Best Practices in Clinical Trainings

Lessons Learned from the Expanding Access to Intrauterine Device Services in India (EAISI) Project

PROJECT BACKGROUND

As a part of its Family Planning 2020 (FP2020) commitments, the government of India strategically shifted focus to prioritizing spacing methods, expanding the basket of contraceptive choice, promoting voluntary adoption of family planning (FP) services, and emphasizing a rights-based approach. Further, recognizing that approximately 65% of postpartum women in India have an unmet need for FP (USAID 2009), the government envisioned capitalizing on the country's phenomenal increase in institutional deliveries between 2005 and 2009 (including from 52.7% to 78.1% in Gujarat and 29.6% to 70.5% in Rajasthan) to provide quality FP services during the postpartum period (Ministry of Health and Welfare 2015). The government also planned to collaborate with different development partners to support implementation of the FP program.

Ensuring access to high-quality FP services, including through building the capacity of health service providers to deliver rights-based FP, especially in public health facilities, is imperative to addressing the challenge of high unmet need. Since 2015, EngenderHealth has worked to increase the demand for and improve the availability, quality, and sustainability of intrauterine device (IUD) services to address the unmet need for contraception through the Expanding Access to IUD Services in India (EAISI) project. We have also sought to scale up and institutionalize project interventions to expand coverage by providing technical assistance to the state governments of Gujarat and Rajasthan.

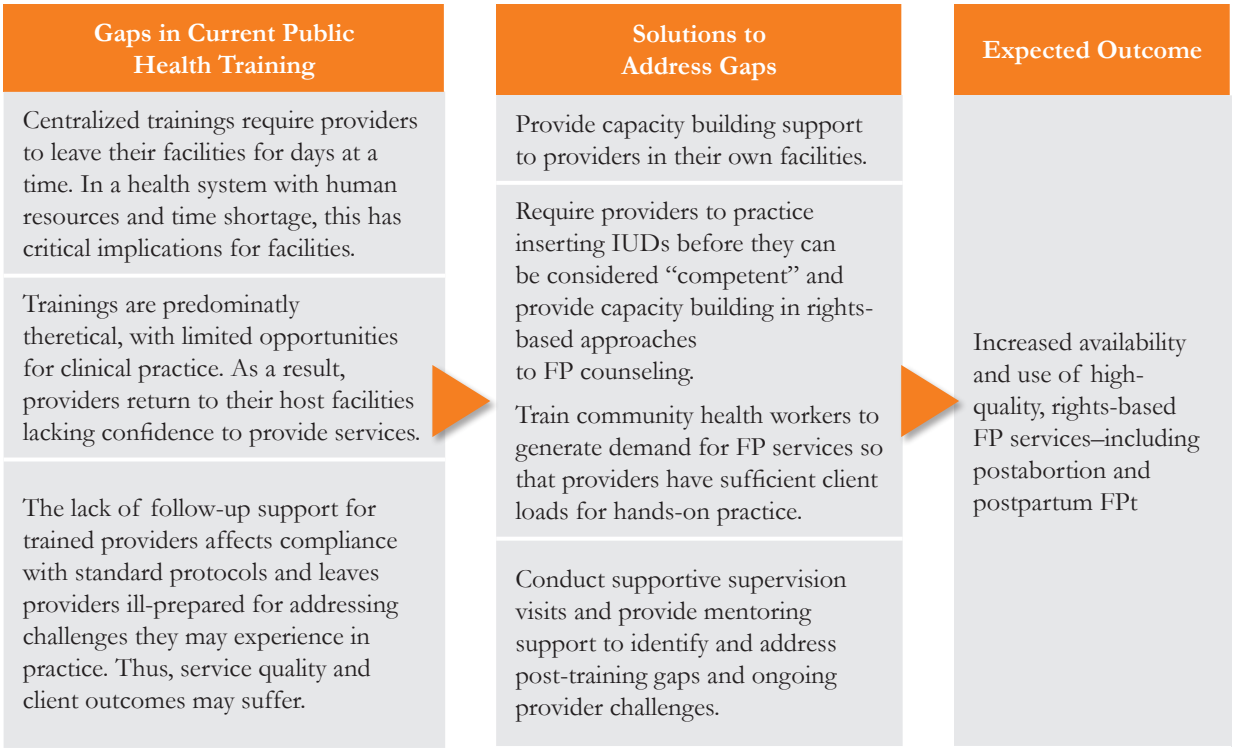
Through EAISI, EngenderHealth implemented an innovative and comprehensive capacity building model for health service providers—including doctors, staff nurses, and auxiliary nurse midwives—which resulted in improved quality of counseling and clinical FP service provision at selected government facilities and consequently increased informed choice and use of FP methods at these facilities. Employing a phased approach, EngenderHealth implemented EAISI in 359 facilities covering all districts within the intervention states (Gujarat and Rajasthan). The first phase of the project focused on providing technical assistance to state and district health systems to improve access to quality IUD services. The second phase built on learnings from the first phase and expanded programming to reach a larger number of facilities using project resources as well as those available within the public health system. The second phase also included an exit strategy that involved institutionalizing program interventions and transitioning responsibilities to program managers at district and state levels. This technical brief documents the training model, its implementation process, and outcomes and learnings from both phases of the project.

