PD-ABE-267

Prepared for

Office of Population
Bureau for Research and Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

EVALUATION OF THE JOHNS HOPKINS PROGRAM FOR INTERNATIONAL EDUCATION IN REPRODUCTIVE HEALTH (JHPIEGO)

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Fieldwork
September 21 - October 21, 1991

Produced by

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July 15, 1992

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Glossary: Abbreviations and Terms

Abbreviations

A.I.D	Agency for International Development
ADPCN	Association of Deans of Philippine Colleges of Nursing
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CDC	Centers for Disease Control
DA	Development Associates
DFH	Division of Family Health (Kenya)
FCC	Fertility Care Center
FHI	Family Health International
FPMD	Family Planning Management Development (project)
FPSD	Family Planning Services Division, Office of Population
GTI	genital tract infection
HPN	Health, Population and Nutrition officer
IAC	International Advisory Council
IP	infection prevention
INTRAH	Program for International Training in Health (project)
IPPF	International Planned Parenthood Federation
IT	Information and Training Division, (Office of Population)
ITC	International Training Center
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
LDC	less developed country
MIS	management information system
MOH	Ministry of Health (multiple countries)
MOPH	Ministry of Public Health (Morocco)
MSH	Management Sciences for Health (project)
NGO	non-governmental organization
NORPLANT	method of contraception which releases the synthetic hormone levonorgestrel through capsules inserted beneath the skin of the upper arm
NTCRH	National Training Center for Reproductive Health
OB/GYN	obstetrics/gynecology
OB/GYNS	obstetrician/gynecologists
OPTEL	distance learning using computerized teleconferencing
PATH	Program for Appropriate Technology in Health
PAC IIb	Family Planning Training for Paramedical, Auxiliary and Community Personnel (project)
PCS	Population Communications Services (project)
PIP	Population Information Program
PY	Program Year [note: PY 4 extends from May 1, 1990 to April 30, 1991, PY 5 extends from May 1, 1991 to April 30, 1992]
RAM	repair and maintenance center
RCT	Regional Center for Training in Family Planning (Cairo)
RTC	Regional Training Center

SAC	Scientific Advisory Committee
SEATS	Family Planning Services Expansion and Technical Support (project)
SOMARC	Social Marketing for Change (project)
STD	sexually transmitted disease
TA	technical assistance
TAG	Technical Advisory Group
TOT	training of trainers
UNFPA	United Nations Population Fund
URC	University Research Corporation
USAID	United States Agency for International Development (overseas missions)
VSC	voluntary surgical contraception
WHO	World Health Organization

Terms (as frequently used by JHPIEGO)

pre-service training, pre-service education or basic training	the basic education of medical, nursing, and midwifery students (i.e., in medical, nursing, or midwifery school)
in-service training	training for in-service providers (workshops, on-the-job training, etc.)
training skills	skills in training others (usually provided as part of some in-service training)
academic skills	skills of academic faculty in medical, nursing, and midwifery schools (i.e., refers to pre-service education)
clinical skills	skills for performing clinical procedures
clinical training skills	skills for training others to perform specific clinical procedures (e.g, VSC, IUD, Norplant)
curriculum development skills	skills for developing a training course or program and the curricula and support materials on which it is based
teaching skills	a less precise term sometimes used interchangeably with the above more precise terms

Note: "Education" refers to pre-service or basic education, whereas "training" usually refers to in-service training. In the context of family planning personnel, education involves the presentation of ideas that expand a person's view of him or herself and of other people; in family planning, "education" can include demography and general family planning knowledge (e.g., an overview of modern contraceptive methods and concepts of counseling). In contrast, training usually includes learning to perform specific techniques and skills. Insofar as possible, this report makes this distinction between the two terms.

Project Identification Data

Scope:	Worldwide
Project Title:	Training in Reproductive Health; Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)
Project Number:	936-3045
Contract/Grant Number:	DPE-3045-A-00-7004-00
Critical Project Dates:	Cooperative Agreement: May 1, 1987 to April 30, 1992; extended to April 30, 1994 Project Assistance Completion Date: Extended to December 31, 1994
Project Funding:	A.I.D. Central Funding: $55,182,033
Mode of Implementation:	A.I.D. Central: Cooperative agreement between Office of Population, Information and Training Division and the Cooperating Agency (JHPIEGO)
Contractor/Grantee:	JHPIEGO Corporation 1615 Thames Street Suite 200, Baltimore, Maryland
Subcontractors:	None
A.I.D./Washington Project Managers:	Allen Brimmer, July 1991-present Previously: Charlotte Ureksoy
Previous evaluations:	None. A.I.D./JHPIEGO management review April 1990.

Executive Summary

Background and Project Overview

Since 1974, the Agency for International Development (A.I.D.) has provided funding through the Johns Hopkins University to train physicians and other clinical health care personnel in reproductive health and family planning. The program is known as JHPIEGO from its original name, the "Johns Hopkins Program for International Education in Gynecology and Obstetrics." The new name, reflecting a broader orientation, is the "Johns Hopkins Program for International Education in Reproductive Health." JHPIEGO is a Cooperating Agency of the Office of Population and receives upwards of 95 percent of its funding from A.I.D.

The project being evaluated, "Training in Reproductive Health," is A.I.D.'s fourth five-year project with JHPIEGO. The current cooperative agreement (#DPE-3045-A-00-7004-00) has a budget of $55,182,033, of which part derives from USAID mission buy-ins. Designed as a five-year project (May 1, 1987 to April 30, 1992), it was amended in May 1991 to allow for a two-year extension; the project is now scheduled to end April 30, 1994. Approximately $35 million had been obligated as of the end of September 1991.

The project purpose stated in the cooperative agreement is (1) to increase the availability of improved reproductive measures; and (2) to increase the number of LDC health professionals with modern, appropriate knowledge and skills in reproductive health, especially family planning. A.I.D. currently states JHPIEGO's mandate to be: (1) "To train developing country physicians, nurses, and midwives in reproductive health and family planning; and (2) to institutionalize appropriate training in developing country medical and nursing schools, thus improving family planning service delivery."

Purpose and Methodology of this Evaluation

This evaluation was to be the standard final evaluation for this project. It was also to be primarily forward-looking with the specific purpose "to help define the need for and role of training in A.I.D.'s population program during the next decade and JHPIEGO's role in that training over the next 5-10 years." Finally, it was to provide a basis for a new cooperative agreement for JHPIEGO. The team was instructed to evaluate activities only since the hiring of the current director, in August 1988, and to focus on the future rather than on quantifiable outputs specified in the cooperative agreement. Evaluation of JHPIEGO's current work was to be a secondary purpose.

The evaluation took place during a four-week period which included field visits to three countries: Philippines, Kenya, and Morocco. Conclusions are based on: interviews and observations at Johns Hopkins University and in the three countries visited; interviews with a sampling of international family planning professionals and representatives of other A.I.D. Cooperating Agencies; comments from USAID/missions in response to a worldwide cable sent by A.I.D. for this purpose; and document review.

Major Conclusions

1. Program in transition. JHPIEGO is in the process of a major transition from a program (the "old JHPIEGO") whose dominant components were courses in Baltimore, laparoscopic female sterilization, and university-based obstetrician-gynecologists, to a more diversified program with a greater public health approach to family planning. Excellent progress has been made. The "new JHPIEGO" is still in an early formative period, however; much remains to be done to follow through on recent initiatives, both in terms of program content and management.

2. Achievements and impact. Since 1988, JHPIEGO has launched several excellent initiatives and is uniquely positioned to have an impact in important clinical areas that contribute to demographic impact. These include: standardization of the teaching of manual clinical skills; measures related to making training efficient; activities related to reviving the IUD (standardization of insertion procedures, management of genital tract infections, and infection prevention); and development of national clinical standards as the basis for training, service delivery, and quality control. The above materials have been developed largely in the context of **in-service training** but could be used for selective pre-service education too. It is not possible to say with any certainty what impact JHPIEGO has had to date, however. JHPIEGO has not sought to evaluate the overall impact or effectiveness of its work -- nor even to document its work in such a way as to facilitate evaluation by others. JHPIEGO appears to have had little impact to date on **pre-service education.**

3. Management. As with almost everything else at JHPIEGO, management structures and systems (including personnel arrangements) are in a state of evolution. The present staffing is thin at the leadership level and not really adequate to carry out the current program, let alone an expanded one. JHPIEGO has expanded its staff and initiated laudable organization development activities that are intended to remedy management weaknesses. The changes under way seem positive, but it is too soon to predict the outcome.

4. Program planning and strategies. JHPIEGO has developed some good **technical** strategies related to standardization of training in specific clinical methods of contraception (IUD, female VSC, Norplant). Beyond this, it has no clearly articulated strategies defining how it approaches or allocates resources to component parts of its program (e.g., institutionalization of pre-service education, institutionalization of in-service training, determination of country strategies, training of doctors vs. nurses or midwives, etc.). Activities too often flow from historical relationships with leading obstetrician-gynecologists and their institutions. Many programming decisions are made on a target-of-opportunity basis -- both as concerns countries in which to work and activities within a country. This may have been appropriate in earlier decades but is no longer so.

5. Current program approaches

a) Training materials and approaches. Perhaps JHPIEGO's most significant contribution to date has been development of prototype training and reference materials to facilitate and standardize competency-based clinical skills training courses for: (1) insertion, management and removal of the **copper-T 380A IUD**, (2) **minilaparotomy**, and (3) insertion, management and removal of **Norplant.** These materials vary in quality, but have many good features. A particular strength is the competency-based approach to the development of technical, clinical skills. Developing these manual skills is an essential part of clinical skills training and is one of the most difficult parts of a clinical skills training course to standardize (i.e., to assure attainment of a certain level of learning

by each trainee). The materials are less strong in other areas, such as counseling, quality control, clinic management and general training skills. These training materials are not yet as widely used as they should be.

In addition to the method-specific manuals, JHPIEGO has developed two important reference manuals, one on **Preventing Infection** and one on **Management of Genital Tract Infections** (GTIs), especially in relation to the use of IUDs. Attention to these problems was needed; JHPIEGO's work in this area has been done well and provides essential support for provision of IUDs and VSC.

b) Pre-service education. JHPIEGO has no clear strategy for introducing and institutionalizing family planning in the pre-service education of health care providers. The assumption (e.g., in JHPIEGO's mission statement) that pre-service education can "ensure a steady supply" of qualified family planning service providers and trainers is questionable. **Basic family planning knowledge and values** should be part of the pre-service curricula for all health care providers. It is not feasible, and will probably never be cost-effective, however, for family planning **clinical skills** to be taught to all medical, nursing and midwifery students during their basic education. JHPIEGO has some good achievements in pre-service medical and nursing education. However, many of its activities are isolated, without follow-through, and have not led to institutionalization or documented impact.

c) In-service training. In-service training addresses needs that will never go away, even though overall need for in-service training can be reduced somewhat by pre-service education. JHPIEGO's main achievements in this area flow from development of its standardized approaches to clinical training (see above). JHPIEGO has begun shifting from training family planning service providers ("direct training") to **training of trainers** who will train the family planning service providers, but is still grappling with how to do this effectively and efficiently. JHPIEGO is also moving toward providing activities that will have a national, rather than isolated local impact. Where projects are based on a careful, in-depth, objective assessment of national training needs, the results tend to be good. JHPIEGO has no protocols for **needs assessment**, however, and does not carry these out consistently.

