Technical Report 4: Follow-up of Family Planning Clinical Service Providers in Tanzania

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ABBREVIATIONS

BCS	Basic Clinical Skills
CCS	Comprehensive Clinical Skills
COC	Combined Oral Contraceptives
CPR	Contraceptive Prevalence Rate
CTT	Central Training Team (member)
DMCHCo	District Maternal and Child Health Coordinator
DISP	Dispensary
FHP	Family Health Project
FP	Family Planning
HC	Health Center
IEC	Information, Education and Counseling
INTRAH	Program for International Training in Health
IUCD	Intrauterine Contraceptive Device
MA	Medical Assistants
MCHA	Maternal and Child Health Aides
MCH/FP	Maternal and Child Health/Family Planning
NO	Nursing Officer
NM	Nurse Midwife
NIC	National Insurance Company
NPF	National Provident Fund
ODA	Overseas Development Association
POP	Projestin Only Pills
PHNA	Public Health Nurse “A”
PHNB	Public Health Nurse “B”
PTSA	Pre/Post Training Skills Assessment
PTS A	Pre/Post Training Skills Assessment Tool
RMA	Rural Medical Aide (Assistant Clinical Officer)
RMCHCo	Regional Maternal and Child Health Coordinator
RTT	Regional Training Team Member
RH	Reproductive Health
SDP	Service Delivery Point
SP	Service Provider
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TOHS	Tanzania Occupational Health Services
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

SUMMMARY

Follow-up is one of the approved activities by the FPU for formally assessing the effect and impact of training on job performance and for providing on-the-job guidance through visits to trainees at worksite. During follow-up, factors and conditions which favor or hinder performance are examined as well as service data to assess whether there have been changes in the quantity of services offered after training of the service provider. On the basis of the results of the follow-up, recommendations are drafted for appropriate future action. Ideally, follow-up is conducted 3-6 months after training of the service provider in order to assist the trainee with re-entry after training and for early diagnosis and solution of environmental problems at the trainee's worksite. However, the frequency is usually determined by the resources available and the objectives of the follow-up.

The last follow-up conducted by the FPU was in 1994. Another follow-up was long overdue considering that between the period of March 1995 to April 1996, 595 clinical service providers had been trained through the National Family Planning Program. As a result, this follow-up was scheduled by FPU for May 1996, to respond to the need to obtain an insight into trainees performance at the worksite, to identify factors enabling or hindering performance, and to provide on-the-job guidance related to skills. The timing of the follow-up was such that it preceded the annual review of the FP training project scheduled for June 1996. This was to maximize the use of follow-up results during the review meeting, for training project performance monitoring/planning to solve nontraining needs and to direct future refresher courses.

Another purpose of the follow-up was to document the contribution of the FP training program efforts to FP service expansion, accessibility, quality and quantity through observation of service providers trained in 1995 at their worksite and through review of service data. The original follow-up sample included 30 clinical FP service providers in Dar-es-salaam and Mbeya regions who had received training between April and November 1995. The bias toward these two regions was because they were easily accessible by road and had a pool of service providers trained in Basic and Comprehensive clinical skills. In addition, by virtue of their individual location and characteristics, clinics in Dar-es-Salaam essentially serve an urban population, while clinics in Mbeya serve a rural population. The similarities and differences between the two regions offered the opportunity to examine trainee performance by course type and to examine the relative change in the quantity of services offered in urban compared to rural clinics.

Out of the 30 trainees identified for follow-up, 29 were actually visited at worksite (16 in Dar-es Salaam and 13 in Mbeya). The majority (72%) of the trainees worked in dispensaries, five in hospitals and three in health centers. The distribution by health worker category revealed that the sample members were mostly MCH Aides (8), PHNA/B (9), and Nurse Midwives (8). The sample was almost evenly divided by course type received. Sixteen trainees had been trained to provide Comprehensive FP clinical services, while 13 had training in Basic Clinical FP skills. Due to time limitations, the

sampling plan designed for the follow-up could not be used in urban areas, making the urban/rural comparisons described above impossible.

Although all but one trainee reported that they had the opportunity to apply new skills immediately following graduation, retention of knowledge among those evaluated was found to be relatively low. Only 4 out of 29 trainees scored above the acceptable cut-off score on a test of the eligibility criteria of all FP methods. Similarly, the quality of overall performance of the trainees was found to be weak. This was illustrated by the poor performance of the trainees on six out of nine FP-related jobs. Trainees who had received Comprehensive Clinical Skills training performed better than trainees with Basic Clinical Skills training. Conclusions about trainees' competence in performing most jobs should be interpreted with caution since few trainees were observed performing any job. General competence in performing IUCD insertion and pelvic examinations is particularly difficult to assess since only one trainee was observed performing each task.

Among the factors cited by trainees and their in-charges as contributing to hindering trainees' performance were irregular or no supportive supervision, lack of follow-up and the absence of some vital supplies and equipment, e.g., IUCD kits, JIK and gloves. One recommendation put forward by trainees and their in-charges for improving trainees' performance was for FPU to explore mechanisms for providing refresher training for service providers.

The effects of training on service provision was investigated by examining changes in the quantity of services offered following training of the service provider selected for follow-up by FP method. The investigation was done separately for SDPs with only one trained service provider and SDPs with more than one trained service provider. Increases of new clients and revisits were evident after training of the service provider selected for follow-up for both categories of SDPs. The increase was more dramatic for clients choosing Depo provera®. In Mbeya region, for example, the mean number of new clients on Depo provera® in SDPs with only one trained service provider increased from 2 to 7 clients per SDP per month following training. Revisits represent counts of services and a single client may be represented in the revisit count more than once. The number of revisits did increase but it is not possible to tell from these data what portion of revisits was by new users of each method and what portion was made by previous users. Neither can one assess who has changed methods.

Access to FP services is known to influence contraceptive acceptance and continuation. One aspect of access which was measured during this follow-up was the increase in the number of SDPs with trained service providers between March 1995 and April 1996, for one district in Dar-es Salaam and three districts in Mbeya Region. Districts showing the biggest increases were Kyela District in Mbeya Region and Temeke District in Dar-es Salaam regions respectively. In Temeke, FP services were offered by trained service providers in 13 out of 32 SDPs (41%) in March 1995. By April 1996, almost all (91%) SDPs had at least one trained service provider. Ten additional SDPs were strengthened in Kyela district between March 1995 and April 1996, increasing the total number of SDPs with trained service providers from 2 to 12 SDPs. The relationship between physical access and service utilization has been difficult to show in prior studies (Evaluation

project 1994). Data compiled for all 116 SDPs with MCH/FP services in Mbeya indicated a gradual increase in the number of new clients and revisits between March 1995 and February 1996. This increase corresponded with the increase in the number of SDPs with trained service providers during the same period but may also by due to other factors that could not be assessed such as changes in the population.

In conclusion, the results obtained from this follow-up indicate that there is a tendency for trainees to quickly lose the knowledge and skills gained during training in the absence of supportive supervision and effective mechanisms for refresher training. Despite this drawback, the data also show gradual increase in FP acceptance and continuation in an SDP following training of a service provider. These results lend support to the assumption that the demand for FP exists in Tanzania, if an appropriate system of providing trained service providers is developed and an adequate contraceptive supply is available.

I. BACKGROUND AND RATIONALE FOR THE FOLLOW-UP OF FP/RH SERVICE PROVIDERS

The Tanzania INTRAH/PRIME training and technical assistance project supports FPU's efforts to meet the demand for family planning services and increase the contraceptive prevalence rate (CPR) from 5.9% to 8% by 1999. The focus of training efforts has been the expansion and acceleration of the FP training program in order to improve service coverage, improve quality, strengthen capability and capacity and expand training to new service provider groups.

In this phase of the project, which was initiated in March 1995, FPU takes leadership in the training of service providers and trainers while INTRAH's technical assistance is directed mainly toward strengthening of management of the training program.

From March 1995 to April 1996, the National Family Planning Programme trained a total of 595 clinical service providers selected from the Ministry of Health and non-governmental organizations MCH/FP clinics with funding support from USAID and UNFPA nationwide. Other donor agencies such as ODA and Pathfinder International supported training at regional levels. The training sessions were conducted by trainers trained under FPU management.

