TRAINING COURSE IN WOMEN'S HEALTH
INTEREST FORM

If you are interested in receiving the Training Course in Women's Health for your training program, please fill out this form and mail it to this address:

Institute for Development Training
P.O. Box 2522
Chapel Hill, North Carolina 27515-2522
U.S.A.

1. Would you find this materials more useful if the content, focus and intended audience were made specific for use in your country?

_____ yes _____ no

2. Would you like to be involved in a workshop on how to use the Training Course in Women's Health modules in a health or family planning program?

_____ yes _____ no

3. Would you like to preview any of the modules in the curriculum? If yes, please check the titles you would like to receive:

_____ Module 1: The Female Reproductive System

_____ Module 2: The Female Urinary System

_____ Module 3: Gynecological Examinations

_____ Module 4: Vaginal Infections and Sexually Transmitted Diseases

_____ Module 5: Health Effects of Female Circumcision

_____ Module 6: Methods of Birth Control

_____ Module 7: Treatment of Complications of Early Spontaneous Abortion

_____ Module 8: Female Voluntary Sterilization*

_____ Module 9: Measuring the Prevelance of Contraceptive Use

_____ Module 10: A Guide to Infection Control in the Health Clinics

_____ Module 11: Clinic Management

*Please write Medical Division/Association for Voluntary Sterilization/ 122 E. 42nd Street/New York, New York 10168/U.S.A. for information on receiving copies of Module 8.

4. Most of the modules in the Training Course in Women's Health are available in 3 languages. Check which version you would like to receive if it is available:

_____ English _____ Arabic _____ French

(over)

BR RSLQC.SHRS.04.FIV

5. Your name: _____

Your full mailing address:

_____

_____

_____

_____

6. Name of the organization or program you work with:

_____

7. Your title/position and major duties with that organization or program:

_____

8. My organization/program is: _____ government _____ private _____voluntary

9. If your organization/program receives international funding, please list the name(s) of the funding agency(ies):

_____

10. My organization/program works with (check all that apply):

_____ family planning

_____ primary health care

_____ maternal and child health (MCH)

_____ community health education

_____ curative health care

_____ other _____

11. Which group(s) of service providers does your organization/program focus on? (check all that apply):

_____ nurses

_____ doctors

_____ primary health care workers

_____ community volunteers

_____ traditional birth attendants (TBAs)

_____ other _____

12. Type of training: _____ pre-service or basic training _____ in-service training

Thank you for filling out this form.