JHPIEGO is emphasizing the development of more effective, efficient and "humanistic" approaches to family planning training. Components of this emphasis include the use of competency-based training methods and materials, analysis of certain complex technical/manual skills in order to teach them most efficiently, and the use of anatomic models for beginning skills acquisition. The issue of efficiency is particularly important in relationship to IUD training, and JHPIEGO has developed a special expertise in quality training related to IUDs. In addition, JHPIEGO has recognized and responded to the need to support the safety, and thus the acceptability, of IUDs by focusing on infection prevention and the management of genital tract infections.

Long-distance learning. JHPIEGO's experimental efforts with **OPTEL (interactive PC teleconferencing)** remain questionable. At this point, OPTEL appears to be primarily a sophisticated technology searching for an application.

Location. JHPIEGO has decreased use of **Baltimore training** (except for courses tailored to a specific group of providers from one country). Results have been mixed. The **regional/international training centers** that JHPIEGO has supported have provided training to substantial numbers of providers and trainers, but JHPIEGO's limited efforts to evaluate results, track trainees, and analyze overall impact leaves questions as to effectiveness and impact.

6. This evaluation. It is not realistic to be so future-oriented during an evaluation as A.I.D. had hoped this team could be. To produce sound and useful recommendations for the future, it is necessary first to have a very sound understanding of present performance, strengths and weaknesses. For an external team to make a valid assessment of a program that operates globally in several dozen countries of widely varying stages of development is a complex task -- which must come first.

Recommendations

For JHPIEGO:

1. Program planning. JHPIEGO should engage in a "strategy-clarification" exercise to develop a set of strategies for working toward program objectives in the most cost-effective ways. JHPIEGO should analyze its experience to extract lessons learned, but it should also look beyond its own experience to examine afresh evolving needs and possible new solutions. For each major problem area, JHPIEGO should produce a short working paper in which the strategy, as well as pending issues, are set forth. Strategies developed should center on principles and processes that emphasize the importance of working from individual country needs; approaches should not be superimposed on countries. A deputy director for program management should be recruited and should lead this exercise. To assist in programming for impact, JHPIEGO's Monitoring and Evaluation staff should participate in this activity while immediately moving forward with its planned evaluation systems.

2. Pre-service education. JHPIEGO should bring nursing/ midwifery/ physician educators, clinicians and service administrators together to identify "core knowledge" and "core competencies" that graduates of pre-service programs should have. Pre-service curricula should be based on a clear understanding of the roles, functions and tasks for which the students are being trained and the level of competence expected of new graduates. Tutors in pre-service educational programs need to understand the demands of the jobs their graduates will fill. Prototypic curricula for nurses, midwives, and physicians will all be different.

3. In-service training. In-service training (and a training strategy for each country) should be based on objective data regarding the pre-service training, numbers, roles and general performance of the various categories of health professionals and other workers who participate in the provision of contraceptive services. It should also focus on strengths and weaknesses of current family planning service systems, including evidence of safety or lack of safety and evidence of effectiveness (i.e., contraceptive prevalence and method-specific continuation rates). Plans to install OPTEL in other countries should be cancelled or deferred until the first installation (in Egypt) can be put into use and shown to be effective.

4. Materials development. JHPIEGO should continue to subject its current training manuals to the process of assessment, field-testing, and revision. It should give more emphasis to training in counseling, quality control and clinic management. JHPIEGO should assess the need and demand for the training products it has already developed and make a plan to produce and distribute large enough quantities of these materials to meet the need.

For A.I.D.

1. Training strategy for the Office of Population. The Office of Population should have a strategy for increasing the effectiveness with which it programs its training resources during the coming five

to ten years. The goal of such a strategy should be to help the Office, and the Information and Training (IT) Division, to design, monitor, and evaluate its training programs with greater ease and success. To this end, the IT Division should consider convening a "Training Strategy Working Group" with representation from the IT Division's training CAs as well as other CAs with substantial training components. This is especially important for maximizing the contribution of training to the Office's BIG Country Strategy (or any similar effort).

2. Country training strategies. In each country in which A.I.D. supports family planning activities, there should be a clearly articulated country training strategy. The Office of Population should have guidelines as to what belongs in a country training strategy and how it is developed. This should be part of the Overall Training Strategy recommended above. It should probably also include some principles as to how the various CAs are to find their roles in the country training strategy as well as the particular role of the specialized training CAs, both vis-a-vis bilateral projects and other CAs. These guidelines should then guide both project design and evaluation as concerns training.

3. Follow-on project with JHPIEGO. The new JHPIEGO project should be designed in the context of an overall training strategy in such a way that A.I.D. can use JHPIEGO to its greatest comparative advantage. JHPIEGO has certain historical emphases and strengths on which A.I.D. should capitalize. Although JHPIEGO has emphasized certain areas, it has ignored others (e.g., the pill, supervision, development of locally suitable training materials to meet local needs, working with certifying and accrediting bodies). This is acceptable, so long as there are other organizations focusing on the other aspects. JHPIEGO should focus on what it is starting to do well; it may be appropriate to expand its scope somewhat, but JHPIEGO should not be expected to meet all family planning training needs.

4. JHPIEGO management. A.I.D. should support JHPIEGO's proposal to strengthen its management by adding two deputy director positions. It should also monitor whether JHPIEGO is moving adequately to fill all associate director positions. Neither the project director nor deputy director should simultaneously be filling regional (associate) director positions.

1. JHPIEGO, A Program in Transition: Mandate and Strategies

1.1 Project Overview

JHPIEGO -- the **Johns Hopkins Program for International Education in Reproductive Health** -- is one of the oldest collaborating agencies of A.I.D.'s Office of Population. It was established by A.I.D. shortly after the Office of Population itself was created in the late 1960s and has been an important partner ever since. Although an old partner, JHPIEGO today is in the midst of a transition to a new type of program -- one oriented relatively less toward obstetricians and gynecologists and more toward other family planning service providers.

Since 1974, A.I.D. has funded a series of projects with the Johns Hopkins University in Baltimore to train physicians and other clinical health personnel in reproductive health. The fourth of these projects is the subject of this evaluation. Officially entitled "Training in Reproductive Health," this current project is being carried out through a cooperative agreement between A.I.D. and the **Johns Hopkins Program for International Education in Reproductive Health** (JHPIEGO). The three earlier projects included a five-year grant followed by two five-year cooperative agreements, with total funding of approximately $120 million. Nearly all of JHPIEGO's funding is and has been from A.I.D.

The current cooperative agreement has a budget (ceiling) of $55,182,033, of which part is to derive from mission buy-ins.[1] Approximately $35 million had been obligated as of the end of September 1991. Designed as a five-year project (May 1, 1987 to April 30, 1992), the agreement was amended in May 1991 to allow for a two-year extension; the project is now scheduled to end April 30, 1994.

The **project purpose**, as set forth in the current cooperative agreement, is two-part:

1. To increase the availability of improved reproductive health measures; and

2. To increase the number of less developed country (LDC) health professionals with modern, appropriate knowledge and skills in reproductive health, especially family planning.

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[1]Cooperative Agreement No. DPE-3045-A-OO-7004-00, April 1987. The part of the $55 million "ceiling" that comes through buy-ins is only potentially available.

1.2 The Focus of This Evaluation: 1988 to Present

This evaluation focuses only on activities since August 1988 (approximately a year and a half after the project began). A.I.D. had not been satisfied with implementation of the project during the earlier period and, in August, 1988, a new project director (the current director) was hired. A.I.D. specified that this evaluation should focus only on activities since the arrival of the current director -- what has been referred to as "the new JHPIEGO."[2] JHPIEGO continues, however, to both benefit and suffer from its legacy of the 1970s and early 1980s. Thus it is necessary to understand where JHPIEGO is coming from in order to judge its performance since 1988.

1.3 Background: the "Old" JHPIEGO, 1974-1988

In 1974 a five-year A.I.D. grant created the **Johns Hopkins Program for International Education in Gynecology and Obstetrics** (JHPIEGO), based in the Department of Obstetrics and Gynecology in the School of Medicine at Johns Hopkins University in Baltimore.[3] Its mandate was to institutionalize the teaching of reproductive health in medical and nursing school curricula, to train developing country physicians in the latest techniques of fertility management, and to provide related technical assistance.

The strategy was to provide educational programs within a broad reproductive health framework to leading clinicians, opinion leaders, and policy-makers, thereby building up a critical mass of developing country professionals who could initiate and sustain reproductive health training in their own countries, which would result in the delivery of quality family planning services.

1.3.1 Focus on Laparoscopy

Within this reproductive health framework, sterilization via laparoscopy became the main priority (a legacy that continues to dominate the image many international family planning professionals still hold of JHPIEGO).[4] There were two reasons for this.

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[2]Because this evaluation was to assess only performance since 1988, the evaluation team was specifically directed that it should not devote attention to quantitative outputs and indicators set forth in the 1987 agreement. This evaluation was also not asked to address financial questions. (See Appendix A: Methodology.)

[3]Funding from A.I.D. actually began even earlier, when the Johns Hopkins University was one of four universities participating in the "advanced technology fertility training centers" project of A.I.D.'s Office of Population, which itself was just launching its program. In 1974 the "advanced technology fertility training centers" project was consolidated into one university, Johns Hopkins.

[4]See Section 6.4: "Impact of JHPIEGO: General Impressions."

First, when JHPIEGO began, female sterilization was commonly performed under general anesthesia as a major inpatient hospital procedure, usually requiring an overnight stay. This made sterilization both too costly and too frightening to be a realistic means of fertility control for most developing country women. Laparoscopy, it was thought, might hold the key to making female sterilization a true part of the contraceptive method mix.[5] Second, in the 1970s laparoscopy was a new technology unavailable to most developing country institutions, but one that offered many advantages for treatment and diagnosis of various gynecological problems. Thus it was believed that the attractiveness and advantages of this new technology would entice developing country obstetricians and gynecologists (ob/gyns) into the field of family planning, or at least familiarize them with family planning and minimize the resistance many would otherwise have put up.