During each training activity, the performance of every trainee is systematically analyzed at pre- and post-training phases to determine acquisition of competence. A trainee's level of competence is established by a comparison of pre- and post-test scores against pre-determined cut-off scores. In virtually all the training conducted so far, the proportion of trainees achieving the minimum level of acceptable performance at the post-training (ie., scoring above the cut-off score), has been significantly higher than the proportion achieving the minimum level of acceptable performance at the beginning of training. On the basis of this positive outcome, trainees have been judged as competent for performing the jobs for which they are trained and the training activities are, therefore, seen as effective.

However, training activities are considered effectively completed only after an assessment of job performance has been made at the worksite. This assessment is to determine if the performance of service providers meets professional and organizational standards and is known as performance evaluation.

Performance evaluation is usually conducted by means of **trainee follow-up**. Ideally, trainee follow-up is conducted 3 to 6 months after training, but the frequency is often influenced by the resources available and the objectives of the follow-up. Follow-up is usually scheduled before annual or mid project reviews in order to maximize the use of the results for training project performance monitoring and to direct refresher training programs. The last follow-up was

conducted two years ago. The current follow up was conducted to evaluate the performance of service providers trained in 1995.

II. PURPOSE AND SPECIFIC OBJECTIVES OF THE FOLLOW-UP

2. 1 Purpose

To document the contribution of the FP training program efforts to FP service expansion, accessibility and quality and quantity of services, through observation at the worksites of service providers trained in 1995 and through review of training and service data.

To train regional FP personnel to conduct trainee follow-up evaluation.

2.2 Specific Objectives

The objectives of the 1996 follow-up were to:

1. Establish the extent to which end-of-training competence has been maintained at the worksite.

2. Compare post-training functions and performance status of trainees with the jobs/tasks for which training was conducted in order to determine their consistency.

3. Review the clinic service statistics in order to determine the degree to which application of learning to the actual work environment has resulted in a change in the quality and/or quantity of services offered.

4. Provide performance-related feedback to trainees to support improved job performance.

5. Obtain information on the training and non-training related causes of performance problems and to seek solutions.

6. Inform the supervisor about on-the-job or other training needed by trainee.

7. Identify training needs:

   a) to be addressed on the job by the supervisor;

   b) to be addressed through other mechanisms.

8. Examine district supervisors' staffing and service statistic records by clinic to determine the extent to which new service sites have been staffed or strengthened with FP trained personnel.

III. METHODOLOGY

3.1 Follow-up population

One of the objectives of the follow-up was to determine the extent to which the training received resulted in changes in the quality and/or quantity of FP services delivered. In the Tanzanian FP environment, changes in the quantity of FP services delivered are more likely to occur within six months after training. The 6-month interval allows for sufficient time for the new graduates to prepare themselves to perform their new roles as service providers. It also gives an adequate period for clinic in-charges to obtain the resources necessary to support the trainees' performance at their worksite.

Based on 6-month interval required to detect training effects on service, the population eligible for follow-up was all service providers who completed training within the 6-12 months (April to November 1995) prior to the follow-up.

3.2 Selection of Regions for Follow-up

During the training period for which follow-up was being conducted (April to November 1995), 13 FP clinical skills courses (6 BCS and 7 CCS courses) were conducted for trainees from 11 regions. However, only 2 out of the 11 regions were selected for this follow up. It was necessary to restrict the number of regions to 2 due to the limited availability of funds for the activity and the need to obtain results as quickly as possible for use in the annual project review scheduled for June 1996.

Dar-es Salaam and Mbeya regions were selected for the follow-up evaluation. Dar-es Salaam is the administrative capital of Tanzania. Mbeya is situated about 950 kilometers from Dar-es Salaam. The choice of these regions was influenced by 3 factors. First, there was a need to minimize travel costs. Second, selection of these regions allowed for examination of trainee performance by course type. Third, it was possible to examine the relative change in the quantity of services offered in urban compared to rural clinics following training of a service provider.

Most service delivery sites in Dar-es Salaam and Mbeya Regions are easily accessible by road. In addition, BCS and CCS courses had been conducted for trainees located in these two regions. Therefore, a pool of trainees was available from which a sample could be selected to represent both course types. By virtue of the location of the two regions, the majority of trained service providers in Dar-es Salaam serve an essentially urban population, while those in Mbeya serve mainly a rural population. This

difference provided an opportunity to examine the quantity of services offered by rural vs. urban worksite location

3.3 Sampling Frame and Selection of the Follow-up Sample

Clinical FP trainees who completed training between April and November 1995 and who worked in service delivery points in the Dar-es Salaam and Mbeya regions formed the sampling frame (Table 1). A total of 132 trainees in the two regions were eligible for follow-up. One-third were in the Dar-es Salaam region and two-thirds in the Mbeya region. About one-third of trainees in each region received BCS and two-thirds received CCS. The size of the sample of trainees to be followed was influenced by time limitations. It was estimated that within the two weeks allocated for data collection, the data collection team would be able to visit a maximum of 15 trainees in each region. This total sample size of 30 trainees (of 132) constituted 23% of trainees eligible for follow-up in both regions (Table 1). Thirty-four percent of eligible trainees in Dar-es Salaam region were sampled while 17% of eligible trainees in Mbeya region were selected.

To select the follow-up sample, trainees were stratified by type of FP clinical training received. The sample members were selected from each stratum using random sampling procedure. The number of trainees sampled from each stratum was proportional to the representation of that stratum in the group as a whole. Due to time constraints, this sampling frame was used for the Dar-es Salaam but not for Mbeya where a convenience sample was selected.

Table 1 - Distribution of Clinical Training Courses Conducted within the Target Dates by Date, Type, and Venue of Training, and Number of Trainees

Dates Of Training	Type Of Training	Training Venue	Number Of Trainees
3rd Jul. - 6th August. 1995	BCS	Dar-es Salaam	15
5th June - 7th July 1995	CCS	Dar-es Salaam	14
3rd July. - 6th August. 1995	CCS	Dar-es Salaam	15
20th March - 21st April 1995	CCS	Mbeya	15
17th July - 11th Aug 1995	BCS	Mbeya	15
14th Aug. - 22nd Sept. 1995	CCS	Mbeya	14
21st Aug - 23rd Sept 1995	CCS	Iringa (for Mbeya trainees)	14
21st Aug. - 23rd Sept. 1995	CCS	Mbeya	15
16th Oct - 11th Nov 1995	BCS	Mbeya	15
Total			132

3.4 Composition of the Follow-up Team

Two teams conducted the follow-up with one team assigned to each of the two regions. Each team was comprised of four team members, each of whom met one or more of the following criteria:

- some background/experience in performance assessment methodology and follow-up management
- being a member of a training team
- having a supervisory relationship to trainee

To meet these team membership criteria, each team was composed of two trainers, one Maternal and Child Health Coordinator and an overall team leader. A Central Training Team (CTT) member served as team leader for the Mbeya team and the INTRAH Regional Research and Evaluation Officer led the Dar-es Salaam team.

3.5 Planning for Data Collection

Planning for the follow-up activity took place between the 9th and 11th of May 1996. The planning group consisted of the CTT member, the INTRAH Evaluation and Research Officer and the other Dar-es Salaam team members, with planning guided by the CTT member and the INTRAH Regional Evaluation and Research Officer. During the planning, the team familiarized itself with the objectives of the follow-up activity and the criteria used for the selection of the regions. The team utilized the proposed sampling plan for the selection of the fifteen trainees to be followed up in Dar-es Salaam.

The planning team members also received an orientation on the use of new and existing instruments which would be used for data collection. The new instruments were pre-tested in the MCH/FP clinic in Amtullabai Health Center located in Dar-es Salaam region. Following pre-testing, the instruments were revised based on the field results.

During a one-day planning session in Mbeya, the CTT representative provided a similar orientation to the Mbeya team on the purposes and objectives of the follow-up and on the use of the revised instruments. A convenience sample was chosen in Mbeya due to time limitations.

3.6 Instruments

Eight instruments were used to collect the required information. Seven were developed specifically for this follow-up and the eighth represented an existing set of instruments (Table 2).

The newly developed instruments were:

i) **Questionnaire for Trainees *(Questionnaire 1)***

The purpose of this questionnaire was to:

- document FP/RH functions of trainees after their training
- document factors which prevent and/or enhance trainees' performance
- document the availability and use of training-related documents at worksite
- assess trainees' knowledge of the eligibility criteria for all FP methods

ii) **Data sheets for Compiling Information on FP/RH service Delivery *(Forms 1-7)***

- *Form 1*- data sheet to document the number of new clients and revisits, by FP method for the 6 months before and 6 months after training. Provision was also made for recording the number of cases referred for other FP/RH services and the number of STD cases managed at the site.

