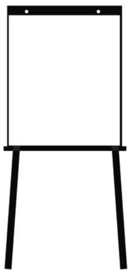
Most trainers use a writing board of some kind. Sometimes the board will look messy at the end of a presentation, with untidy diagrams and no pattern to the words. Before you start, decide

what you will illustrate on the board. During the presentation, write the key words or phrases in order, according to the structure of the presentation. Remember that participants tend to copy the words and the layout as they appear on the board. Make sure that what you write on the board is what you want the participants to write in their notes.

Tips for using a writing board:

- Keep the board clean.
- Use chalk or pens that contrast with the background of the board so that participants can see the information clearly.
- Make text and drawings large enough to be seen in the back of the room.
- Underline headings and important or unfamiliar words for emphasis.
- Do not talk while facing the board.
- Do not block the participants' view of the board; stand aside when you have finished writing or drawing.
- Allow sufficient time for participants to copy the information from the board.
- Summarize the main points at the end of the presentation.

Flipcharts



A flipchart is a large tablet or pad of paper, usually on a tripod or stand. You can use a flipchart for displaying prepared notes or drawings, as well as for brainstorming and recording ideas from discussions. You can also use flipcharts before and after clinical practice visits to introduce objectives and group exercises, or to summarize the experience.

The **possible uses** for a flipchart are the same as those listed for the writing board, but also include the following:

- Note objectives or outcomes before or after clinical practice sessions.
- Create flowcharts to work through clinical decision-making in different situations, such as during a complicated labor and childbirth.
- Record discussions or ideas during small group exercises.

The **advantages** of using a flipchart:

- Flipchart stands and paper are relatively inexpensive, easy to move from room to room, and do not require electricity.
- They are small enough that several may be used simultaneously (e.g., for small group work).
- They are suitable for use by both trainers and participants.

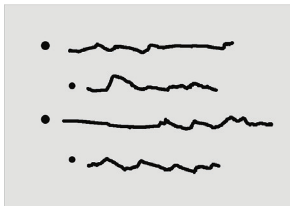
- Pages of information can be prepared in advance and revealed at appropriate points in the presentation.

Disadvantages of the flipchart are essentially the same as those listed for the writing board. Flipcharts, however, provide a permanent record of the information presented.

Tips for using a flipchart:

- Make it easy to read. Use bullets (■) to highlight items on the page, leave plenty of white space and avoid putting too much information on one page. Print in block letters using wide-tipped pens or markers.
- Make the flipchart page attractive. Use different colored pens to provide contrast, and use headings, boxes, cartoons and borders to improve the appearance of the page.
- Have masking tape available to hang flipchart pages on the walls during brainstorming and problem-solving sessions.
- To hide a portion of the page, fold up the lower portion of the page and tape it; when you are ready to reveal the information, remove the tape and let the page drop.
- Face the participants, not the flipchart, while talking.
- When you finish with a flipchart page, tape it to the wall where you and the participants can refer to it.

Transparencies



The overhead projector is one of the most commonly used and most versatile pieces of audiovisual equipment. This visual aid projects images onto a screen using transparency film. Trainers should pay attention to the amount, size and clarity of writing and images they present on an overhead transparency. Writing and images should not be too small, overcrowded or difficult to read.

Transparencies are very useful for presenting a large amount of information efficiently (e.g., during an interactive presentation). You can use transparencies to outline the main topics and highlight important points throughout a presentation.

Following are some **possible uses** for transparencies:

- Provide an outline for the trainer to follow in discussing the main points of a presentation.
- Show images, illustrations, charts, or diagrams to support a topic.
- Provide visual support to participants as they make their own presentations and oral reports.
- Show them to clinical practice sites to describe practices and procedures to tutors or participants.

The **advantages** of using transparencies are:

- When they are handwritten, they can be prepared quickly and easily.
- They can be stored and reused in the future.
- The projector is easy to use, and can be used in almost any room that has electricity.
- When prepared in advance, they save the trainer time (writing on a board or flipchart takes more time than talking) and allow more time for discussion with participants.
- Points gathered from a discussion can be immediately written on a transparency.