JHPIEGO thus focused during the 1970s on laparoscopy. (Minilaparotomy with local anesthesia, which has since gained favor, was not particularly known and available at that time.) JHPIEGO brought ob/gyns from many countries to Baltimore for didactic training in diagnostic and therapeutic laparoscopy. Trainees received clinical training in laparoscopy at an international network of JHPIEGO clinical training centers. After successfully completing the clinical training, the trainees' institutions were provided with a laparoscope. In key countries, JHPIEGO established laparoscopic **repair and maintenance (RAM) centers**. These were crucial for the equipment to remain in use. According to JHPIEGO, its laparoscopy training helped sensitize leading ob/gyns in more than 75% of the medical schools in developing countries to a new approach to female sterilization which could be performed as an outpatient procedure. Since the training was provided within the overall framework of reproductive health, these same clinicians were also sensitized to the important health benefits of all methods of family planning.

In the 1980s, JHPIEGO broadened its focus somewhat, adding short courses targeted to physicians, nurses, and administrators on a range of topics. Courses, included, for example: "Management of the Infertile Couple," "Integrating Management of STDs into Family Planning Programs," "Microsurgery for Tubal Reanastomosis", "Curriculum Development in Reproductive Health," "Integrating Family Planning into Primary Health Care Programs," and "Administration of Reproductive Health Training Programs." Most of these courses were offered at JHPIEGO's training center in Baltimore.

Also in the 1980s, in accord with guidance from the Office of Population, JHPIEGO began to shift much of its training

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[5]The earlier procedure was laparotomy, which required a long incision opening the abdomen. In contrast, laparoscopy requires only a small incision at the navel.

overseas, helping to develop regional training centers in countries such as Thailand, the Philippines, Morocco, Kenya, Indonesia, Nigeria, Thailand, and Colombia. By the late 1980s, more than 95 percent of JHPIEGO training was conducted in developing countries.[6]

1.3.2 Administrative Issues

For its first decade, JHPIEGO was an ancillary program of the Department of Obstetrics and Gynecology in the School of Medicine, directed by members of that department or others for whom it was only one of several priorities. A critical evaluation in 1985 pointed out that, while JHPIEGO had both a president and a project director, neither worked full time on the project. JHPIEGO's president was also Vice President of the Johns Hopkins Hospital and thus spent only "minimal time" on JHPIEGO; likewise, JHPIEGO's project director was spending more and more time on research and university clinical commitments, and less on JHPIEGO. Day-to-day management had by default been taken over by an assistant to the president, creating "confusion" among all concerned.[7]

The 1985 evaluation recommended both full-time management and major changes in program direction, especially a significant broadening of the program beyond laparoscopy and a more substantial shift to training overseas. In August 1988, following a national search, a new project director was hired, JHPIEGO's first full-time director. He remains in this position today and has been responsible for many of the new initiatives JHPIEGO has launched in the three years since his hiring.[8]

In 1988 JHPIEGO changed its name to **"JHPIEGO, a Johns Hopkins Program for International Education in Reproductive Health."** JHPIEGO judged this important to de-emphasize obstetrics and gynecology and reflect the organization's shift to a broader focus in which key service providers also include nurses, midwives, and doctors not specialized in ob/gyn. The familiar acronym remained unchanged.

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[6]JHPIEGO: information provided to IT Division Strategic Planning process, 1991.

[7]Richard Derman et al., *Evaluation of the Johns Hopkins Program for International Education in Gynecology and Obstetrics*, October 3, 1986, p. 28.

[8]The position of president is currently unfilled. No moves are under way to fill it. This may become an issue in the next cooperative agreement, but no action seems needed at this time.

1.4 JHPIEGO Today: Mandate and Mission

1.4.1 The Present Cooperative Agreement and A.I.D. Mandate

As noted above, the current cooperative agreement sets forth two purposes for the project:

1. **To increase the availability of improved reproductive health measures; and**

2. **To increase the number of less developed country (LDC) health professionals with modern, appropriate knowledge and skills in reproductive health, especially family planning.**

In designing this project, JHPIEGO and A.I.D. also agreed upon five activities JHPIEGO would pursue. These were listed in the cooperative agreement "in no order of preference." They were:

1. Pre-service education in medical schools, nursing schools, midwifery schools, postgraduate medical training centers, Ministry of Health major hospitals, etc.;

2. Modern academic skills, technologies, and appropriate approaches;

3. Provision of effective methods of family planning services by skilled health professionals;

4. Expansion of JHPIEGO's training center network; and

5. Provision of medical equipment, supplies, and education materials as necessary.

Eight specific outputs relating to these activities were agreed upon, again in no order of preference. Strengthening of pre-service education would be accomplished through **curricula reviews** and **development of model curricula and related materials for reproductive health**, leading to institutionalizing reproductive health training in developing country institutions. Related outputs included **identification and assessment of skills and technologies relevant to reproductive health** through international forums and meetings and developing **strategies for reproductive health training.** In addition, JHPIEGO was expected to achieve quantitative outputs in the areas of **U.S.-based training, assistance and support to developing country institutions, clinic staffing by personnel trained in family planning**, and **short-term technical assistance.**

Although A.I.D. did not set priorities for JHPIEGO, JHPIEGO, in its proposal to A.I.D., made some choices, proposing to

"concentrate its efforts in medical schools and the most important nursing schools."[9] In-service training received less emphasis: JHPIEGO's proposal said only that "continuing education will also be provided in other institutions." The term "in-service training" was not used.

In addition to these statements of purpose, the Office of Population currently states JHPIEGO's mandate to be:

1. **"To train developing country physicians, nurses, and midwives in reproductive health and family planning; and**

2. **To institutionalize appropriate training in developing country medical and nursing schools, thus improving family planning service delivery."**[10]

1.4.2 JHPIEGO's Operational Definition of Its Mandate and Mission

How does JHPIEGO see its mandate? Elements JHPIEGO emphasizes are the following:[11]

- To train nurses, midwives, and doctors in family planning (especially clinical methods);
- Within this framework, to shift:
  - to greater numbers of nurses than physicians;
  - from laparoscopy to minilap; and
  - from training of providers to training of trainers; and
- To concentrate on the public sector over the private sector in a ratio of about 90 to 10 (while most other cooperating agencies [CAs] focus on non-governmental organizations).[12]

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[9]Cooperative Agreement No. DPE-3045-A-OO-7004-00, April 1987.

[10]A.I.D., *Users' Guide to the Office of Population, 1991*, p. 21.

[11]Statement at opening session during current evaluation.

[12]Staff stated, however, that JHPIEGO does not see the distinction between public and private sectors as very important. First, pre-service education feeds into both the public and the private sectors. Second, many public sector providers also or eventually work on the private side.

A rationale behind this mandate is: Clinical methods play a vital part in the contraceptive method mix and JHPIEGO, because of its Johns Hopkins University relationship, is pre-eminently positioned to train developing country clinicians in these methods.

JHPIEGO Mission Statement

Since May, 1991 JHPIEGO has been carrying out an **organization development** process led by a management consultant (see Chapter 5). As part of this process, JHPIEGO has now developed a "mission statement" (see below). This is intended to define the core of the organization's program, as distinct from an A.I.D.-specified project mandate. Given that JHPIEGO receives almost all of its funding from A.I.D., the two should not diverge tremendously -- and they do not.

JHPIEGO's mission statement reflects JHPIEGO's aspirations to broaden its program if it could get funding from sources other than A.I.D. Whereas A.I.D.'s priority for JHPIEGO is training in family planning (i.e., contraception), the heart of JHPIEGO's mission statement is reproductive health. This includes family planning, of course, but JHPIEGO would also like to include other measures related to reducing maternal mortality and morbidity (e.g., screening for cervical cancer). JHPIEGO believes such measures would not only save women's lives, but also make family planning services more acceptable to more clients.

1.5 "The JHPIEGO Way": New Approaches and Program Decision-Making

1.5.1 New Approaches

How have JHPIEGO activities actually changed since 1988? When asked to describe current strategies, senior staff tend to describe various approaches to clinical training which they often refer to as "the JHPIEGO way." This includes the following new approaches (details of which are presented throughout this report). Since 1988, JHPIEGO has:

- **Reduced and altered the training courses in Baltimore** -- closed the training center and stopped the regularly-scheduled standard courses in favor of courses tailored to specific groups;

- **Established and increased the use of regional (international) training centers** in key developing countries;

- **Developed new approaches to make training more efficient** -- that is, to shorten training time, improve performance, and conserve limited resources (e.g., use of

JHPIEGO Mission Statement

MISSION: JHPIEGO is dedicated to improving maternal and child health in developing countries by increasing the availability of reproductive health services worldwide.

GOAL: JHPIEGO works to increase the number of qualified health professionals trained in modern reproductive health care, especially family planning.

STRATEGY: For the nineties and beyond, JHPIEGO will accomplish this goal by

- Promoting integration of basic reproductive health training in the curricula of schools of medicine, nursing and midwifery to:
  - Ensure a steady supply of qualified trainers and health professionals
  - Complement in-service training programs
  - Decrease donor-dependency and reduce training costs
- Developing and field-testing new teaching technologies to shorten training time, enhance performance and conserve limited resources
- Increasing training capability in modern methods, such as IUDs, injectables and implants, and voluntary sterilization, to meet the projected increased demand and shift in contraceptive method mix over the next 20 years.

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anatomical models and of only "need-to-know" information presented in easy-to-use reference manuals);

- **Standardized and systematized clinical skills training** by developing standard step-by-step approaches that increase efficiency and effectiveness of training in clinical family planning methods: IUD, minilaparotomy, and Norplant;

- **Developed prototypic training and teaching materials** to disseminate the standard approaches;

- **Pursued initiatives to make the IUD a safer, more acceptable method;**

- **Developed guidance for preventing and managing infection** (in the context of family planning clinical and surgical procedures);

- **Assisted in development of national family planning clinical service guidelines** as the basis for training, service delivery, and quality assurance (in Egypt); and

- **Experimented with advanced computer-based technologies for distance learning.**

Most of these approaches are significant contributions which, when further and optimally pursued, can undoubtedly have a major impact in improving the quality and increasing the availability of family planning services in the coming decade.