- *Form 2* - summary sheet for recording the data obtained on new clients and revisits (Form 1) aggregated by 6-month periods prior to and after training.

- *Form 3* - data sheet for classification of cases referred by type of problem or service needed for the 6 months before and 6 months after training.

- *Form 4* **-** data sheet for documenting whether or not each activity listed in the trainee's Back Home Application Plan was implemented as planned.

- *Form 5* - data sheet for collecting information on the extent to which service sites at the district level were strengthened.

- *Form 6* - summary sheet for documenting training and non-training causes of performance problems and the solutions proposed by the trainee and the in-charge for solving these problems.

- *Form 7*- data sheet for compiling FP/RH service data at the district level for the period between April 1995 to March 1996.

The existing standard set of instruments for assessing performance was:

- **Pre/Post Training Skills Assessment Tools *(PTSA)*** - This set of instruments was used to assess the trainees' performance level, for any FP job performed by the trainee at the time of the visit.

3.7 Data Collection Procedures

Data were collected over a period of 10 working days (May 13th to May 24th 1996) in the Dar-es Salaam region. In Mbeya, due to a late start, data were collected over a period of 7 days (May 16th to May 24th 1996). The process of data collection is described below and in Table 2:

- The MCHCo on the team used the questionnaire to conduct an interview with each trainee in the sample. Following the interview, the trainee completed a table on the eligibility criteria for all FP methods.

- The two trainers on the team assessed trainees' level of competence in performing an FP job independently. After the assessment, the trainers compared their ratings for each sub-task. Through discussion, trainers reached consensus on the final score to be assigned in instances where their ratings differed.

- The trainers were also responsible for discussing with the trainees and their in-charges the training and non-training related problems observed to affect trainee performance at work site. Jointly they identified and documented the possible solutions to these problems. Through observation and discussion, trainers also documented the extent of application of trainees' Back Home Application Plans.

- The team leaders were responsible for compiling service data at the clinic sites and at district level through document review.

Table 2 - Summary of Type of Data to be Collected, Information Sources and Instruments

What Was Collected	Source(s) of Information	Instrument(s) Used
Post-training skill level (at worksite)	• Trainee	• PTSA Tools
Knowledge on eligibility criteria for all FP methods	• Trainee	• Questionnaire
Extent of achievement of back home application plans	• Trainee	• Data sheet for compiling information on the extent of achievement of Back Home Application Plans (form 4)
Training and non-training related causes of performance problem	• Trainee • Observation	• Data sheet for compiling information on training and non-training related causes of performance problems (form 6) • Questionnaire

What Was Collected	Source(s) of Information	Instrument(s) Used
Change in quantity of FP/RH services offered at sites where trainees evaluated		
• New clients by method 6 months before and after training.	• Trainee Incharge	• Summary sheet for compiling information on FP/RH service delivery (forms 1 and 2)
• Revisits by method 6 months before and after training.	• Trainee • Incharge	• Forms 1 and 2
• Continuing clients who use condom in addition to another modern FP method (see Section 3.9)	• Trainee • Incharge	• Forms 1 and 2
Extent of strengthening service sites at district level	• DMCHCo	• Data sheet for collecting information on extent service sites were strengthened (form 5)
Number of new clients and revisits between April 1995 and March 1996 by district	• DMCHCo • RCHCo	• Summary sheet for compiling FP/RH service data at district level (form 7)

Note: All instruments used are contained in a separate bound volume

3.8 Data Analysis

The data collected were tabulated manually because the sample size was small. Trainees responses to individual questions were tallied against broad categories. Summary statistics and percentage scores were calculated for each category of response.

Grading rules were established by the trainers for test of knowledge of FP eligibility criteria. The maximum attainable score using these rules was 40 and the cut- off score was set at 25 (60%). Mean percentage scores for all the methods combined and both the number and the proportion of trainees below or above the cut-off points were computed for all methods combined.

For each dimension of performance, mean percentage scores were computed for trainees observed performing the job. The proportion of trainees below or above the established cut-off points was calculated.

For the analysis of the FP service data, service delivery sites visited in each region were classified into 2 groups. One group represented service sites with only one trained service provider and the other represented service sites with more than one trained service provider. Data in each group comes from sites where trainees were evaluated and sites where they were not. The average number of new clients per SDP per month was computed for each group, to reflect the client load before and after training. Similarly, monthly totals for the period April 1995-February 1996 for new and revisits in all SDPs in the selected districts were calculated. The trend by district was presented graphically.

To assess similarities and differences, the responses or indices computed were compared by Region and type of training received.

3.9 Limitations Encountered in the Conduct of Trainee Follow-up

1. Due to time constraints, the sampling plan developed for the follow-up could not be followed in Mbeya region and a convenience sample was selected instead. The urban/rural comparison originally planned could not be conducted because the trainees from Mbeya who were included were primarily urban providers.

2. The follow-up activity was conducted during the rainy season. Unfavorable weather conditions might have resulted in fewer clients seeking FP services on the days of the follow-up visits in both regions. As a result, it was not possible to carry out an assessment of FP skills for some trainees because of low client turn-out at the time of the visit.

3. Lack of equipment (speculum) resulted in failure to assess some of the trainees' competency levels in performing pelvic examination, even when clients were available.

4. Most trainees visited in Dar-es Salaam region could not produce their Back Home Application Plans making it impossible to assess the completion of these plans for that region.

5. The monthly summary record form for all MCH/FP activities (MCH3) makes provision for summarizing FP data on new and continuing acceptors by method only. Data for other service indicators such as clients switching to longer term methods, clients using more than one method at a time, IUCD removals and STD management and referrals could not be obtained from this summary data record.

IV. RESULTS

4.1 Accomplishment of the Data Collection Activity

Table 3 presents a summary of data collection activity. Out of the 30 trainees identified for follow- up, 29 were actually visited at their worksite. The Dar-es Salaam team visited one extra trainee in addition to the 15 in their sample while the Mbeya team saw 13 of 15 in their sample.

Seventy two percent (21 of 29) of the trainees worked in dispensaries, 5 worked in hospitals and 3 worked in health centers. The 16 service delivery points in which the trainees worked in Dar-es Salaam were located in Ilala, Kinondoni and Temeke districts. In Mbeya, the 13 SDPs were located in Mbeya Urban, Kyela and Rungwe districts.

Service data was compiled for 27 of 29 service sites.

The performance of 20 out of the 29 trainees (69%) was assessed through observation. In all, trainees were observed performing a total of 9 FP jobs.

Table 3 - Summary of Data Collection Activity

	Dar-es Salaam	Mbeya	Total
Number of trainees targeted for follow-up	15	15	30
Number of trainees actually followed up at the worksite	16	13	29
Number of trainees whose skills were assessed at the worksite	11	9	20
Clinic sites visited by type			
• Hospital	2	3	5
• Health Centers	0	3	3
• Dispensaries	14	7	21
Number of health units for which service data was compiled	14	13	27

4.2 Profile of FP Trainees Participating in the Follow-up Evaluation and their Work Environment

4.2.1 Profile of FP trainees

A profile of the trainees assessed in the follow-up evaluation is essential to the interpretation of the results. Table 4 gives the distribution of the trainees by cadre, type of training received and work location. In Table 5, the distribution by cadre and type of course received is presented.

Five cadres are represented in the group of trainees who were evaluated. These include MCHAs, Nurse Midwives, PHNA/Bs, Medical Assistants and Rural Medical Aides. The Medical Assistant and Rural Medical Aides are represented only in the Mbeya sample.

The sample is almost evenly divided by course type received. Sixteen trainees had received Comprehensive Clinical Skills (CCS) training while 13 trainees had received Basic Clinical Skills (BCS) training. Eight out of the 13 trainees with BCS were located in SDPs in Mbeya Region. In Dar-es Salaam, trainees with CCS were in the majority.

All Nurse Midwives and the Medical Assistant received CCS training. Of the 9 PHNA/Bs, 7 received CCS and 2 BCS training. All MCHAs and RMAs in the sample received BCS training.

4.2.2 Work Environment

The majority (72%) of trainees worked in dispensaries, 5 worked in hospitals and the remaining 3 in health centers. Two of the hospitals located in Dar-es Salaam and 2 of the 3 health centers in Mbeya served as practicum sites for FP clinical training. These health centers and one hospital in Mbeya have received INTRAH equipment. In Dar-es Salaam, only one of the 16 SDP sites visited (a hospital) had received similar equipment.