The primary **disadvantage** of transparencies is that text and images cannot be projected directly from the printed page, but must be enlarged and copied onto a transparency sheet. Also, you must be careful that you do not stand between the projector and the screen and block the participants' view.

There are three ways to **produce** transparencies:

- Use permanent or non-permanent (water soluble) pens to create text or drawings on plastic or acetate sheets.
- Use a copy machine with transparency film designed for copiers. Any original document that produces a copy of acceptable quality on paper will produce an equivalent copy on transparency film.
- Use a computer and printer. The information to appear on the transparency is produced on the computer using word processing or graphics software. The page is then printed on special transparency film.

When you **prepare** transparencies:

- Create a transparency in landscape (horizontal) rather than portrait (vertical) format (see samples at the end of this module). The information is easier to read when presented in a landscape format.
- Be consistent. Use the same general style and tone throughout.
- Proofread. You are more likely to catch errors if you proofread on paper before creating the transparencies.
- Limit the information on each transparency to one main idea that can be grasped in 5–10 seconds.
- State the main idea in the title. Use about three to five bullets per slide. Limit a bulleted item to six to eight words. Use no more than seven lines of text.
- Whenever possible, use pictures, charts, or graphs to support or replace text. Bar graphs, pie charts, and line graphs are effective tools to show trends and statistics. Photographs and line drawings are useful for showing clinical signs and symptoms and demonstrating clinical procedures.

- Make graphics and drawings large enough to be seen easily in the back of the room. Use large lettering (at least 5 mm tall, preferably larger if printing, or 18 point or larger if using a computer) as seen in the sample transparency at the end of this module. Do not use ordinary typed materials or a page from a book unless they are enlarged, because the transparency will be difficult to read.
- Print your text. It is easier to read than script handwriting. If you are using a computer to prepare transparencies, use only one typeface (font) per slide. Use italics or bold to emphasize points rather than using another font.
- Use overlays to present complex images or diagrams. An overlay is one transparency placed over another. For example, in a presentation on female anatomy, you may use one transparency to show the uterus and a second transparency, which is laid over the first, to show the surrounding organs.
- Number the transparencies to keep them in the correct order (the number can be written on the transparency itself or on its outside frame).
- Store the transparencies in a box with a lid, an envelope, or a "pocket" made from folders or sheets of clear plastic to protect them from dust and scratches.

Tips for using an overhead projector:

- Before the presentation begins, you should locate and check the operation of the on/off switch and make sure the bulb is working. Ideally, have an extra projector bulb available.
- Before beginning the presentation, focus the projector and use a transparency to check the position of the image on the screen.
- Once the projector is on and the image is on the screen, move away from the projector to avoid blocking the participants' view of the screen.
- Face the participants, not the screen, while talking.
- Use a pointer or pencil to show one point at a time. Control the pace of the discussion by covering selected information with a piece of paper and revealing new information when you are ready.
- Allow plenty of time for the participants to read what is on the screen and take notes, if necessary.

PowerPoint Presentations

PowerPoint presentations are becoming one of the most commonly used audiovisual teaching media in areas where electricity is stable and where computers and projectors are present. This visual aid projects images from a computer onto a screen that can be seen by all participants. As with transparencies, trainers should pay attention to the amount, size and clarity of text and images present on an individual slide. Text and images should not be too small, overcrowded or difficult to read.

Also, as with transparencies, PowerPoint presentations are very useful for presenting a large amount of information efficiently (e.g., during an interactive presentation).

Following are some **possible uses** for PowerPoint slides:

- Provide an outline for the trainer to follow in discussing the main points of a presentation.
- Show images, illustrations, charts or diagrams to support a topic.
- Provide visual support to participants as they make their own presentations and oral reports.
- Provide a written/visual presentation of the main points of an oral presentation.

The **advantages** of using PowerPoint slides include:

- They can be stored in a computer or on a disc and reused in the future.
- When prepared in advance, they save the trainer time (writing on a board or flipchart takes more time than talking) and allow more time for discussion with participants.
- Points gathered from a discussion can be immediately written into a PowerPoint slide.