1.5.2 Training Strategies at the Field Level

In some countries JHPIEGO's new approaches for clinical training have already begun to have an impact. Their use is not widespread, however. According to JHPIEGO's director, "In the field, 10% of sites might demonstrate 100% of the teaching advances, whereas the rest of the sites may have incorporated only some segments of the newly developed manuals and courses." For example, the pelvic models needed for JHPIEGO's new approach to IUD training are not consistently available (noted as a problem in Brazil). Even newly developed projects (e.g., in Chad) do not incorporate the "competency-proficiency" approach which JHPIEGO leadership cite as central in their overall training strategy.[13]

There are several reasons for this. First, JHPIEGO training approaches are in such a state of ongoing evolution (including development in various countries and field testing in others) that it is not possible for every activity in the field to represent the latest thinking in Baltimore. Second, JHPIEGO has not developed a documentation strategy that permits it to communicate new approaches effectively to others. Third, in many countries, JHPIEGO has tended to continue working with long-existing personal contacts and institutional linkages, and this has impaired its ability to step back and undertake new approaches. Finally, field constraints make it impossible for any CA to carry out all strategies consistently.

At the same time as not all new training approaches have been widely introduced, JHPIEGO activities continue to include

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[13]JHPIEGO identifies three levels of achievement in clinical skills training: (1) *skills acquisition* -- the trainee knows the component tasks and sequence for performing a certain procedure (skill); (2) *skills competency* -- the trainee is able to perform the procedure safely under supervision; and (3) *skills proficiency* -- the trainee is able to perform the procedure efficiently without supervision.

carry-overs from the "old JHPIEGO." Notable is the continued training of ob/gyns to perform laparascopic tubectomies, coupled with training and support for maintenance and repair of laparascopic equipment. This is not necessarily bad, but represents a problematic issue (see Appendix D).

1.5.3 Program Decision-Making

Strategic Planning vs. Target of Opportunity

Central to the new training approaches, of which JHPIEGO is rightly proud, is systematization and development of standard step-by-step approaches that increase efficiency and effectiveness. This is what JHPIEGO means by "the JHPIEGO way." In striking contrast, while JHPIEGO has adopted this approach for clinical skills training, it does not apply the same principles for the overall management of its program. It should.

JHPIEGO's program continues to be dominated by a "target-of-opportunity" approach rather than strategic planning. As staff acknowledge, many activities are simply initiated in response to targets of opportunity -- and staff defend this approach. JHPIEGO has made little effort to use strategic planning: systematic analysis of options and establishment of priorities and related strategies aimed at achieving the best use of limited resources. JHPIEGO has engaged in some strategic planning during 1991, as part of the organization development process noted above, but the effort has focused chiefly on internal personnel and management issues rather than JHPIEGO's training program.

JHPIEGO's mission statement (see above) contains three statements under the heading "strategy." These are quite general statements, however, which are actually more like objectives than strategies. For example, the first "strategy" is stated as: "Promoting integration of basic reproductive health training in the curricula of schools of medicine, nursing and midwifery...." But how is JHPIEGO doing this? What approaches has it found to be most successful? To be most cost-effective? Similarly, we may look at the third "strategy": "Increasing training capability in modern methods, such as IUDs, injectables and implants, and voluntary sterilization...." Again, how is JHPIEGO doing this? What approaches has it found most successful? To have the greatest impact? To be most cost-effective? Answers to these questions are not readily available -- but should be.

In addition to responding to targets of opportunity, JHPIEGO also tries to be responsive to A.I.D. -- which is appropriate. However, the combination of responsiveness to A.I.D. and responding to targets of opportunity may result in substantial activity with relatively little to show in the end, and needs to be

guided by rational technical criteria.[14] To institutionalize family planning training in a country, and to also achieve a multiplier effect (and impact) in improving service delivery, requires much more than responsiveness to A.I.D. and targets of opportunity.

Many of the "targets of opportunity" have grown out of relationships developed with ob/gyns trained in Baltimore. This is changing, but many projects still reflect the older approach. Sometimes these ties have resulted in JHPIEGO's supporting activities that appear at odds with country strategies. For example, in Morocco, JHPIEGO's long-standing links with the National Training Center for Reproductive Health (NTCRH), whose director continues to favor laparoscopy, conflict with USAID and Ministry of Public Health efforts to introduce minilap training and to expand IUD training (despite JHPIEGO's having participated in a laudable multi-agency country strategy planning exercise). The implications are serious; expanding the method mix and making VSC more widely available is essential to increasing prevalence in Morocco, where currently 80 percent of prevalence stems from pill use. In the Philippines, JHPIEGO's long-standing ties with the Fertility Care Center (FCC) again box it into training for laparoscopy, whereas an increase in minilap is needed for extending VSC access countrywide.

Strategies are important for achieving a wise use of scarce resources -- for getting the greatest impact with a fixed amount of funds. Responding to targets of opportunity was a reasonable approach in the early decades of family planning. However, as the number of clients to be served with contraceptive services increases exponentially in the 1990s and early 21st century, more effective use of resources will be essential. This means also more effective use of resources allocated to training.

Program Strategies vs. Training Strategies

JHPIEGO does not make a clear distinction between overall **program** strategies and technical **training** strategies. Program strategies should include, for example: how JHPIEGO's budget, including personnel time, is allocated among major program areas (e.g., pre-service vs. in-service); how to determine the regions and countries in which to concentrate; and how to determine what

[14]The history of JHPIEGO in Brazil seems to illustrate this issue. Active in that country since 1979, JHPIEGO has pursued four different approaches, all of which are either ended or about to end, and is now launching a fifth. Admittedly, Brazil represents a particularly difficult case, but JHPIEGO nevertheless appears to have given less strategic thought to its programming in this country than other Cas operating in the same problematic milieu. A 1991 evaluation faulted JHPIEGO for inadequate in-country presence and monitoring of its activities (Lassner, 1991). The situation may be improved now that JHPIEGO has recently appointed an associate director for Latin America, but the evaluation still points to the need for better strategies as well as more in-country presence.

interventions are most appropriate (needed and likely to have an impact) in an individual country. Training strategies can be further divided into: (1) generic training strategies (e.g., how to design a training course, how to make a workshop interesting and effective, how to train trainers-of-trainers, and how to evaluate and follow-up trainees); and (2) clinical skills training (e.g., how to train others to insert an IUD or Norplant).

Regional Strategies and Country Selection

JHPIEGO has not made a systematic effort to set priorities among regions and countries. Rather, in its choice of countries and activities, JHPIEGO has been guided primarily by whether assistance was requested by A.I.D. and/or some host-country entity and whether a proposed project seemed viable. No criteria exist to guide decisions as to the countries in which staff time or project funds should be invested (e.g., small country vs. big; high-prevalence country vs. low; country with good training infrastructure vs. poor, etc.).

Only with regard to sub-Saharan Africa has there been a clear effort to direct resources (but this in response to A.I.D. requests). Staff increases have been greatest in JHPIEGO's Africa division (6 persons to 12), and the percentage of central monies going to Africa has also increased.

Country Training Strategies and Needs Assessments

Nor does JHPIEGO have criteria to guide its decision-making at the country level. As of September 1991, JHPIEGO had no standard format or protocol for training needs assessments -- an essential tool for targeting training resources most effectively. JHPIEGO does conduct needs assessments but these are done in an idiosyncratic manner with thoroughness and accuracy varying with the orientation, expertise, and time availability of the individual JHPIEGO staff member. Where JHPIEGO has worked from a good needs assessment, results have been very positive -- as in the case of in-service training for nurses in Kenya (see Appendix L). In some cases, however, JHPIEGO decides what it will do without conducting an adequate needs assessment.

Related to this, JHPIEGO also has no criteria or conceptual framework as to what should go into a country training strategy. JHPIEGO has not yet developed criteria that would enable staff members to select institutions that are most likely to use JHPIEGO assistance to best advantage. Nor has JHPIEGO developed criteria to guide staff in deciding with which categories of health

care provider to work for the greatest impact. The Philippine case study presented in Appendix K illustrates this point.[15]

Encouraging Beginnings

A fair amount of strategic thinking is increasingly taking place. However, except for JHPIEGO's well-detailed training materials, few other approaches or strategies are documented in comprehensive enough detail to allow new staff or consultants to understand and then implement them. (For example, even the important "skill acquisition-competency-proficiency" approach which JHPIEGO leadership espouses most vigorously is not understood by all the JHPIEGO staff.) Some strategy beginnings appear here and there in writing, but the information presented is not readily available to the staff or consultants. For example, there is a great deal of good strategic analysis on computer discs and buried in trip reports written by the Associate Director for Asia and the Near East, but these need to be taken further in a systematic way.[16] Similarly, a preliminary schema linking training to stages of family planning program development has been set forth by JHPIEGO's Africa Office, but not taken any further.

Recently, in some countries, JHPIEGO has begun to take a more strategic approach. For instance, in Papua New Guinea, which JHPIEGO views as a model effort, JHPIEGO has worked closely with other agencies (World Bank and A.I.D.'s SEATS project) from the earliest planning stages to develop a joint training and service delivery strategy. JHPIEGO's training plans grew out of an in-depth study of the government's needs for service delivery personnel and trainers and includes a number of stages designed to lead eventually to institutionalization of training capacity within the country. Morocco is another example where JHPIEGO has recently worked closely with the mission to develop a "global strategy." In Brazil too JHPIEGO is seeking to coordinate inputs with those of other agencies.

JHPIEGO is also discussing ways to increase its impact by becoming more involved in work of other donors -- and "leveraging" their input. For example, JHPIEGO has discussed possible collaboration with IPPF in developing and producing training materials. JHPIEGO's director has also suggested that JHPIEGO should participate in World Bank project appraisal teams, thus influencing the design of that donor's programs to include appropriate training components.

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[15]One approach JHPIEGO is following, in a limited context, may be questionable. This is the "reproductive risk approach." Reasons for caution with this approach are discussed in Appendix E.

[16]A typical example is a xeroxed paper titled "Transcript of Presentation Made By Dr. Clayton A. Ajello, 'Insights into the Training Process," July 11, 1991. Another good example is Dr. Ajello's "Requirements for Establishing a Clinical Training Facility" (buried away on a 1989 Egypt disc).

1.5.4 Fit with IT Division's Operating Principles and Objectives

In 1990, the Office of Population's Information and Training (IT) Division developed a set of "Operating Principles and Objectives for Training" (see Appendix B). In general, the fit is good between JHPIEGO's program and the IT Division's operating principles and objectives, but some discrepancies exist.

For example, the first IT operating principle is:

> "Education and training have more impact when closely linked to service delivery."

JHPIEGO is aware of the importance of linking training to service delivery and now conducts most of its training in developing countries rather than Baltimore. Nonetheless, whether persons trained by JHPIEGO actually provide family planning services remains variable. For instance, in a nurse trainers' course in Egypt in December 1990, only 4 or 5 of the 15 nurses taking the course were directly involved in family planning.