Trainees apparently had access to training-related documents for use as reference materials in their clinics. In almost all 29 SDPs, procedure manuals and a copy of the policy guidelines were observed to be available for use. Half of the trainees visited at worksite had their handouts which had been distributed during training.

Table 4 - Profile of the FP Trainees Participating in the Evaluation

Characteristics	Dar-es Salaam	Mbeya	Total
Cadre			
MCHA	3	5	8
Nurse Midwife	5	3	8
PHNA/B	8	1	9
Medical Assistant	0	1	1
Rural Medical Aide	0	3	3
Type of training received			
BCS	5	8	13
CCS	11	5	16
Type of SDP			
Hospital	2	3	5
Health Center	0	3	3
Dispensary	14	7	21

Table 5 - Distribution of Trainees by Cadre and Type of Course Received

	Dar-es-salaam		Mbeya		Total	
Cadre	BCS	CCS	BCS	CCS	BCS	CCS
MCHA	3	0	5	0	8	0
Nurse Midwife	0	5	0	3	0	8
PHNA/B	2	6	0	1	2	7
Medical Assistant	0	0	0	1	0	1
Rural Medical Aide	0	0	3	0	3	0

4.3 Post-Training Functions and Extent of Achievement of Back Home Application Plans

4.3.1 Post Training Functions

All but one trainee reported that they provided FP services immediately after graduation. To assess the types of FP/RH activities that trainees perform most frequently following training, trainees were asked to report how often they performed each activity on a scale ranging from "very often" to "not at all", described below:

- very often (3-5days a week)
- often (1-2 days a week)
- sometimes (at least once every month)
- rarely (at least once every 3 months)
- not at all

Each response on the frequency scale was assigned points ranging from 4 for "very often" to 0 for "not at all". An overall score representing how frequently an activity was performed was computed by multiplying the number of trainees reporting that frequency by the number of points assigned to that frequency and summing the scores for each frequency category for each activity.

The number of trainees performing each activity by the frequency of performance is provided for each region as Appendices 1 and 2.. Table 6 gives the summary scores for the frequency of performing each FP/RH activity and ranks activities by frequency . The table indicates that the FP activities trainees perform more frequently in Dar-es Salaam and Mbeya include: counseling/educating clients for FP services, counseling for informed choice, conducting physical assessment for contraception and giving instructions on use of FP methods. Performing pelvic examinations for FP was a frequent activity in Dar-es Salaam but not in Mbeya. Those that are performed less frequently include: pelvic examination for FP (Mbeya only), inserting IUCD, managing clients with side effects or complications due to the use of FP methods, screening and managing clients for STD and referring FP clients for other services. It should be noted that data on the frequency of managing clients for STDs exists for only 11 of 16 trainees in Dar-es Salaam.

4.3.2 Trainees' Perceptions of the Benefits/Implications of Training

The trainees' overall perception of the training was positive. The benefits of training were described as:

- confidence in providing FP services
- improved knowledge of FP methods and eligibility criteria
- acquiring skills to provide a variety of FP services
- the ability to identify high risk clients
- the ability to manage clients with problems related to FP method use

The trainees reported the followed perceived changes in services as a result of their training:

- increase in the number of new and continuing acceptors
- decrease in the number of revisits with side effects
- provision of a variety of FP methods (method mix)

4.3.3 Extent of Achievement of Back Home Application Plans

The relevance of developing Back Home Application Plans during training was not clearly appreciated by all trainees. Of the 16 trainees visited at their worksite in the Dar-es Salaam region, only four (25%) produced their Back Home Application Plans for assessment of the extent of achievement of these plans. In Mbeya, however, plans were available for review for 12 of the 13 trainees (92%).

Among those trainees who were able to produce their plans, trainees had generally not been able to completely implement their plans by the time of the follow-up. Thirty of 47 activities (62%) listed in the plans developed by the 12 trainees in Mbeya had been implemented Trainees with CCS training had succeeded in implementing more activities (73%) than their counterparts with BCS training (55%).

Table 6 - Frequency of Performing FP/RR Procedures after Training with Rank

Activity	Dar-Es-Salaam N=16		Mbeya N=13	
	Score	Rank	Score	Rank
Counseling/educating clients for FP services	60	1	50	1
Counseling for informed choice	60	1	47	3
Giving instructions on injectables	59	2	47	3
Giving instructions on condoms	58	3	40	6
Giving instructions on combined oral contraceptives	57	4	44	4
Giving instructions on progestin only pills	57	4	50	1
Conducting physical assessment for contraception	50	5	48	2
Performing pelvic examinations for FP	34*	6	15	12
Giving instructions on IUCD	34	6	41	5
Managing clients with side effects or complications related to Combined oral contraceptives:	23	7	20	11
Referring FP clients for other services	22	8	24	9
Managing clients with side effects or complications related to injectables	21	9	27	8
Managing clients with side effects or complications related to progestin only pills	20	10	29	7
Inserting IUCD - CuT 380, 380a	18	11	13	14
Managing clients with side effects from complications related to IUCD	13	12	14	13
Screening clients for STD	11	13	22	10
Managing clients for STD	4**	14	29	7

*n=15

**n=11

4.4 Trainees' FP Knowledge and Quality of Performance

4.4.1 Knowledge of Eligibility Criteria for all FP methods

For each FP method, trainees were asked to identify who could use the method, who could use it with consideration, and who could not use it. Knowledge on the eligibility criteria for all FP methods was generally weak. Only 4 of the 29 trainees (2 from Dar-es Salaam and 2 from Mbeya regions) achieved the level of 60% determined as acceptable by the team (Table 7). The 4 trainees scoring above the acceptable score had received Comprehensive FP services training (Table 8).

4.4.2 Quality of Performance

The average quality of trainee performance was below the acceptable level for 6 of 9 jobs explored by the performance assessment (Table 9). The jobs which were most poorly performed were pelvic exams and giving instructions on combined oral contraceptives. Performance was relatively better for counseling for informed choice and IUCD insertion. Conclusions about trainees' competence in performing most jobs should be interpreted with caution since few trainees were observed performing any job. General competence in performing IUCD insertion and pelvic examinations is particularly difficult to assess since only one trainee was observed performing each task.

As expected, the performance scores were generally higher for those trainees who had received Comprehensive Clinical Skills (CCS) training than for those who had received Basic Clinical Skills training (BCS) (Table 10). Three factors possibly contribute to the weaker performance among trainees with BCS.

i) The trainees are often of a lower cadre (MCHAs and RMAs).

ii) The courses are frequently conducted in Swahili but handouts are in English. Trainees may therefore have difficulties in interpreting the information contained in the handouts.

iii) The duration of practice for BCS courses is 2 weeks as opposed to 3 weeks for CCS courses. Trainees with BCS are, in effect, expected to acquire FP skills within a shorter period of time.

As was noted above, the results of the evaluation of the quality of performance must be interpreted with caution. Very few trainees were observed performing any task and the performance of these trainees may not represent the performance of the group as a whole.

Table 7 - Percentage Knowledge Scores on FP Eligibility Criteria

Maximum expected score = 40
Cut-off percentile = 60%
Cut-off score = 25

Region	Number of Trainees	Mean % Score	No/% of Trainees above or at Cut-off point	No/% of Trainees below Cut-off point
Dar-es Salaam	16	46%	2 (12.5%)	14 (87.5%)
Mbeya	13	41%	2 (15.4%)	11 (84.6%)
Total	29	44%	4 (13.8%)	25 (86.2%)

Table 8 - Percentage Knowledge Scores on FP Eligibility Criteria by Type of Training Received

Maximum expected score = 40
Cut-off percentile = 60%
Cut-off score = 25

Region	Number of Trainees	Mean % score		Number (%) above or at Cut-off point	
		CCS	BCS	CCS	BCS
Dar-es Salaam	16	47% (n=11)	41% (n=5)	2 (13%)	0(0.0%)
Mbeya	13	48% (n=5)	38% (n=8)	2 (40%)	0 (0.0%)
Total	29	44% (n=16)	39% (n=13)	4 (25%)	0 (0.0%)

Table 9 - Mean Performance Scores at Assessment at the Worksite by FP Job Assessed (Dar-es Salaam and Mbeya)

Job	Number of Trainees Assessed	Mean % score	Cut-off score (%)	Comments
Group client education	3	57	60	Below cut-off
Instructions on combined oral contraceptives	3	32	65	Below cut-off
Counseling for informed choice	7	58	53	Above cut-off
Counseling high risk clients	4	44	57	Below cut-off
Physical Exam	3	41	41	At cut-off
Physical and Pelvic Exam	4	41	43	Below cut-off