The primary **disadvantage** of PowerPoint presentations is that they require a computer, a projector/box light and a stable electricity supply.

When you **prepare** a PowerPoint slide:

- Be consistent. Use the same general style and background throughout.
- Proofread. You are more likely to catch errors if you proofread prior to the presentation.
- Limit the information on each slide to one main idea that can be grasped in 5–10 seconds.
- State the main idea in the title. Use no more than five to six bullets per slide, limiting each to six to eight words. Use no more than eight lines of text.
- Whenever possible, use pictures, charts or graphs to support or replace text. Bar graphs, pie charts and line graphs are effective tools to show trends and statistics. Photographs and line drawings are useful for illustrating key points.
- Make graphics and drawings large enough to be seen easily in the back of the room. Use large lettering (at least 20–24 point) and a font that is clear, simple and easy to read.

APPENDIX 3: PERFORMANCE IMPROVEMENT THROUGH SUPPORTIVE SUPERVISION IN THE WORKPLACE

Training is one component in bringing about behavior change and improved performance in the workplace. In order ensure that positive changes and improvements are maintained and can be built on in the future, several factors must be in place.

To change/improve performance, health care workers need strengthened/updated:

- Knowledge
- Skills
  - Practice essential to competency
  - More practice essential to proficiency
- Attitudes, such as:
  - Motivation
  - Understanding/appreciation of client-centered care

And to maintain positive changes and continue to improve their performance, they also need a supportive environment, including:

- Adequate resources, such as supplies, equipment, time and space;
- Appropriate policies and clear performance standards and guidelines; and
- Supportive on-site supervision.

Learning is not complete in the classroom. Participants need continued practice to develop competency and then proficiency in newly acquired knowledge and skills. On-site supportive supervision helps them maintain positive changes and continue to improve their performance.

Methods for on-site supportive supervision include:

- Discussing performance
  - With the provider
  - With the supervisor
- Observing performance
  - Using a standardized observation tool (checklist)
  - Providing coaching, mentoring and positive/constructive feedback
- In partnership with provider, identifying gaps between current practice and quality service
- Identifying strategies to close gap, through:
  - Participatory problem-solving
  - Developing plan of action

Basic parameters for of on-site supportive supervision are as follows:

- Each visit should follow-up on previously developed action plan
- All feedback should be supportive

- Accomplishments should be acknowledged
- Clinical observations should not interfere with client–provider interaction—**Never correct or criticize a provider in front of others.**

LAM TRAINING SKILLS COURSE EVALUATION

(To be completed by the participant)

5—Strongly Agree **4—Agree** **3—No Opinion** **2—Disagree** **1—Strongly disagree**

	COURSE COMPONENT	RATING
1	The training methods were effective in helping me to learn about LAM.	
2	The training methods were effective in helping me to learn about **training others** about LAM.	
3	The course materials were effective in helping me to learn about LAM.	
4	The course materials were effective in helping me to learn about **training others** about LAM.	
5	I feel confident in providing LAM counseling, including for HIV-positive women.	
6	I feel confident in **training others** to provide LAM counseling, including for HIV-positive women.	
7	I am able to explain the three LAM criteria, including transition; the basic mechanism of action and effectiveness of LAM; optimal breastfeeding; and appropriate contraceptives for breastfeeding mothers (or to which LAM users can transition) at various times during the postpartum period.	
8	I feel confident in **training others** to do the same (as described above).	
9	I am now able to discuss the benefits of healthy timing and spacing of pregnancies.	
10	I feel confident in **training others** to do the same (as described above).	
11	I am now able to identify opportunities for integrating LAM counseling with other services.	
12	I am now able to address many of the misconceptions health workers have about LAM.	
13	I am confident that the training skills and learning methods I have learned will strengthen my effectiveness as a teacher/trainer/facilitator.	

Circle one: The course was: Too Long Too Short Correct Length

We needed more time for: ____________________

We spent too much time on: ____________________

What topics (if any) should be **added** (and why) to improve the course? ____________________

____

What topics (if any) should be **deleted** (and why) to improve the course? ____________________

____

The best aspect of the course was: ____________________

The least helpful aspect of the course was: ____________________