The second IT operating principle is:

> "Training activities should flow from a comprehensive strategy based on the needs, resources, and stage of development of the country being assisted."

As noted above, JHPIEGO has no standard protocol or conceptual framework for training needs assessments (although this is said to be in the planning stages). Sometimes its training activities flow from a comprehensive strategy, but often they do not. From JHPIEGO's recent participation in several country program strategy planning exercises, however, it now has a good basis for developing its own comprehensive framework and strategy.

1.6 Overlapping Mandates

JHPIEGO's mandate overlaps those of numerous other CAs. The most direct overlap is with the three other CAs who implement the Family Planning Training for Paramedical, Auxiliary and Community Personnel (PAC IIb) project: the Program for International Training in Health (INTRAH), Development Associates (DA) and Pathfinder.[17] There is also overlap between the mandates of JHPIEGO and those of service delivery CAs (managed by A.I.D.'s Family Planning Services Division, FPSD) which support training as one of several components needed for good service provision. These CAs include the Association for Voluntary Sterilization (AVSC), the

[17]DA works in Latin America and Asia; DA's subcontractor, Pathfinder, works in the Near East-North Africa; INTRAH works in sub-Saharan Africa. For further details on "overlapping mandates," see Appendix C.

Family Planning Service Expansion and Technical Supports (SEATS) project and, again, the Pathfinder Fund. In addition, some other CAs also provide training, but primarily in management and in counseling and interpersonal skills, areas in which JHPIEGO does not now concentrate.[18]

Overlapping mandates have the potential for duplication of effort in the field and some competitiveness among the various CAs with regard to proprietary interest in materials developed. To their credit, JHPIEGO and the other CAs involved have made substantial effort to collaborate, and no serious duplicative efforts have been observed. Resolution of overlap issues generally takes place on a country-by-country basis, often at the field level, with different solutions being arrived at in different countries. Often these reflect long histories of relationships with host-country institutions as well as particular strengths of the individual CAs.

A.I.D.'s project monitors are generally aware of the broad mandates of the various CAs, but often they are not well informed at the subproject level of the other projects' work. When projects are in different divisions of the Office of Population, communication between project monitors may be minimal (e.g., between JHPIEGO in the IT Division and AVSC in FPSD). Moreover, the Office has no system that reviews training activities or strategies in a comprehensive way.

The existence of multiple organizations with overlapping mandates to conduct training is similar to the situation of overlap in other areas (e.g., management information systems, logistics) in the Office of Population and is inherent to the way the Office operates. A.I.D. has encouraged specialization among its CAs and supported certain CAs in developing expertise in specific areas (e.g., AVSC for counseling, Development Associates for materials development, and JHPIEGO for training related to IUDs). This has been important in minimizing duplication.

1.7 Conclusions and Recommendations

Conclusions

1. **Program in transition**. JHPIEGO is in the process of a major transition from a program (the "old JHPIEGO"), whose main components were training courses in Baltimore and a concentration on laparoscopy, to a far more diversified

[18] Management-oriented projects include principally the Family Planning Management Development (FPMD) project, whose mandate is to provide training in management skills, but also John Snow, Inc., University Research Corporation (URC), Pathfinder (institutional development), ABT Associates, and the Management Sciences for Health (MSH) Health Financing Project. Training in counseling and interpersonal skills is provided by the PACIIb Cas as well as by AVSC, Pathfinder, and other service delivery projects.

program. Over the past three years, JHPIEGO has made good progress. The "new JHPIEGO" features more targeted technical assistance and training in developing countries, inclusion of other contraceptive methods, and related technical approaches to make family planning safer and more acceptable. The "new JHPIEGO" is still very much a program in transition, however. In Baltimore, many of the staff are new, having only recently been hired. In the field, new approaches are not widely implemented and many old programs continue on. Much remains to be done to follow through on recent and current initiatives and to arrive at program strategies that result in cost-effectiveness and impact.

2. **Strategy development**. JHPIEGO has made laudable progress in developing strategies and standardized approaches for training in specific clinical skills (e.g., IUDs, VSC, Norplant). JHPIEGO has placed lower priority, and made less progress, in the equally important area of generic training skills (e.g., how to design an effective training course). JHPIEGO has also placed lower priority and is relatively weak in the area of program strategies (e.g., criteria for determining in which countries to work and what interventions are most appropriate -- needed and likely to have an impact -- in an individual country). Strategies for institutionalizing family planning training (pre- and in-service) remain to be fully and clearly articulated. JHPIEGO's program continues to be dominated by a target-of-opportunity approach rather than strategic planning.

Recommendations

To JHPIEGO:

1. **Strategy-clarification**. **JHPIEGO should engage in a "strategy-clarification" exercise to develop a set of strategies for working toward program objectives in the most cost-effective ways.** JHPIEGO should analyze its experience to extract lessons learned, but it should also look beyond its own experience to examine afresh evolving needs and possible new solutions. For each major program area, JHPIEGO should produce a short working paper in which the strategy, as well as pending issues, are set forth. Strategies developed should center on principles and processes that emphasize the importance of working from individual country needs; approaches should not be superimposed on countries. The deputy director for program management recommended below (see Chapter 5) should lead this exercise.[19]

[19]Recommendations in boldface type are the principal recommendations in this report.

To the Office of Population:

2. **CA mandates. The Office of Population should not try to define mandates so narrowly as would be necessary to prevent all overlap.** Nor should it prescribe roles so narrow that JHPIEGO and other CAs would be prevented from working with organizations with which they have long-term relationships and a natural entrée. Finally, **A.I.D. should not assume that having only one training project, or one training CA, would be a good situation, even** though this would minimize issues of overlapping mandates.

3. **CA sharing of training expertise. The Office of Population should find effective ways to facilitate sharing of expertise among its training CAs.** The following are appropriate topics: counseling; improving clinic management; clients' perspective regarding quality of service; IUD insertion, management and removal; infection prevention; management of genital tract infections in family planning service settings; curriculum development; development of effective simple training aids; natural family planning; management of family planning service delivery systems; family planning commodities management; supervision; and competency-based training and evaluation.

2. Training Materials and Methods

2.1 Training Materials

JHPIEGO's special area of expertise, for which it is A.I.D.'s lead agency, is training in long-term clinical methods of contraception: the IUD in particular and, although to a lesser degree, Norplant, and voluntary sterilization. Perhaps "new" JHPIEGO's most significant contribution has been the standardization of clinical procedures and the development of prototype training and reference materials for these three contraceptive methods, complemented by guidelines for infection prevention and management, all aimed at rendering these methods safer and services higher-quality.

An important contribution of JHPIEGO's training materials is the competency-based approach to the development of technical, clinical skills, especially those related to surgical and other sterile techniques. Developing these manual skills is an essential part of clinical training and one of the most difficult parts of a clinical skills course to standardize, i.e., to assure attainment of a specific level of learning by each trainee. JHPIEGO's training materials are particularly valuable because they facilitate and standardize a consistent, effective and efficient approach to developing these manual clinical skills.

These materials have not yet been widely introduced in developing countries, but have significant potential for both pre-service and especially in-service training. They include the following: (1) training packages for the three contraceptive methods; (2) reference manuals, and (3) prototypic family planning service guidelines.[20]

2.1.1 Training Packages and Manuals

The purpose of JHPIEGO's "training packages" is to facilitate and standardize effective and efficient competency-based clinical skills training courses for individual contraceptive methods. These training packages, which can be used "as is" or adapted to individual countries and training programs, are:

1. IUD insertion, management and removal (for the Copper-T 380A),

2. Minilaparotomy with local anesthesia, and

3. Norplant insertion, management and removal.

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[20]See "JHPIEGO Training Materials" (dated July 10, 1991) for a list and description of these training materials, including the languages in which each is available, its approximate cost, contents, and countries in which it has been successfully used.

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The heart of each training package is a prototype training manual designed to be used by both trainers and trainees. (JHPIEGO's minilaparotomy package uses AVSC's manual.) For each of the three contraceptive methods, the complete package contains four principal elements:

1) a **course outline**, which provides a day-by-day training schedule keyed to the training manual;

2) a **training manual**, which constitutes the heart of each training package. This is designed to be used by both trainers and trainees and to provide essential "need-to-know" information on the topic. The manual also describes how this information should be presented in a training course. It thus includes written pre- and post-tests to measure trainees' knowledge before and after the course); competency-based evaluation checklists (for pre- and post-training assessment of trainees' clinical skills); and a course evaluation tool.

3) **audio visual materials**, usually a set of 35-mm slides and a video cassette; and

4) **anatomic models** (in the IUD and Norplant packages) for students to use in practicing manual skills. (The IUD package contains two kinds of pelvic models and a hand-held uterine model for practicing clinical skills; the Norplant package has a model of the upper arm). These help trainees develop skills with less need to practice on clients.

All materials in each package are consistent and thus reinforcing in their content and approach.

The audio visual materials and anatomic models play a central role in the **"humanistic" approach** which is an important part of JHPIEGO's training philosophy. Throughout the world, clinical training has generally required that completely unskilled trainees practice techniques such as IUD and Norplant insertion on female clients to gain initial skills, thus subjecting many women to discomfort or pain. By "humanistic" approach, JHPIEGO means that it promotes the use of **training aids** to help trainees acquire basic skills without extensive practice on actual clients. This is an important objective. The training aids are of two types: anatomic models for practicing clinical procedures, and other visual aids (chiefly slide sets and videos). There is a vast need and demand for these training aids. The good ones are highly valued and make a significant difference in training.

2.1.2 Reference Manuals

In addition to the training manuals, each of which is part of a method-specific training package, JHPIEGO has produced

two important reference manuals. JHPIEGO undertook these on its own initiative, to standardize and raise the quality of care, especially in relation to use of IUDs. They are:

1. Infection Prevention for Family Planning Service Programs, and

2. Genital Tract Infection Guidelines for Family Planning Service Programs.

These reference manuals focus on the information necessary for clinical care. They differ from the training manuals in that they are not presented in the format of a training course or exercise.

A **reference manual on training skills** has been in process (several starts with several consultants) since about 1988. The latest effort, titled "Training Skills for Reproductive Health," is still being developed. This will apparently cover all the skills needed to design and implement a training program. If well done, it could make a major contribution in improving the efficiency and ultimate impact of training.

2.1.3 Characteristics and Qualities of JHPIEGO's Training Materials

Manuals and Related Print Materials

JHPIEGO strives to achieve certain qualities in its training and reference manuals. These can be considered general characteristics, although the materials vary in quality and the extent to which these characteristics are actually achieved. Specific qualities of the materials include the following:

1) The information presented is accurate, up-to-date, and consistent with the opinions and standards of leading authorities in the field.