Pelvic Exam	1	32	60	Below cut-off
IUCD Insertion	1	61	54	Above cut-off
Maintaining asepsis	2	77	100	Below cut-off

Table 10 - Mean Performance Scores above and below the Cut-off by Type of Clinical Skills Training Course (Dar-es Salaam and Mbeya)

Job	Cut-off Score Overall Mean Score (%)	Mean Score (%) (N)		
			CCS	BCS
Group Client Education	Cut-off score = 60% Mean score = 57%	Above	94 (1)	
		Below		39 (2)
Instructions on combined oral contraceptives	Cut-off score = 65% Mean score = 32%	Above		
		Below	39 (2)	19 (1)
Counseling for informed choice	Cut-off score = 53% Mean score = 58%	Above	68 (1)	82 (2)
		Below	41 (3)	51 (1)
Counseling high risk clients	Cut-off score = 57% Mean score = 44%	Above	82 (1)	61 (1)
		Below		17 (2)
Physical examination	Cut-off score = 41% Mean score = 41%	Above	56 (1)	45 (1)
		Below		21 (1)
Physical and pelvic examination	Cut-off score = 43% Mean score = 41%	Above	52 (2)	51 (1)
		Below		9 (1)
Pelvic examination	Cut-off score = 60% Mean score = 32%	Above		
		Below	32 (1)	

IUD insertion	Cut-off score = 54% Mean score = 61%	Above	61 (1)	
		Below		
Maintaining asepsis	Cut-off score = 100% Mean score = 77%	Above		
		Below	77 (2)	

4.5 Hindering and Helping Factors Influencing Trainee Performance

4.5.1 Hindering Factors

A number of factors that hinder trainee performance and service provision were identified by the trainees and the clinic in-charges. These factors and proposed solutions are summarized in order of priority for Dar-es Salaam and Mbeya separately (Tables 11 and 12).

Irregular or no supportive supervision and lack of follow-up was reported as a hindering factor by trainees in both regions, but was reported more frequently by trainees in Dar-es Salaam. Lack of necessary equipment and supplies was also commonly reported by trainees in both regions. These included examination couches, IUCD Kits, Jik and gloves. Another important factor which contributed to low performance standards among trainees in Dar-es Salaam was the persistent use of outdated FP practices.

Recommendations were made for provision of basic FP equipment and supplies, for conducting regular follow-ups and for refresher courses.

4.5.2 Helping Factors

Four major factors were identified as having contributed to supporting trainees' performance at the worksite. These factors were:

- deployment in MCH/FP clinics immediately after training (26)
- support from other FP service providers in the same clinics for solving FP-related problems (17)

- supportive supervision through face-to-face dialogue with the major aim of improving quality of service (16)

- availability of the necessary equipment and supplies (9)

Table 11 - Hindering Factors and Proposed Solutions (Dar-es Salaam)

Hindering factors	Number of Trainees Reporting Problem	Proposed Solutions
Adherence to outdated FP practices. For example, a client requesting pills was asked to return to the clinic at the end of her menstrual period.	11	FPU to explore mechanisms for providing refresher courses for service providers, and for conducting frequent follow-up for trainees. Supervisors and Trainers to provide Service Provider with any new FP update during follow-up visits.
Supervision is irregular and does not solve the FP problems encountered by trainees. Trainees therefore, become unmotivated and this leads to poor performance.	10	Supervisors and trainers to do frequent follow-ups, specifically to monitor FP performance.
Lack of equipment and supplies e.g., Speculum, IUCD kits, sterilizers, cupboards, jik, gloves) . Procedures requiring the use of such instruments are performed below the required standard.	10	Supervisors to seek help from FPU.
Only one trained service provider in clinic, therefore, heavy workload. The SP cannot maintain quality care	5 (Parastatals and NGOS)	RMCHCo and DMCHCo to communicate with FPU for the possibility of training more service providers.

No separate room for FP services. Clients are deprived of confidentiality. Service Provider omits important information due to the presence of other clients.	4	Supervisors to communicate with FPU and/or inform the authorities concerned in Rangi Tatu, Chanika, Ufi, Marie Stopes (Mabibo) and Railways.
Rooms for FP are too small to ensure privacy.	4	Supervisors to request for help from FPU /authorities concerned
No MCH services offered therefore limited opportunities for recruiting new clients. This leads to loss of skills because of lack of practice.	5 •TOHS (Morogorstore) •NPF •Railways •Marie Stopes (Mabibo) •NBC (Twiga)	RMO, RMCHCo and OTTU to consult with the Parastatals on the need to run integrated FP with MCH services.

Table 12 - Hindering Factors and Proposed Solutions (Mbeya)

Hindering Factors	Number of Trainees Reporting Problems	Proposed Solutions
Lack of equipment and supplies e.g., IUCD kits, speculum, Jik, gloves. This results in loss of skill in pelvic exam and IUCD insertion due to lack of practice.	12	FHP and FPU to provide equipment and supplies Use User Changes funds to purchase supplies.
Male resistance to FP. Clients, therefore, prefer Depo and clinics cannot easily achieve method mix.	5	Involve men during client education. Involve village and community leaders in discussions about FP .
Absence of other trained service providers in same clinics, resulting in heavy workload and poor quality services.	6	FPU to train more service providers in same SDP.
Irregular or no supervision of FP service providers at worksite.	2	DMCHCo to do regular supervision. FHP to provide vehicles for supervision.

Lack of IEC materials. There is no other access to FP information, thus fewer clients are motivated sufficiently to seek FP services.	1	IEC activities should be decentralized to ensure maximum awareness creation among the community members.
Heavy client load resulting in difficulties in effectively conducting counseling for informed choice.	1	RTTs to offer TA on how to shorten counseling for informed choice.

4.6 Effects of Training on FP service

4.6.1 Service Utilization

a) Changes Observed in SDPs with only One Trained Service Provider

Figures 1 and 2 and Appendices 3 and 4 show the distribution of the monthly average of new clients per SDP by method, for SDPs with only one trained service provider in Dar-es Salaam and Mbeya respectively. The information displayed in these figures shows an increase in the number of new clients recruited particularly for oral contraceptives and for Depo provera®, following training of the service provider. The change is more dramatic for Depo provera®. In Mbeya, the mean number of new clients on Depo provera® increased from 2 to 7 clients per SDP per month (250%). The corresponding change in Dar-es Salaam was from 4 to 10 clients per month (150%). The increase in new users of Depo provera® may have been due to reduced medical barriers for its use, client preference for the method, or effective counseling.

Revisits for clients using Depo provera® increased markedly following training especially in Mbeya Region where the mean number of revisits for this method increased from 2 to 12 clients per SDP per month (500%)(Figures 3 and 4, Appendices 5 and 6). This increase in the number of revisits for Depo provera® in both accompanied the increase in the number of new clients for this method. There was also an increase in the number of revisits for pills although it was less marked, particularly in Mbeya. Revisits represent counts of services and a single client may be represented in the revisit count more than once. The number of revisits did increase but it is not possible to tell from these data what portion of revisits was by new users of each method and what portion was made by previous users. Neither can one assess who has changed methods.

In these service delivery points with only one trained service provider, very few clients were using condoms or other barrier methods such as foam and foaming tablets. In Mbeya, no IUCD insertions were done, possibly because all the trainees received BCS with the exception of one, working in a health center in Mbeya. This Health center however had no equipment for IUCD insertion.