OVERVIEW OF ENGENDER HEALTH'S TRAINING MODEL

Our training model employs a robust approach that extends beyond traditional approaches, which often involve didactic, one-time, classroom-based

trainings. Instead, we developed a comprehensive, flexible, need-based model that stresses quality and accountability. We based the conceptual framework for our model on reviews of existing traditional training processes and materials and an assessment of gaps and weaknesses associated with traditional training approaches. Figure 1 illustrates this model.

Figure 1. EngenderHealth Health Service Provider Training Model



TRAINING PROGRAM DETAILS

Preparatory Activities

- **Facility selection.** We first mapped facilities to identify those with caseloads of more than 50 deliveries per month for inclusion in the project. By the second phase, we expanded program reach to facilities with 50 or less deliveries per month, by training providers from those facilities at their respective district hospitals, as these district facilities were likely to have adequate caseloads for the providers to practice insertions.
- **Cluster creation.** We clustered groups of districts geographically within each state (six in Gujarat and eight in Rajasthan) in order to organize and schedule trainings efficiently. This approach enabled us to optimize available resources and minimize disruptions of routine service provision at target facilities. This approach was particularly critical during the first phase of the project.
- **Trainee selection.** We requested the medical officers in-charge at target facilities to nominate providers to participate in the training. Participants were expected to be able to continue to provide services for a reasonable period of time; hence, those on the verge of retirement or who were awaiting transfer were not eligible. The project also established preferences for participants who demonstrated a willingness to update their knowledge, were interested in

acquiring new skills, and were perceived to display positive attitudes related to the provision of IUD services—including interval IUD (IIUD), postabortion IUD (PAIUD), and postpartum IUD (PPIUDD) services—in compliance with existing protocols for service provision. Further, in accordance with the government's approach to task shifting for the provision of comprehensive IUD services to staff nurses, the project also prioritized nurses serving in labor rooms who were willing to learn new skills and provide such services. EAISI also provided counseling training to reproductive, maternal, newborn, child, and adolescent health (RMNCHA) counselors, and (when RMNCHA counselors were unavailable) to staff nurses. Similarly, we provided infection prevention training to all staff in intervention facilities.

- **Training team formation.** We formed mobile clinical training teams (MCTTs) that could shift from facility to facility to conduct trainings, provide follow-up support and mentoring, and assess progress and service quality. Each MCTT included a doctor, nurse, and project officer—the latter bearing responsibility for administrative and planning tasks. We also employed a clinical training specialist in each state to support the MCTTs within their purview, including through overseeing the training sites, monitoring the quality of training provided to MCTT members to ensure adherence to established guidelines, and monitoring the quality of trainings MCTTs delivered to providers. We also engaged district-level trainers from within the public health system and those working in training centers to participate in EAISI trainings and become master trainers. This strategy was key to institutionalizing and ensuring government ownership of the intervention for sustainability.

- **Team capacity building.** Our project team conducted a five-day training for MCTTs. This training aimed to enhance MCTT members' clinical and training skills using targeted training modules. Our staff also conducted a training module for MCTTs focused on improving counseling skills. We repeated these trainings semiannually to refresh and enhance skills.

- **Demand creation.** In order to enable providers participating in the training to practice inserting IUDs, identifying willing clients was critical. To ensure an adequate caseload for this purpose, we implemented four strategies for generating awareness, supporting potential clients in making informed choices, and referring clients to facilities at the time of the trainings:

  - Orientation of service providers on sexual and reproductive health rights and informed, voluntary decision-making to generate client referrals from within the health facility.
  - Orientation of frontline health workers (accredited social health activists, or ASHAs) on FP and informed, voluntary decision-making to generate client referrals from local communities.
  - Dissemination of information about the training to and requests for referrals of potential IUD clients from other public health facilities in the vicinity of the intervention facilities.
  - Direct follow-up telephone calls to labor rooms staff in the days leading up to the training for identification and referral of potential clients.