2) The training materials are based on clear, detailed definitions of the knowledge and clinical practice behaviors (competencies) that are the objectives of the course or training experience. The goal is for both the trainees and the trainers to know exactly what the trainees are supposed to learn and be able to do at the end of the training. Training manuals come complete with written tests to measure trainees' knowledge before and after the course, and guides for pre- and post-training assessment of the trainees' clinical skills. Since the course objectives are keyed to essential knowledge and skills for safe practice, trainees are expected to a achieve all of the objectives.

3) The information included has been selected on a "need-to-know" basis (i.e., it does not include unnecessary details or complexities) and is presented in a manner that facilitates its use. For instance, information in the IUD manual is presented in a sequence which follows the usual way patients are cared for, starting with general counseling and ending with management of side effects and serious complications; the Infection Prevention Manual uses decision-tree flow charts. JHPIEGO is trying to apply principles of good teaching and learning in the organization and presentation of the material in its documents.

4) JHPIEGO has refined the manual skills involved in basic clinical procedures and disaggregated them into a sequence of short, distinct steps which make the procedure more efficient to perform and easier to learn; this also facilitates assessment of a trainee's competency. JHPIEGO's "no touch method" of IUD insertion is an example.

5) Course outlines call for the use of a variety of participatory or learner-active (i.e., "adult") teaching/learning methods. They also emphasize the use of anatomic models for the acquisition and refinement of manual skills.

Although the manuals have some common characteristics, they vary in many ways, including scope. For instance, each of them focuses on the knowledge and skills required for the technical aspects of the clinical care of individual patients; however, the IUD manual contains less guidance related to counseling and none on clinic management; by comparison, the Norplant manual is richer in both areas.

Audio-Visual Materials

Audio-visual materials have been a lower priority than the print materials. JHPIEGO has developed some slide sets and videos, of the generic prototype sort, to be used in classroom teaching and has distributed these to some of its trainees to use for "second-generation" training of service providers. JHPIEGO has also supported some local development of audio-visual materials. The quality of these materials could almost certainly benefit from the same level of attention that has gone into the manuals.

For example, a GTI video made for distribution throughout Egypt was a good idea but was amateurish and of a quality too poor to distribute. While the technical content may have been sound, the presenter lectured rapidly, violating most of the principles of adult learning that JHPIEGO seeks to teach trainers. The video would have been incomprehensible to viewers who had not already participated in JHPIEGO's GTI training course.

JHPIEGO has not sought assistance or collaboration in this regard from the Center for Communications Programs, the other A.I.D.-funded family planning program at Johns Hopkins University. Given the success the Center's Population Communication Services (PCS) project has had in producing compelling and professional-quality visual communications, it would seem that JHPIEGO could benefit substantially from working with PCS in this area.

2.1.4 Development and Dissemination

How Are JHPIEGO's Materials Developed?

Some of these materials started as products developed to meet the needs of specific JHPIEGO projects in one or more countries. In this case, the original document (and approach) were then reviewed and field tested in other settings, resulting in improvements and eventually generic products potentially adaptable worldwide. For instance, the Genital Tract Infection Guidelines for Family Planning Service Programs evolved from a module developed by the Zimbabwe Ministry of Health to provide "the minimum necessary knowledge for a nurse to manage patients with STDs.... " Similarly, JHPIEGO's manual, Infection Prevention for Family Planning Service Programs, evolved from an initiative in Nepal and was subsequently elaborated and refined in Kenya (with funding provided by USAID/Kenya). After these two field experiences, it was taken to experts for review. This manual will be used for training of trainers and assessed further.

In contrast to these examples, some JHPIEGO materials are adapted from documents originally produced by others. For example, JHPIEGO's Norplant materials are based on a thick compendium developed by The Population Council, the Program for Appropriate Technology (PATH), and the World Health Organization (WHO). One might ask why JHPIEGO needed to produce yet another manual. The answer is that the earlier materials were produced to meet multiple needs -- not just training. JHPIEGO has revised them to include only "need-to-know" information material pertinent to training and reformatted them to support competency-based training and assessment. Basing a JHPIEGO manual on other documents also helps assure technical consistency between a variety of materials on the same subject.

JHPIEGO's materials are at various stages of development. Some are still considered drafts (e.g., the Norplant manual). All materials are dated on every page and stored on computer disks, implying that they may eventually be revised. This is important, since various improvements are needed. For some topics, JHPIEGO has submitted the draft manual to various experts for technical review in order that the manual produced represent a consensus in the field. For instance, the Infection Prevention manual was reviewed by experts from the World Health Organization, the U.S.

Centers for Disease Control, the International Planned Parenthood Federation, and AVSC (and will be published under the imprimatur of these organizations).[21]

JHPIEGO is aware that its materials are not perfect and is committed to further field-testing of some. Its annual workplan for PY 5 calls for field-testing and evaluating the clinical skills training packages for IUDs, Norplant, GTIs, and infection prevention in more than 12 countries. The goal is to have generic products which are adaptable worldwide.

Dissemination and Local Adaptation

JHPIEGO presents its manuals as prototypes and invites local adaptation and revision. Each manual carries a statement that "This publication is in the public domain and can be used or adapted freely by anyone" and an offer to send copies of the document on computer disk or by modem to facilitate local revision. This is very appropriate. Even the training course outlines seem to be used mainly as reference documents -- that is, they are not being used "as is" but rather used to support the local development of specific courses.

JHPIEGO's manuals are being used in some manner in a variety of JHPIEGO curriculum development and training projects. They have been shared with other international family planning and reproductive health agencies, including all of the Office of Population CAs. The task of dissemination has only begun, however, as is illustrated by the fact that staff of INTRAH's Regional Office in Nairobi had not seen and did not have copies of JHPIEGO's manuals. JHPIEGO has made efforts to distribute copies to CAs and other lead agencies, but greater efforts are needed to get materials to the field.

2.1.5 Content and Use of Specific Materials

This evaluation was not able to examine every detail of each training package or manual and its use in the field. Some achievements stand out, however, along with areas needing improvement.

The IUD: Revitalizing An Important Method

One of the "new" JHPIEGO's major areas of emphasis has been the IUD. JHPIEGO has worked hard to make this method, which had fallen into disfavor in many countries, safer and more acceptable.

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[21]JHPIEGO has been working hard to arrange large-volume printing of this manual so that its low cost ($.90/copy) will permit mass distribution to all organizations working with the sponsoring organizations.

In the early 1960s, IUDs surfaced as an important method of contraception. Unfortunately, following rapid, widespread introduction in South Asia, by the 1980s backlashes had occurred there and elsewhere due both to inadequate provision of this method and to problems with the early devices. The IUD has now gone through several generations of technical refinement, resulting in the new Copper T 380A. Although highly promising, this new IUD was nevertheless launched into an environment of substantial negativism due to past problems and complications including infection, perforation, and infertility resulting from insertion by poorly trained service providers (see Appendix H).

To its credit, JHPIEGO recognized the great potential of the Copper T 380A and moved in several important ways to revive and extend the use of the IUD. Specifically:

1) JHPIEGO's IUD training manual, Copper T 380A IUD Guidelines for Family Planning Service Programs, standardizes and details each step in the process of "safe and gentle" IUD insertion and removal. Information is presented in a sequence that follows the typical progression of patient care, starting with general counseling and ending with management of side effects and serious complications. Its discussion of the "no touch method" of IUD insertion, which permits insertion of the IUD directly from the package, is an example of JHPIEGO's efforts to disaggregate clinical skills into short steps that make learning the procedure easy.

2) JHPIEGO has helped produce an anatomic pelvic model and introduced its use to develop a "humanistic approach" in IUD insertion training. This has the advantage of avoiding the usual situation in which completely unskilled trainees practice IUD insertion on female clients to gain initial skills.[22] A second important advantage is reducing the need for large numbers of IUD clients in order to train service providers in IUD insertion.

3) JHPIEGO's most comprehensive training package is for the Copper T 380A IUD. This is formatted to be conducted as either a one- or two-week course. The complete package includes: a set of slides; family planning service program guidelines; guidelines for developing an IUD program; two kinds of pelvic models and a hand-held uterine model for practicing clinical skills; and a video

[22]JHPIEGO has found that both IUD and Norplant training can be completed in less time with better results through use of anatomic models. An important study in Thailand showed that midwives who practiced IUD insertion first on anatomic models achieved competence after only 1.6 insertions on clients, in contrast to the 6.5 insertions on clients required without previous practice on a model.

cassette (available in English, French, Spanish, Arabic, Nepalese, or Thai).[23]

4) Consistent standards have been established so that quality control visits can effectively be carried out by a number of examiners in different parts of a country expecting uniform outputs in terms of client teaching and clinical use of the IUD; and

5) To minimize complications directly related to IUD insertion, JHPIEGO has brought together specialized information on genital tract infections and infection prevention. This is presented in the two complementary reference manuals listed above.

A major field-level effort related to the development of JHPIEGO's IUD materials took place in Egypt, where JHPIEGO was the lead agency in helping establish the Regional Center for Training in Family Planning (RCT) (see Appendix I). A central objective in establishing the RCT was to extend Egypt's national IUD program in a safe, uniform and replicable way and thus expand its chances for success. JHPIEGO's contribution was crucial and, at the same time, this gave JHPIEGO opportunity to develop and improve its generic IUD training materials.

Lessons learned in the process of codifying and creating uniformity in IUD training and services should have far-reaching effects in the advancement of other contraceptive methods such as Norplant. In addition, there will be important spin-off effects on techniques of training medical professionals in developed as well as developing countries.

Areas Needing Improvement. The IUD manual was JHPIEGO's first; in comparison to the later manuals, it is less complete. While strong on the manual skills involved in IUD insertion and removal, it is weaker in related program areas. The manual does not address or designate time for training related to ensuring privacy, record keeping, and other aspects of clinic management for quality care.

The content on counseling seems thin. (One afternoon is designated for learning related to counseling and counseling skills are included in the post-training clinical competency assessment, but relatively little substance is provided). In addition, the counseling section refers to another document, identified only as

[23]In Kenya, Ministry of Health officials were impressed by the IUD training package. Both physicians and nurse-midwives had expressed concerns about Copper T 380A IUDs, in relation to safety (due to tarnishing in the package), efficacy (alleged high expulsion and failure rates), and acceptability (potential users refusing to accept a tarnished IUD). A JHPIEGO demonstration of its IUD training package, however, helped convince Ministry of Health trainers to request technical assistance from JHPIEGO in revamping Kenya's in-service training program.

"Path", which is neither reprinted nor clearly referenced within the actual manual. This implies that a second, supporting document is needed to teach the course and is quite confusing.