Figure 1:
Average Monthly Number of New Clients per SDP by FP Method before and after Training for SDPs with only One Trained Service Provider
Dar-es Salaam, N=6 (6 Dispensaries)

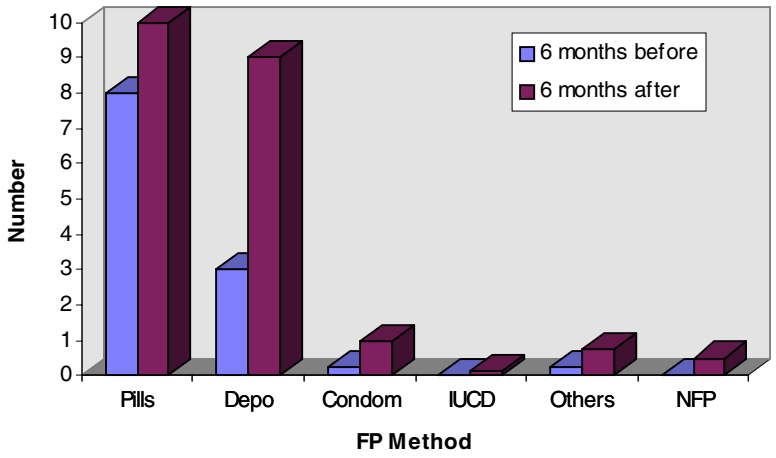


Figure 2:
Average Monthly Number of New Clients per SDP by FP Method before and after Training for SDPs with only One Trained Service Provider
Mbeya, N=5 (1 Health Center, 4 Dispensaries)

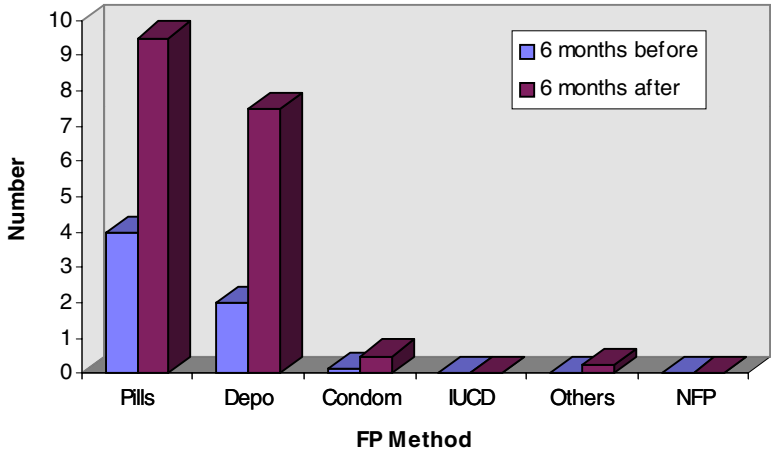


Figure 3:
Average Monthly Number of Revisits per SDP by FP Method before and after Training for SDPs with only One Trained Service Provider
Dar-es Salaam, N=6 (6 Dispensaries)

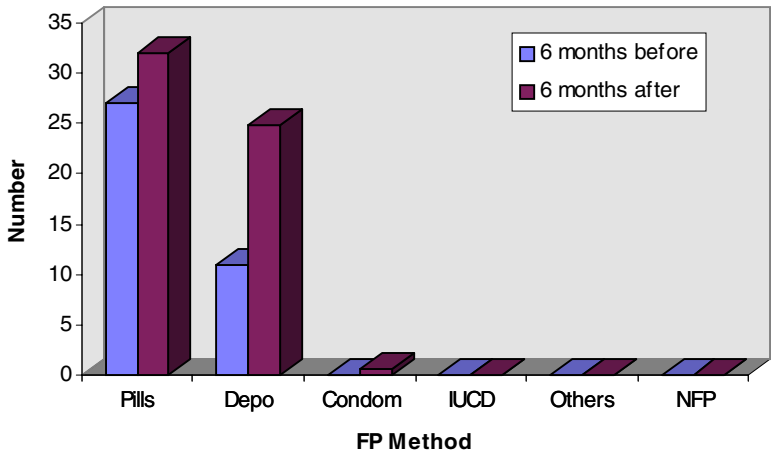
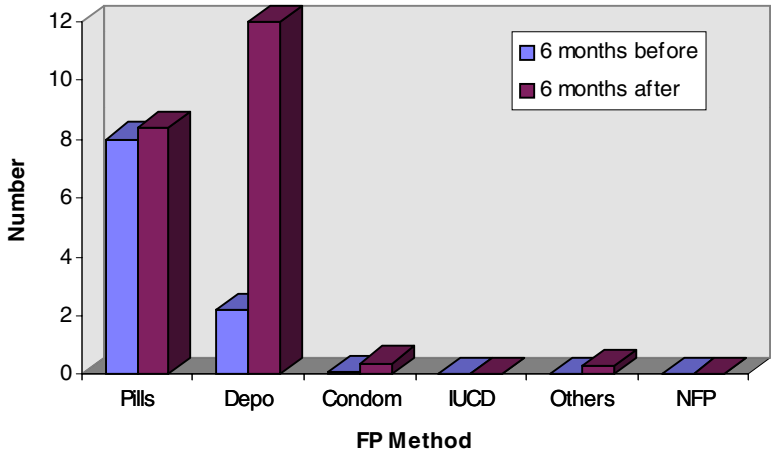


Figure 4:
Average Monthly Number of Revisits per SDP by FP Method before and after Training for SDPs with only One Trained Service Provider
Mbeya, N=5 (1 Health Center, 4 Dispensaries)



b) Changes Observed in SDPs with More than One Trained Service Provider

In all fifteen SDPs , (8 in Mbeya and 7 in Dar-es Salaam) with more than one trained service provider, an increase in new clients and revisits were also evident for most FP methods following training. Generally, the increase in the number of revisits was higher than the number of new clients. Depo provera® was the dominant method followed by pills, condoms, IUCD and other barrier methods (Figures 5 and 6, Appendices 7 and 8).

In Dar-es Salaam and Mbeya, both the number of new Depo provera® users and revisits for Depo provera® increased. Again, the increase in new users of Depo provera® may have been due to reduced medical barriers for its use, client preference for the method, or effective counseling. In both regions, changes in the number of new users of pills and revisits for pills were small.

Although one cannot attribute the changes directly to the presence of the trained service provider in question, positive changes have occurred in service delivery following training of a service provider.

Figure 5:
Average Monthly Number of New Clients per SDP by FP Method before and after Training for SDPs with More than One Trained Service Provider
Dar-es Salaam, N=7 (2 Hospitals, 5 Dispensaries)

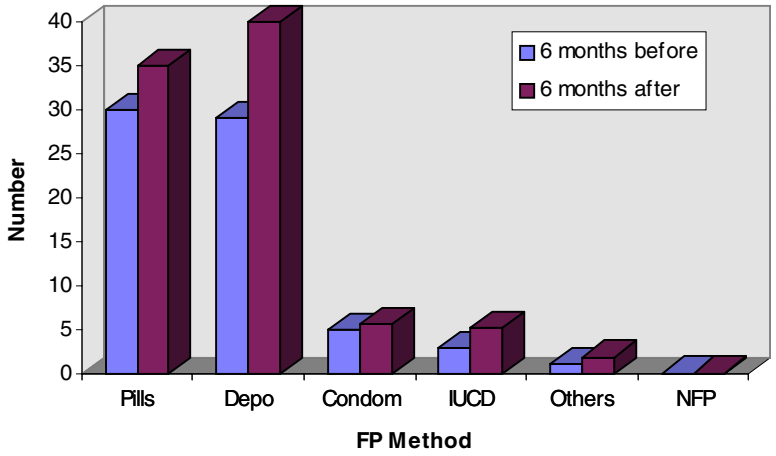


Figure 6:
Average Monthly Number of New Clients per SDP by FP Method before and after Training for SDPs with More than One Trained Service Provider
Mbeya, N=8 (3 Hospitals, 2 Health Centers, 3 Dispensaries)

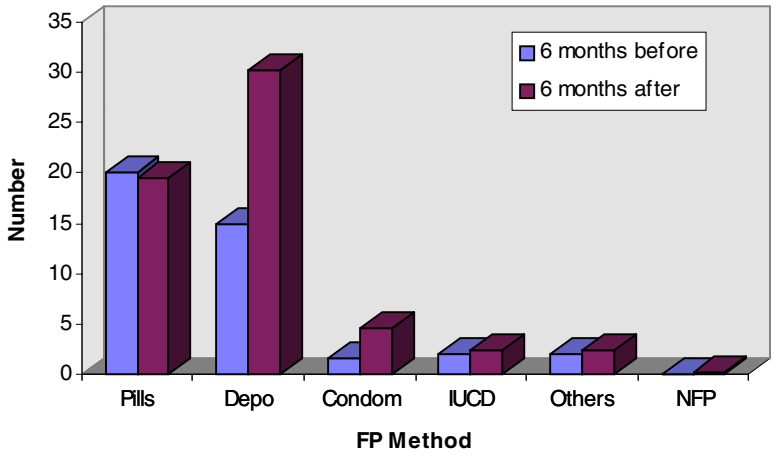


Figure 7:
Average Monthly Number of Revisits per SDP by FP Method before and after Training for SDPs with More than One Trained Service Provider
Dar-es Salaam, N=7 (2 Hospitals, 5 Dispensaries)