TRAINING COMPONENTS

- **Clinical skills training.** The core component of our training model was a six-day structured on-the-job training (SOJT) that focused on clinical skills building in IUD insertions. Our SOJT approach built the confidence of the providers, as they were able to practice delivering services in an environment familiar to them and in which they would be continuing to perform such services after the training. The SOJT approach also enabled us to optimize time and resources and ensure a dynamic, needs-oriented training. Further, as

DEFINING CLINICAL COMPETENCY

Competency is defined as the skill level that a participant is required to demonstrate at the end of training—a skill level that indicates that the participant can provide the services on which they were trained safely and effectively to clients. Our assessment of competency was based on the correct performance of the critical steps included in the observation checklist and a score of at least 80% on a knowledge test. The government's training protocol requires each participant to observe at least two insertions each for IIUD and PPIUD in clients, insert at least two such cases each on an anatomical model, and competently complete at least one insertion each with live clients under the supervision of the trainer.

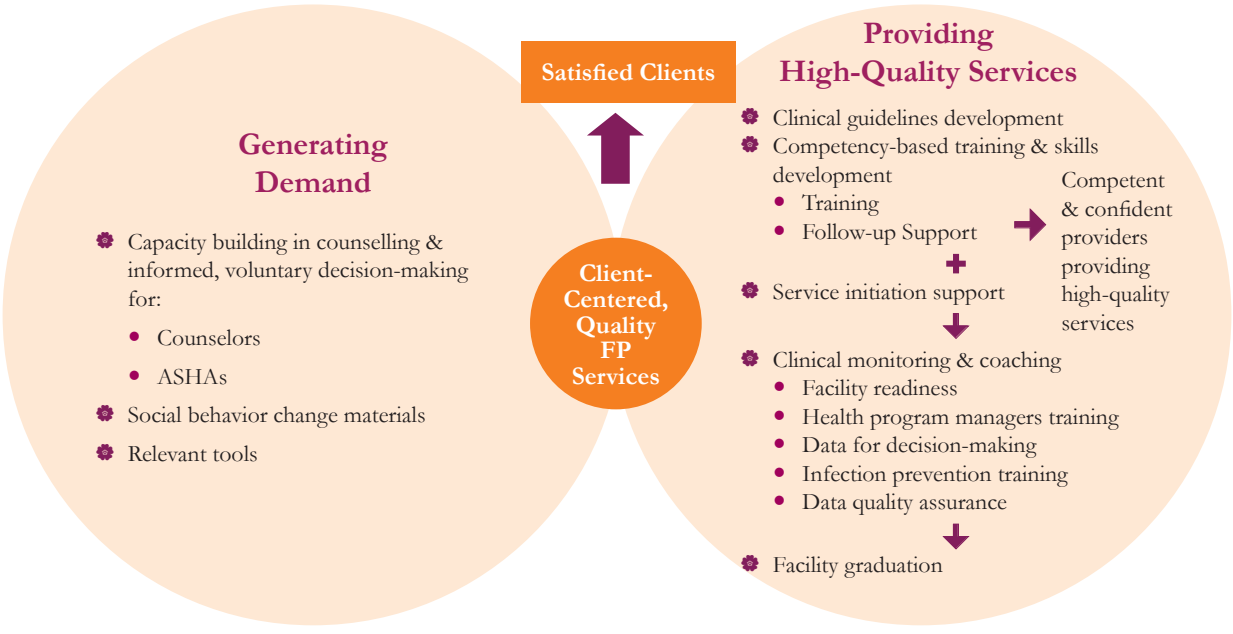
conducted these trainings within the facilities where participants worked, providers were able to attend the training while still performing their routine duties. Ensuring ample time for hands-on practice was our priority; 30% of the training program focused on theory, and 70% was devoted to practicum. Providers first practiced IUD insertions using anatomical gynecologic simulation models before practicing with live clients. This emphasis on the practicum was critical to ensuring that providers obtained the requisite skills to be considered "competent" to deliver IUD services according to the government protocol (see textbox). Additionally, we strategically structured the program not as a one-time, one-sized-fits-all training, but rather we employed a self-paced learning approach and incorporated refresher trainings. This structure was especially beneficial for providers whom the training team found to lack full competency in counseling or clinical skills. In districts with high attrition and for facilities with few relevant providers, we also conducted centralized trainings at district-level facilities.