The content on managing side effects and complications, adapted from an INTRAH manual,[24] is inadequate, weak, or confusing in several important areas. One is ectopic pregnancy, a potentially life-threatening complication. Also lacking is adequate guidance on what to do if the cervix is red, "inflamed," or has an "erosion," situations that cause many women who want IUDs to be denied them unnecessarily.[25]

Minilaparotomy

JHPIEGO's minilap materials derive in large part from its pioneering work in Kenya, as well as from similar work in Zimbabwe. For the manual in its minilap training package, JHPIEGO uses AVSC's Safe and Voluntary Surgical Contraception (which it acknowledges as AVSC's). In Kenya, JHPIEGO has also supported production of a Kenyan minilap manual (developed together with the local Department of Obstetrics and Gynecology and AVSC). The course outline and teaching slide set have been extensively field-tested in Kenya and Zimbabwe and most of course components are designed for use in an African setting. The slides show minilap as actually performed in Africa. A video on the procedure itself was produced in clinics and hospitals in Kenya. A second video, on counseling, is targeted toward African health care providers.

Infection Prevention: An Important Initiative

The reference manual, Infection Prevention for Family Planning Service Programs, is a unique resource. It brings together for the first time information designed to promote the safety of clients and providers involved in invasive family planning methods: IUDs, VSC, and Norplant. This is information that would otherwise be inaccessible to most developing country family planning program managers, trainers, and clinicians. The manual is thus a significant and much needed contribution to the field. Even though quite new, the manual is relatively widely known, is highly valued, and is being used.

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[24]INTRAH, *Guidelines for Clinical Procedures in Family Planning and Sexually Transmitted Diseases: A Reference for Trainers*, 1989.

[25]Many developing country doctors, midwives, and nurses lack adequate information regarding cervical ectopy and how to distinguish it from cervical conditions that may require treatment or that contraindicate IUD insertion. A red and inflamed cervix can occur with no abnormal cervical or vaginal discharge and no pain, itching or other symptoms of genital tract infection. This condition is apparently common, especially among oral contraceptive users, in Morocco (and other countries, such as Turkey). In some cases it may reflect cervical ectopy, a benign condition that can result from use of oral contraception. Cervical ectopy is often misdiagnosed as cervicitis, however, causing some women to be denied an IUD when it would not be harmful.

Areas Needing Improvement. One specific problem with this manual concerns its directive to soak in bleach all materials contaminated with blood or body secretions. Such soaking causes rapid deterioration of expensive cloth and latex products -- and appears to be resisted by many people in the field. For example, although physicians at the Fertility Control Center in Manila said they like the infection prevention manual, they were not following this particular recommendation, which they may consider impractical, even though it is theoretically necessary to protect personnel, including cleaning and laundry staff, from AIDS.

Although JHPIEGO sought expert opinion regarding these standards, it may not have subjected them to adequate pre-publication testing in the field. When even the Fertility Care Center in Manila -- a JHPIEGO "international training center" -- fails to follow the manual's directives completely, as was observed during this evaluation, something is wrong: The recommended standard may be unnecessarily rigid and high, in which case alternative approaches should be offered. Or, if the standard is absolutely necessary and should be retained, then the manual should be revised to communicate the need for the standard so effectively that it will be followed. It is counterproductive to set a standard with which even a JHPIEGO training center does not comply.

Genital Tract Infection Guidelines for Family Planning Service Programs

This reference manual focuses on abnormal vaginal and cervical discharges and other symptoms which arise from the uterus, cervix, vagina, pelvis and external genitalia. It was developed in large part to support the safe use of IUDs and was undertaken by JHPIEGO, on its own initiative, as part of its effort to revitalize the IUD. This manual -- and JHPIEGO's generally high level of attention to prevention, diagnosis, management and treatment of GTIs -- constitute an important contribution to preventing IUD insertion in women with vaginal/cervical infections, thus protecting those women and, as a consequence, the acceptability and reputation of IUDs.[26]

JHPIEGO distinguishes between genital tract infections (GTIs) and sexually transmitted diseases (STDs) for two reasons. The first is because of the negative social implications associated with STDs. Second, some vaginal and cervical infections result from causes other than sexual transmission of infection and some STDs (such as AIDS) are manifested through disease complexes which

[26]The term "reproductive tract infections" (RTIs) is also used for what JHPIEGO refers to as "genital tract infections." Women's health advocates have recently highlighted the need for family planning service providers to show more concern for problems of reproductive tract infections (e.g., Ruth Dixon-Mueller and Judith Wasserheit, *The Culture of Silence: Reproductive Tract Infections Among Women in the Third World*, New York, International Women's Health Coalition, 1991). JHPIEGO's manual provides concrete guidance.

do not include the usual signs and symptoms of genital tract infection.

The manual is organized by categories of symptoms (presenting problems), instead of being based on disease entities. This is a very useful orientation.

Areas Needing Improvement. Unfortunately, the manual does not adequately address the problem, mentioned earlier, of a red, apparently inflamed cervix in the absence of abnormal discharge. There is a chapter on vaginal discharge, but none on cervical abnormalities. The manual fails to address the need for a better way to differentiate between cervicitis associated with infection (i.e., a contraindication to IUD insertion) and cervical ectopy (i.e, a common benign abnormality which is not known to increase risks associated with IUDs).[27]

The GTI manual also seems difficult to use, in part because it contains several flow charts that refer back and forth to one another. The actions prescribed by the flow charts[28] are not uniformly followed, even at JHPIEGO international/regional training centers (e.g., in Morocco) that have been provided with the necessary laboratory equipment.

Additional Topics Needing Attention

JHPIEGO has by no means exhausted all the topics that could benefit from well-designed training and reference manuals. One particularly urgent area is that of septic abortion. Incomplete abortions are responsible for one-third of all maternal deaths in developing countries; treatment of septic abortion absorbs large amounts of hospital staff time; and a large proportion of the beds in gynecological wards are filled with women suffering from this condition. In most developing countries, the aspiration equipment that could successfully treat most of these women does not exist and hospital personnel are helpless. Recent testimony by A.I.D. before Congress has clarified that the Mexico City policy guidelines allow for provision of training and

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[27]Concerning **cervical ectopy**, the following conclusions are relevant: (1) Cervical ectopy may be a relatively common condition among women, especially oral contraceptive users, in some countries. (2) Many developing country doctors, midwives, and nurses lack adequate information regarding cervical ectopy and how to distinguish it from cervical conditions which may require treatment and/or which contraindicate IUD insertion. (3) This lack of information may cause many women who want IUDs and who could safely use IUDs to be unable to get them. (4) JHPIEGO's training materials do not adequately address the problem of cervical ectopy. Recommendation: JHPIEGO should study the issue of cervical ectopy and decide how to advise clinicians in developing countries to proceed when they encounter a client with red, inflamed-appearing tissue surrounding the cervical os but no other signs and symptoms of vaginitis and/or cervicitis. JHPIEGO should seek help from outside experts to decide this. It should then revise its IUD and GTI training materials to incorporate this advice.

[28]E.g., to gram stain endocervical exudate from women with a friable (bleeds easily on touch) cervix.

equipment to treat septic and incomplete abortions (including illegal abortions) as well as post-abortion counseling and services, including contraceptive services (see Appendix F).[29]

Cervical cancer, the leading cause of cancer death in women in developing countries, is another important reproductive health area which could benefit from JHPIEGO's attention. The use of pap smears as a mass screening method for pre-cancerous conditions of the cervix is beyond the capacity of most developing countries. An important initiative would be to evaluate, by clinical research or pilot project(s), the value of gross inspection in the early diagnosis of cancer of the cervix (using the facilities of a university department of ob/gyn and an associated department of pathology in a country where the incidence of cervical cancer is high).[30] Subsequently, if proven advantageous, gross screening of the cervix for suspected cancerous lesions can be added to the GTI manual (see Appendix G).

2.1.6 Other Limitations

1) Beyond manual skills. Although JHPIEGO's training materials are consistently excellent in regard to the development of manual skills for clinical contraceptive procedures, manual skills are not the only objective of family planning training. JHPIEGO's materials are less strong in such equally important areas as counseling, quality control, clinic management, and general training skills.

2) Course outlines. The training course outlines are not as widely known and used as they should be. It appears that the course outlines are most often used as reference documents (rather than as the actual basis for a course). They may be difficult to use and have not been adequately field tested. (Being sent to affiliated regional/international training centers for comment is good but does not constitute adequate field testing.) Documents which establish technically correct standards but are not followed are not good enough. The outlines could and should be improved.

3) Use of pre-packaged training courses. A pre-packaged course is extremely valuable as a model, guide, or point of departure for trainers who are establishing a new training course or augmenting an existing one. However, the most effective and efficient training builds on the pre-existing knowledge, attitudes, and skills of the people to be trained and must be designed to achieve specific abilities based on the job(s) the trainees are being prepared to fill or to correct specific service delivery

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[29]Population Crisis Committee, *U.S. Government Clarifies Implementation of Mexico City Policy Abortion Restrictions*, 1991.

[30]Gross inspection or screening: screening by the naked eye.

problems. No pre-packaged course is able to provide a perfect fit with these specific training needs. Thus even the best training materials must be adapted and/or used in combination with other materials to create a course which is appropriate for local use. While the JHPIEGO training manuals do not seem to be (and probably cannot be) picked up and used as the basis for a comprehensive training course, they provide an excellent basis for the difficult clinical skills core and may also be used to augment or fill in other spots in a course.

4) Audio-visual materials. These have been a lower priority than the print materials; the quality is not uniformly high.

5) Dissemination. Despite JHPIEGO's efforts to make its training materials available, they are not as widely known as they should be.

2.1.7 Conclusions and Recommendations

Conclusions

1. General. **JHPIEGO's training materials have many good features, although they vary in quality.** Some aspects are excellent, others weak. The materials are strongest in the area of training in manual techniques of clinical skills. They are less strong in areas such as counseling, quality control, clinic management, and general training skills.

2. **Standardization and competency-based approach to clinical skills training. A unique contribution of JHPIEGO's training materials is the competency-based approach to the development of technical, clinical skills, especially those related to surgical and other sterile techniques.** Developing these manual skills is an essential part of clinical training and is one of the most difficult parts of a clinical skills course to standardize, i.e. to assure a minimal level of learning in each trainee. JHPIEGO's training materials are particularly valuable because they facilitate and standardize a consistent, effective and efficient approach to developing these manual clinical skills. Such materials make it easier for a proficient clinician to teach; however, they do not eliminate the need for involvement of a clinically proficient role model or preceptor in clinical training.