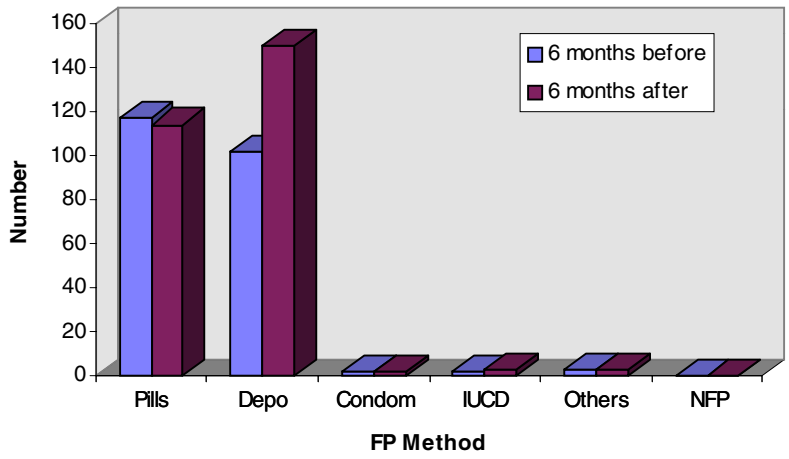
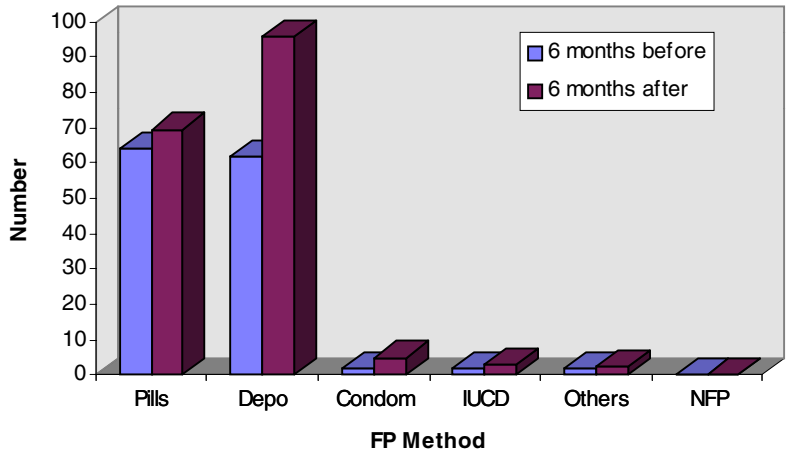


Figure 8:
Average Monthly Number of Revisits per SDP by FP Method before and after Training for SDPs with More than One Trained Service Provider
Mbeya, N=8 (3 Hospitals, 2 Health Centers, 3 Dispensaries)



4.6.2 Physical Accessibility to FP services

Access to FP services influences contraceptive acceptance and continuation. One aspect of access which was measured during this follow-up was the increase in the number of SDPs with trained service providers between March 1995 and April 1996.

Table 13 examines the change in the number of SDPs with at least one trained service provider in the 3 districts in Mbeya and 1 district in Dar-es Salaam from which trainees were selected for follow-up. In each of the 4 districts, the percent of SDPs with at least one trained service provider increased within the reference period. Districts showing the biggest increases were Kyela in Mbeya Region and Temeke in Dar-es Salaam region. In Temeke, FP services were offered by trained service providers in 41% (13 of 32) SDPs in March 1995. By April 1996, 91% of SDPs in this district (29 of 32) had at least one trained service provider, a 123% increase in the number of SDPs with trained providers. In Kyela district in Mbeya region, the number of SDPs with trained service providers increased from 2 to 12 (500%) between March 1995 and April 1996.

The relationship between physical access and service utilization has been difficult to show in prior studies (Evaluation Project, 1994). Figures 9 and 10 display the monthly trend of new clients and revisits for all methods over an eleven-month period for each region. The service data compiled for all 116 SDPs with MCH/FP services for the 3 districts in Mbeya indicates that both the number of new clients and revisits have increased.. This increase corresponds with the increase in the number of SDPs with trained service providers but may also be due to other factors that could not be assessed such as changes in the population. A lack of change in the number of users of services in Dar-es Salaam may be due to decreases in services provided at sites other than those whose providers were evaluated in this follow-up or, as above, may be due to other factors such as changes in the population.

Table 13 - Extent of Strengthening Service Sites at District Level

District	Total number of SDPs in District	Total number of SDPs with Trained SP in March 1995	Total number of SDPs with Trained SP in April 1996	Increase in Number Of SDPs with Trained SP
Mbeya Region				
Kyela	25	2	12	10
Mbeya Urban	37	9	13	4
Rungwe	54	9	12	3
Dar-es Salaam Region				
Temeke	32	13	29	16

Figure 9:
Trend of New Clients and Revisits for All FP Methods for SDPs with MCH/FP Clinics in 3 Districts (N=103)
Dar-es Salaam Region, April 1995 - February 1996

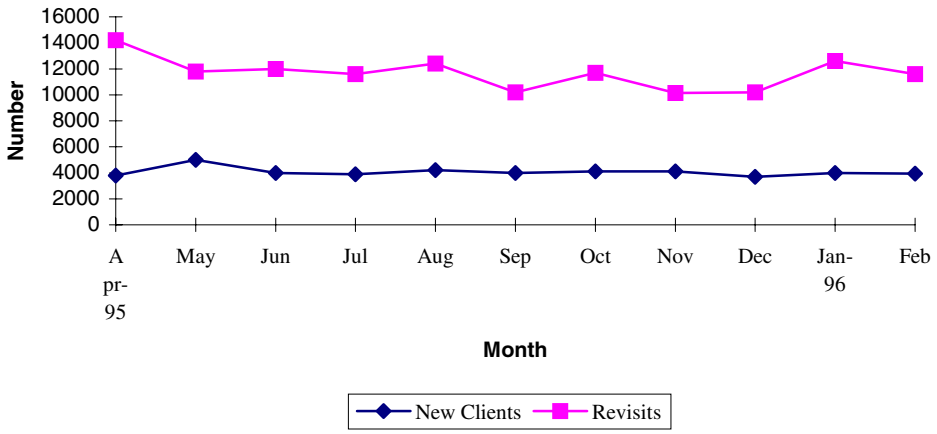
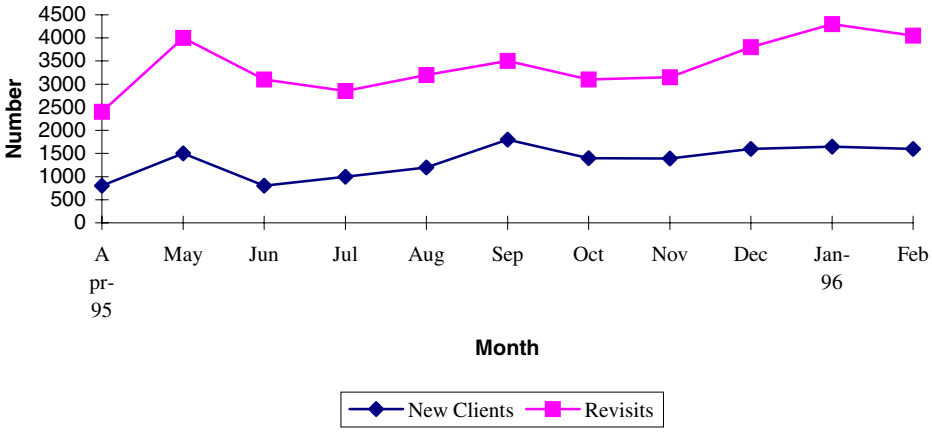


Figure 10:
Trend of New Clients and Revisits for All FP Methods for SDPs with MCH/FP Clinics in 3 Districts (N=116)
Mbeya Region, April 1995 - February 1996



IV. FINDINGS AND RECOMMENDATIONS

1. Finding

Retained knowledge on the eligibility criteria for all FP methods is generally weak. Out of the 29 trainees, only four achieved marks above the cut-off score of 60% for all FP methods combined.

Recommendation

FPU to explore mechanisms for providing refresher courses for service providers**.**

2. Finding

The overall quality of 7 out of 9 jobs explored by the performance assessment was below the acceptable level of performance for these jobs. The jobs for which trainees scored the least were pelvic examination and giving instructions on combined oral contraceptives.

Recommendation

Follow-up and supervision should be done routinely to monitor performance of the FP service providers.

