### Appendix 8-1: Sample Action Plan for Linking Training to Performance

<table>
<thead>
<tr>
<th>Action Plan</th>
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</thead>
<tbody>
<tr>
<td>Learner:</td>
</tr>
<tr>
<td>My Support Team:</td>
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</tbody>
</table>

#### Specific areas to improve:
(Write down distinct accomplishments and activities to achieve)

#### Issues to address:
(Describe the barriers that must be eliminated or reduced and how this will be done)

<table>
<thead>
<tr>
<th>Detailed specific actions (in sequence)—include regular progress reviews with support team as part of the specific actions</th>
<th>Responsible person(s)</th>
<th>Resources</th>
<th>Date/time*</th>
<th>Changes to look for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
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<td>Step 2</td>
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<td>Step 3</td>
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<td>Step 5</td>
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<td>Step 6</td>
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<td>Step 7</td>
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</tbody>
</table>

*Establish set day and time for ongoing activities

#### Commitment of support team:
I support the action plan described above and will complete the actions assigned to me. If I am unable to complete an activity, I will help make arrangements to modify the plan accordingly.

- Signature of learner: _____________________________
- Date: _________________________________________
- Signature of supervisor: __________________________
- Signature of trainer: _____________________________
- Signature of co-worker: __________________________

Appendix 8-2: Training Follow-Up Form

Follow the instructions given below to use this follow-up of training form for providers.6

The purpose of this form is to document:
1. The number of participants who apply their new skills on the job
2. The number of participants who retain their skills competency posttraining
3. The existence of factors limiting the use of participants’ skills on the job

At least one follow-up visit should be conducted, ideally within six months of training, to as many newly trained RH/FP providers as possible. All participants who were rated qualified at the end of the training should be considered candidates for follow-up visit. Facility managers and providers should be notified of a visit in advance, so that the provider (or his or her supervisor) can schedule one or more cases for observation. The evaluator should use the same skills checklist used during the RH/FP training when assessing the provider’s skills at the end of training.

A. General Information

1. Provider’s name: ___________________________________________________________

2. Training event dates: From _______________________ to _________________________

3. Date of visit: __________________________________________________________________

4. Facility name: __________________________________________________________________

5. The provider:
   ___ Is in the same facility as she/he was when trained
   ___ Is in a different facility from when she/he was trained

6. Service procedure being assessed: (check only one per form)
   ___ Counseling ___ Injectables ___ IUD
   ___ Implants ___ No-scalpel vasectomy ___ Minilaparotomy
   ___ Postabortion care ___ Other (specify) __________________________________________________________________

7. Was this service offered in this facility before the provider was trained?  
   ___ Yes ___ No

8. Approximately how many times has the provider performed this service since training?  
   (“0” if none) ____________

9. Is the provider currently providing the service?  
   ___ Yes ___ No

6 Form adapted from “follow up site visit form” from JHPIEGO. 1997. Instructional design skills for reproductive health professionals. Baltimore.
Appendix 8-2

Appendix 8-2: Training Follow-Up Form (cont.)

10. If no, check the difficulties that prevented service provision. (Check all that apply).
   ___ Provider lacks confidence in skills.
   ___ Service procedure in which training was received is not provided at the facility.
   ___ Provider is not in a job position to provide the service procedure.
   ___ There is a lack of demand/clients.
   ___ There is a lack of supplies/equipment/instruments.
   ___ There are other service system barriers (e.g., lack of operating room time, lack of support staff).
   ___ Other (specify) ________________________

11. If yes, is the provider experiencing any difficulties provider in regular service provision. (Check all that apply)
   ___ Low demand/low client caseload
   ___ Periodic stockout of supplies/equipment/instruments
   ___ Other service system barriers (e.g., insufficient operating room time or support staff)
   ___ Other (specify) ________________________

B. Assessment of Clinical Skills

Please rate the service provider’s performance in the clinical procedure noted in No. 6 above by placing a check in the appropriate box for each skill/activity listed. Use the clinical skills checklist from the training course as the basis for making your assessment. If no procedure or skill/activity was observed, please check “Not Observed.”

<table>
<thead>
<tr>
<th>Skill/Activity</th>
<th>Satisfactory</th>
<th>Not Satisfactory</th>
<th>Not Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preprocedure counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client assessment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical procedure</td>
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<td></td>
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<tr>
<td>Postprocedure counseling</td>
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<td></td>
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<tr>
<td>Infection prevention practices</td>
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<td></td>
<td></td>
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<tr>
<td>Overall Performance</td>
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</tbody>
</table>

continued
Appendix 8-2: Training Follow-Up Form (cont.)

If the performance was not satisfactory in any area, please list in the comments section below, those steps/tasks needing improvement, and indicate the action required to correct deficiencies.

Comments: _________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Recommended Action: ________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Site Visit Evaluator: ____________________________ Date: ______________________

Facility Manager: ______________________________ Date: ______________________