- **Counseling training.** In addition to the clinical skills training, EngenderHealth also conducted a four-day counseling skills training, using our REDI—*R*apport Building, *E*xploring, *D*ecision Making, and *I*mplementing the Decision—framework. This training built the skills of the providers to help clients select the methods of contraception that best suited to their personal situations, health needs, and social environments, thereby facilitating satisfaction and continuation. We particularly targeted FP and RMNCHA counselors, where available, but also trained staff nurses in labor and delivery departments and antenatal care clinics in intervention facilitates, to expand service availability.
- **Infection prevention training.** EngenderHealth staff assessed infection prevention practices in labor and delivery wards and IUD procedure rooms in intervention facilities using a standardized checklist in order to ensure the infection prevention training responded to local needs. Standard components of this training included demonstrations of the proper approaches to hand washing; donning and doffing (wearing and removing) of gloves and gowns; processing, sterilizing, and storing of instrument; and managing spills and biomedical waste.
- **Data management training.** The final component of the EAISI training included a one-day training of facility data managers on data management.

QUALITY ASSURANCE

EngenderHealth strengthened the health system by training providers on state-level protocols and standards and ensuring adequate supply of requisite equipment and medicines at all levels while simultaneously generating awareness and demand for services in the community. We applied a quality assurance framework with three critical components to support our work: (1) updated and evidence-based clinical guidelines and standards; (2) clinical training with new technologies, practices, and services coupled with refresher trainings; and (3) clinical, monitoring, and coaching (CMC) for

Figure 2: EAISI's Client-Centered Quality Framework



assessing readiness and ensuring proper service delivery processes are completed.

We conducted CMC visits every six months following the training, during which our staff assessed progress by interviewing facility mangers and staff, reviewing facility records, and conducting facility walk-throughs to observe service provision. Our teams engaged the facility-in-charge as well as district-level program managers in these visits to foster ownership and facilitate sustainability. Our project team observed trainings and service quality at 10% of intervention sites and provided feedback for timely quality improvements and corrections to facility managers. Additionally, we established facility-based quality circles that were charged with discussing identifying quality issues and reviewing clinical data to support evidenced-based decisions and corrective measures to support progress.

FOLLOW-UP SUPPORT

Providing follow-up support to the newly trained providers and their respective facilities was integral to our training program as we sought to standardize and institutionalize practices that providers could maintain with quality long after the end of project. The purpose of our follow-up visits was to observe and assess service delivery quality; identify challenges and address gaps in practices (e.g., by conducting demonstrations of proper infection prevention protocols); provide feedback in real-time to the provider and facility to directly address issues, or if necessary, engage higher-level authorities for support; assist facility staff in preparing FP action plans and determining course correction, as needed; and monitor and document progress.

We delivered stringent post-training follow-up to providers adhering to a standard format. First, we contacted (via phone) providers approximately two weeks after the training to identify any individuals requiring additional support for delivering IUD services. Our MCTT members then conducted two in-person follow-up visits—the first one month after the training and the second three to six months after the training. We combined the latter follow-up with a CMC visit—while this visit focused on ensuring the competence of the individual provider, the CMC visit (discussed previously) focused on the facility and service quality overall. Further, we provided additional follow-up support by phone or through additional in-person visits as needed.

PEER SUPPORT SYSTEM

In the course of its implementation, we found that the stringent criterion requiring a set number of IUD insertions under the guided supervision of a trainer was impractical due to inadequate client caseloads at the facilities within the six-day training timeframe. Project staff had to repeatedly visit facilities to observe the providers in order to meet this requirement, which led to increased project expenditures associated with trainers' time and travel costs. To address this challenge, EngenderHealth developed a peer training system, pairing providers needing to fulfil their training competency requirements with providers who completed the competency requirements and were willing to serve as coaches and mentors to their peers. We developed a structured checklist for the peer trainers to use to document feedback to share with providers seeking competency and relevant MCTT members. The MCTT then used this feedback to plan any follow-up support necessary to strengthen the provider's clinical skills to ensure competency.

OUTCOMES

Training Deliverables

Over the course of program implementation across 66 districts in two states, EngenderHealth demonstrated notable results (see textbox).

As a result of these trainings, our assessments—which included questions about the features of an IUD, IUD insertion and removal, FP counseling, medical eligibility criteria for FP, infection prevention, side effects and complications, follow-up care, and IUD service quality assurance—showed notable improvements in provider competence and confidence. Average participant scores on these assessments increased from 57% before the training to 88% after the training. Further, complication rates among clients of trained providers was only 3%, a marked different compared to 5% of untrained providers, demonstrating improvements in clinical care.