3. Finding

Overall, FP service providers who had been trained in CCS performed better.

Recommendation

FPU to explore the characteristics of BCS and CCS trainees in order to establish the real causes of performance difference.

4. Finding

The medium of instruction for the Clinical Skills Courses (BCS and CCS) is Swahili, but the reference materials are written in English. Trainees might be having difficulties interpreting the information contained in the reference materials.

Recommendation

Training reference materials should be translated into Swahili and distributed.

5. Finding

Only 4 out of the 16 trainees with Comprehensive Clinical Skills training were deployed in SDPs with equipment for IUCD insertion. The remaining 12 trainees with CCS had not had the opportunity to insert IUCDs since training. These trainees are likely to loose their skills with time.

Recommendation

- In the future, participants for CCS training should be recruited from SDPs with IUCD kits or the region should be in a position to provide IUCD kits to the SDPs from which trainees are recommended for CCS training.

- MCHCo that supervise dispensaries of health centers with the dispensary equipment kit should assist the trained FP providers (CCS graduates) to prepare one or two IUCD insertion sets from the kit.

6. Finding

The relevance of developing a Back Home Application Plan is apparently not clearly appreciated by trainees, particularly those located in SDPs in the Dar-es Salaam region. Out of the 16 visited at worksites, only 4 produced their plans for assessment of extent of achievement of the plans.

Recommendation

Trainers should assist trainees in understanding and appreciating the need for developing Back Home Application Plans during training. Supervisors should check and insist on the presence and application of the plans during supervisory visits.

7. Finding

The number of new clients and revisits increased following training of the service provider selected for follow-up. This was true for SDPs with only one trained service provider as well as for SDPs with more than one trained service provider.

8. Finding

The increase in the number of revisits on Depo provera® was very striking. Clients may be switching to Depo due to reduces medical barriers to the use of this method, client preference, or improved counseling technique as a result of training.

Recommendations

- The National Family Planning Programme and other training related NGOs should continue conducting training in the country in order to increase the number of clients recruited for FP and clients retained in the Programme.

- NFPP to explore and implement mechanism or study to find out factors that influence the sharp switch from other FP methods to Depo provera® in order to ultimately prepare relevant guidelines for the purpose of maintaining a balanced FP method unit.

9. Finding

The number of SDPs with at least one trained service provider had increased in Dar-es Salaam and Mbeya Regions since March 1995. The number of SDPs strengthened to provide FP services, in Kyela District in Mbeya Region increased from 2 in March 1995 to 12 in April 1996.

10. Finding

In Mbeya, there had been a steady increase in the number of new clients and revisits for FP during 1995 and early 1996. Mbeya is the region which receives funding and other technical assisted in Family Health.

Recommendation

ODA/ Family Health Project should continue conducting training in Mbeya in order to expand FP services by service providers in the Region.

APPENDICES

Appendix 1: Number of Trainees Performing FP/RH Procedures after Training by Frequency of Procedure, Dar-es Salaam Region (N=16)

Procedure	Very often (*3-5 days a week*)	Often (*1-2 days a week*)	Sometimes (*at least once every month*)	Rarely (*at least once every 3 months*)	Not at all
Counseling/educating clients for FP services	14	1		1	
Counseling for informed choice	14	1		1	
Giving instructions on the following methods:					
- Injectables	13	2		1	
- Progestin only pills	12	2	1	1	
- Combined oral contraceptives	13	1		2	
- Condoms	12	2	2		
- IUCD	7	1		3	5
Conducting physical assessment for contraception	11	1	1	1	2
Performing pelvic examinations for FP	5	2	3	2	3
Managing clients with side effects or complications related to:					
- Injectables	1	1	4	6	4
- Progestin only pills	1		2	12	1
- Combined oral contraceptives	1		5	9	1
- IUCD		1	2	6	7
Inserting IUCD - CuT 380, 380A		2	4	4	6
Screening clients for STD		1	1	6	8
Managing clients for STD		1		1	9
Referring FP clients for other services		2	4	8	2

Appendix 2: Number of Trainees Performing FP/RH Procedures after Training by Frequency of Procedure, Mbeya Region (N=13)

Procedure	Very often (*3-5 days a week*)	Often (*1-2 days a week*)	Sometimes (*at least once every month*)	Rarely (*at least once every 3 months*)	Not at all
Counseling/educating clients for FP services	11	2			
Counseling for informed choice	9	3	1		
Conducting physical assessment for contraception	10	2	1		
Performing pelvic examinations for FP	2	2		1	8
Inserting IUCD - CuT 380, 380A	2	1	1		9
Giving instructions on the following methods:					
- Injectables	9	3	1		
- Progestin only pills	11	2			
- Combined oral contraceptives	8	3	1	1	
- Condoms	8		3	2	
- IUCD	7	2	3	1	
Managing clients with side effects or complications related to:					
- Injectables	3	1	5	2	2
- Progestin only pills	5	1	2	2	3
- Combined oral contraceptives	3	1	1	3	5
- IUCD	2	1	1	1	8
Screening clients for STD	3	1	2	3	4
Managing clients for STD	4	2	3	1	3
Referring FP clients for other services	1	2	7		3

Appendix 3: New Clients Served by FP Method before and after Training of the Service Provider Selected for Follow-up Dar-es Salaam Region SDPs with One Trained Service Provider (N=6)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	272	355	7.6	9.9
Depo	106	302	2.9	8.4
Condoms	7	31	0.2	0.9
IUCD	0	3	0	0.1
Others	6	24	0.2	0.7
NFP	1	11	0	0.3

Appendix 4: New Clients Served by FP Method before and after Training of the Service Provider Selected for Follow-up Mbeya Region SDPs with One Trained Service Provider (N=5)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	100	290	3.3	9.7
Depo	45	218	1.5	7.3
Condoms	4	18	0.1	0.6
IUCD	0	0	0	0
Others	0	10	0	0.3
NFP	0	0	0	0

Appendix 5: Revisits by FP Method before and after Training of the Service Provider Selected for Follow-up
Dar-es Salaam Region SDPs with One Trained Service Provider (N=6)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	935	1,151	26.0	32.0
Depo	354	863	9.9	24.0
Condoms	6	28	0.2	0.8
IUCD	0	2	0	0.1
Others	0	8	0	0.2
NFP	0	6	0	0.2

Appendix 6: Revisits by FP Method before and after Training of the Service Provider Selected for Follow-up
Mbeya Region SDPs with One Trained Service Provider (N=5)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	240	253	8.0	8.4
Depo	70	360	2.3	12.0
Condoms	2	12	0.1	0.4
IUCD	0	0	0	0
Others	0	8	0	0.3
NFP	0	0	0	0

Appendix 7: New Clients Served by FP Method before and after Training of the Service Provider Selected for Follow-up Dar-es Salaam Region SDPs with More than One Trained Service Provider (N=7)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	1,278	1,452	30.0	34.6
Depo	1,221	1,682	29.1	40.0
Condoms	203	258	4.8	6.1
IUCD	146	233	3.5	5.5
Others	83	130	2.0	3.1
NFP	12	15	0.3	0.4

Appendix 8: New Clients Served by FP Method before and after Training of the Service Provider Selected for Follow-up Mbeya Region SDPs with More than One Trained Service Provider (N=8)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	950	910	19.8	19.0
Depo	752	1,459	15.7	30.4
Condoms	91	303	1.9	6.3
IUCD	104	163	2.2	3.4
Others	127	174	2.6	3.6
NFP	6	29	0.1	0.6

Appendix 9: Revisits by FP Method before and after Training of the Service Provider Selected for Follow-up
Dar-es Salaam Region SDPs with More than One Trained Service Provider (N=7)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	4,866	4,609	115.9	109.7
Depo	4,292	6,523	102.2	155.3
Condoms	150	192	3.6	4.6
IUCD	143	156	3.4	3.7
Others	226	245	5.4	5.8
NFP	6	5	0.1	0.1

Appendix 10: Revisits by FP Method before and after Training of the Service Provider Selected for Follow-up
Mbeya Region SDPs with More than One Trained Service Provider (N=8)

Method	Total, New Clients Served in All Sites		Mean Number of New Clients Served per SDP per Month	
	Six Months before Training	Six Months after Training	Before Training	After Training
Pills	3,083	3,252	64.2	67.8
Depo	3,049	4,662	63.5	97.1
Condoms	90	317	1.9	6.6
IUCD	127	233	2.6	4.9
Others	78	179	1.6	3.7
NFP	11	18	0.2	0.4