TRAINING RESULTS

- 190 master trainers and 699 state-, district-, and block-level managers trained
- 5,706 intervention facility staff trained on infection prevention
- 5,021 intervention facility staff trained on sexual and reproductive health rights
- 2,793 providers completed SOJTs in IIUD and PPIUD, 802 completed counseling training, and 1,989 received orientation for PAIUD
- 2,321 trained providers received initial follow-up visits and 1,904 received second visits
- 98% of providers who received follow-up support were deemed "competent" per established qualification criteria and proved to be compliant with quality service delivery protocols
- 22,166 ASHAs oriented to provide community-based counseling and referrals

Facility Preparedness and Service Delivery

Our intervention resulted in improvements in facility preparedness as well as service delivery. Through follow-up visits to intervention facilities, we found that all but one (a total of 358) were providing IIUD and PPIUD services and 227 were providing PAIUD services. All of the facilities demonstrated adherence to infection prevention practices, including through employing the "no-touch technique" for IUD insertion, and nearly all of the facilities were maintaining correctly completed insertion and follow-up registers. We also observed that 87% of intervention facilities had established counseling corners and found that 89% were operating quality circles. Likewise, more than 80% of intervention facilities were offering FP information, education, and communication materials and displaying infection prevention protocols and the national Citizen's Charter.

By the end of the project, 224 of the 359 interventions facilities "graduated" and were technically equipped

to provide high-quality FP services. Facilities were required to meet 10 criteria for this graduation: 2 criteria focused on service delivery, 2 focused on facility readiness to provide services, 3 focused on the enabling environment, 2 focused on record keeping, and 1 focused on counseling.

Service Uptake and Client Satisfaction

As a result of the training intervention and facility improvements, service uptake increased and client satisfaction improved. A total of 490,135 clients adopted an IUD (IIUD, PPIUD, or PAIUD) in the intervention facilities during the life of project. PPIUD and PAIUD uptake rates specifically increased from less than 9% to more than 14%. The proportion of clients receiving counseling at antenatal clinics improved from 14% to 47%.

Of the 22% of clients who received follow-up—either telephonically or during subsequent facility visits—nearly 95% reported having had an opportunity to ask questions and having received information and services they were seeking, more than 75% reported no complaints, and 84% were continuing with their method. Client interactions during CMC visits suggested service quality improvements as well: most clients reported receiving relevant information, being able to choose from different methods and encouraged to make their own decisions about method selection, and receiving follow-up support from ASHAs and/or auxiliary nurse midwives.

Institutionalization and Sustainability

EngenderHealth institutionalized and facilitated the sustainability of EAISI interventions by developing training materials; establishing cadres of master trainers in each state; training district- and block-level administrators; and equipping state, district, and regional training centers with essential items for IUD trainings. We provided orientations for district- and block-level health managers to strengthen their abilities to support the trained providers including through supportive supervision. These orientations covered key topics including: our quality framework and CMC approach, FP methods basics and FP compliance, sexual and reproductive health and rights, the government's monitoring tools for IUD services, as well as logistics and supply management and record keeping necessary at the facility level.

State Institutes of Health and Family Welfare in both Gujarat and Rajasthan are now using the technical resources that we developed for this project. The Rajasthan institute is utilizing the counseling corner that we established in the skills lab and the government of Rajasthan has integrated FP counseling into its Mother and Child Protection card (known as the MAMTA card) and uses it to ensure counseling during pregnancy. District officials who completed the health managers' training are now able to ensure uninterrupted supplies of FP commodities using the government's FP logistic management information system. District officials participated in 154 of the 1,288 CMC visits to intervention facilities completed during the project period and program managers at state and district levels trained through EAISI are now directly conducting CMC visits to review the quality of FP services and improve IUD service provision. As a result of all of above, state and district officials in both states acknowledged our project's contributions to improving FP services.

CONCLUSIONS

EngenderHealth developed the EAISI training model through a rigorous process of conceptualization and implementation. We intentionally designed it as a dynamic model with the ability to respond to emerging challenges and needs at the service delivery level and within different contexts and communities. Our model reflects a comprehensive, robust, and efficient capacity building strategy that includes SOJTs, follow-up support and mentoring, and quality assurance. We ensured our interventions were ethical and accountable by aligning with existing government norms and standards for service delivery.

This model proved relevant to the needs of the public health system; effective in creating of a cadre of providers trained to offer high-quality, client-centered IUD services and improve clients' utilization of and satisfaction with these services; and efficient and sustainable by leveraging and strengthening existing resources within the public health system to bring programming to scale across all districts in both intervention states. Therefore, our training model meets globally recognized criteria for best practices and has demonstrated value for replication and scale up across other states in the country.

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