3. **Revitalization of the IUD. One of the "new" JHPIEGO's major areas of emphasis has been the IUD.** JHPIEGO has worked hard to make this method, which had fallen out of favor in many countries, safer and more acceptable. JHPIEGO has now laid important groundwork which, with continued follow-through, could have a major impact in increasing the contribution that the IUD makes to contraceptive usage throughout the world.

4. GTI and infection prevention. **JHPIEGO's initiative and the quality of its work regarding the management of GTIs and infection prevention is praiseworthy.** Attention to these problems was needed. JHPIEGO's work to date has been done well; it provides essential support for the provision of IUDs and VSC.

Recommendations

There are, nevertheless, many ways in which JHPIEGO's training materials can be improved. Suggestions follow.

1. Revision of manuals. **JHPIEGO should continue to subject its current training manuals to the process of assessment, revision, field-testing, and revision.** Some changes are recommended below; others have been suggested in the text.

   - Training and reference manuals should describe acceptable alternatives to ideal practices whenever possible in order to make it as easy as possible for developing country institutions to use them.

   - Documents that seek to establish standards should attempt to motivate compliance with those standards by explaining clearly why each recommendation is necessary.

   - JHPIEGO (and other CAs) should include names of authors and/or contributors on the inside cover of a manual. To minimize inter-organizational resentment when adapting materials developed by another organization, names of the original authors should be retained as part of the credit given the organization whose material is adapted.

2. Counseling, quality control and clinic management. **JHPIEGO should expand its attention beyond the technical aspects of the physical care of individual clients and give more emphasis to training in counseling, quality control and clinic management.** Where possible, it should incorporate materials already developed by others (with proper attribution) or collaborate with CAs specialized in these areas.

3. IUD training. **JHPIEGO should continue to play its key role in reviving the IUD and promoting its widespread availability and acceptability.** It should clarify lessons it has learned in the process of standardizing IUD training and services and use these for advancement of other contraceptive methods such as Norplant. Results from the Thai study (which documented IUD insertion competency after only a few insertions in actual clients by trainees who had used anatomic models for acquisition of initial skills) should be published, the study

repeated elsewhere and, if results are similarly positive, incorporated into new standards for IUD training.

4. GTI management and infection prevention. JHPIEGO should continue its work in infection prevention and the management of genital tract infections in family planning service settings. Further work is needed on the issue in the Infection Prevention manual of soaking in bleach. If the standard is found to be absolutely necessary, the manual should be revised to communicate the need so effectively that it will be followed.

5. General training skills. JHPIEGO should develop greater clarity and competence regarding the general training skills needed to design and implement a training program. It should finish, circulate, and field test the draft manual which has long been under development.

6. Distribution of teaching aids. JHPIEGO should assess the need and demand for the training products it has already developed (manuals, slide sets, videos, and anatomic models) and make a plan to produce and distribute large enough quantifies of these materials to meet the need for them in a far more comprehensive way. Plans for low-cost publication of the Infection Prevention manual should be pursued.

7. Audio-visual materials. JHPIEGO should produce more slide sets and videos to use in training. (Slides would be a good adjunct to training materials related to differential diagnosis of cervical abnormalities.) JHPIEGO should get technical input from Johns Hopkins' Population Communication Services Project in this area.

8. Evaluation of the cervix. JHPIEGO should study the issue of cervical ectopy and decide how to advise clinicians in developing countries to proceed when they encounter a client with red, inflamed-appearing tissue surrounding the cervical os but no other signs and symptoms of vaginitis and/or cervicitis. JHPIEGO should seek help from outside experts to decide this. It should then revise its IUD and GTI training materials to incorporate this advice.

9. Screening for cervical cancer. The use of pap smears as a mass screening method for pre-cancerous conditions of the cervix is beyond the capacity of most developing countries. JHPIEGO should evaluate, by clinical research or pilot project(s), the value of gross inspection in the early diagnosis of cancer of the cervix. Subsequently, if proven advantageous, gross screening of the cervix for suspected cancerous lesions can be added to the GTI manual.

10. Emergency treatment of septic and incomplete abortion. JHPIEGO should prepare a training module for the emergency treatment of septic and incomplete abortion. Wherever possible, this clinical training should be planned and carried out in conjunction with activities (including those sponsored by other organizations) to provide post-abortion contraceptive counseling and services.

2.2 National Family Planning Service Guidelines

A related part of JHPIEGO's overall strategy of standardization to reduce training inefficiencies is the development of national family planning service guidelines.[31] It is not efficient for dozens of different training and service delivery organizations in a given country to direct service providers to do things in contradictory ways. In contrast, if a country can develop and put into practice a uniform set of service standards (or clinical guidelines), according to which service providers are trained and subsequently perform, the quality and efficiency of service provision are almost certain to improve.

To support countries in developing their own national clinical standards, JHPIEGO has now produced, and made available on computer disc, a set of prototypic family planning service guidelines.[32] As with many of JHPIEGO's prototype products, this too evolved from a specific country experience, this one in Egypt.

In 1988, USAID/Cairo asked JHPIEGO to help establish a family planning training center. Family planning demand was increasing rapidly in Egypt but there were too few service providers able to meet that demand with quality services. USAID/Cairo wanted to increase rapidly the numbers of competent service providers and to do so established a buy-in to JHPIEGO to create what is now the Regional Center for Training in Family Planning (RCT).

When JHPIEGO began to help design the RCT courses and curricula, family planning services were provided in idiosyncratic and often inefficient ways. The Ministry of Health viewed national guidelines as essential for improving the quality of family planning services in Egypt. JHPIEGO and RCT staff realized the

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[31]INTRAH has also worked closely with several governments in developing national standards (e.g., Botswana Family Planning General Policy Guidelines and Service Standards. Botswana Ministry of Health, October 1987.)

[32]JHPIEGO has provided these prototypic guidelines, for example, to the Philippine Department of Health to help it in developing clinical standards for the Philippines; JHPIEGO also hopes to help Turkey develop guidelines as it did in Egypt.

Center itself needed a set of standards on which to base its courses and agreed to expedite the process. Many drafts later, several thousand copies of National Family Planning Guidelines for Egypt were published by the Ministry of Health.

Today all major family planning organizations in Egypt use some form of these guidelines for training and service delivery. Contraceptive prevalence has increased significantly. The RCT, with JHPIEGO assistance, is judged to have contributed substantially to this increase. An important element has undeniably been the national standards. This experience shows both how training can be linked to service delivery, and how training can have an impact on contraceptive prevalence.

Conclusions

National family planning service guidelines. **National standards of family planning clinical practice (also called "practice guidelines" or "national family planning service guidelines") can play an important role in standardizing training and service delivery.** If properly developed and implemented, national standards can link training to service delivery and increase contraceptive prevalence.

Recommendation. **A set of agreed-upon and appropriate standards of family planning clinical practice must exist to serve as the basis for all clinical work,** both in the classroom and in the family planning clinic. If guidelines don't exist, they should be developed.

2.3 Distance Learning Using Computerized Teleconferencing (OPTEL)

As part of its efforts to develop new training approaches and technologies, JHPIEGO has been experimenting with a teleconferencing technique (OPTEL) that allows for distance communication and learning. OPTEL equipment has been installed at JHPIEGO headquarters in Baltimore and in the Regional Training Center (RCT) in Cairo. JHPIEGO is eager to expand its use to other countries.

Interactive teleconferencing is an intriguing concept which captures the imagination and enthusiasm of participants and allows for accurate long-distance presentation of visual information. In the health and family planning context, OPTEL's most powerful capability is its ability to transmit pictures -- for example, microscopic slides for microbiology or tissue pathology, gross pathology such as skin lesions on living clients, charts, graphs, X-rays, ultrasound pictures, and fetal or cardiac

monitoring strips. These can be manipulated by the presenter as well as by the recipients of the communication.

On the negative side, OPTEL requires detailed advance preparation prior to a transmission. It requires intensive preparation of visual materials, and it requires orientation and accommodation on the part of all participants. The preparation time for a teleconference is beyond that needed for the usual lecture/conference/seminar event. It is also fairly expensive, although future advances are likely to simplify it and make its use less costly.

2.3.1 Use of OPTEL by JHPIEGO

OPTEL Capability in Baltimore

JHPIEGO's OPTEL staff is enthusiastic and knowledgeable. During the past two years, they have ironed out most of the irregularities and technical interruptions in the system. They have also prepared three manuals, which offer an introduction to the equipment, a short tutorial on the use of the electronic writing tablet, and some helpful information on how to design programs that emphasize the interactive features of the system. A library of images has been established, which stores material created for a particular session. These materials can be used over and over again in new contexts.

OPTEL Overseas: Cairo

The OPTEL installation in Cairo is not meeting its intended purpose and is rarely used. Teleconferencing between JHPIEGO/Baltimore and the Cairo center has been conducted at infrequent intervals. In total, over a 7-month period (January 1991-August 1991), only 25 hours of operating time were logged, only one hour of which was of high priority transmission.

The most valuable program transmitted to Cairo was a 60-minute quality assurance follow-up on laboratory techniques used in the diagnosis of GTIs. Its purpose was to reinforce an earlier, live GTI course at the RCT in which there were quality problems with the visual aids. The least valuable use, in terms of cost/benefit, was 10 hours of administrative meetings conducted between JHPIEGO's Baltimore staff and the RCT administrative staff in Cairo during the Gulf war -- communications that could just as well have been carried out by telephone and/or fax, at much less cost.

The system's relative isolation in the Egyptian RCT administrative area (which is separate from the medical school's department of ob/gyn) plus the busy teaching and clinical duties of the RCT staff, contribute to OPTEL's underutilization. No effort

has been directed to expanding its use; currently no JHPIEGO staff member has the both the ability and the time needed to develop any cost-effective use for this OPTEL installation.

In the West Indies

A similar system is in general use under the auspices of the University of the West Indies. This was not established by JHPIEGO, but JHPIEGO has used it for several courses directed to clinicians in the Caribbean.

2.3.2 Future Plans

JHPIEGO is eager to expand the use of this technology and, at the time of this evaluation, was proceeding with plans to install OPTEL in the Philippines, Indonesia, Morocco, and Turkey. JHPIEGO says it has already purchased teleconferencing hardware which it now plans to use to link two sites in Turkey. One of these, the Department of Community Medicine at Haceteppe University in Ankara, has many of the characteristics of an ideal receiving site, but the other, the Human Resources Development Foundation, Istanbul, has virtually none. This latter site is new and does not have the trainee base to justify its use for OPTEL activities. Most likely, it would resemble the Cairo RCT, in which OPTEL has clearly not fulfilled its promise to date.

2.3.3 Conclusions and Recommendations

Conclusions

Optel. **For JHPIEGO and A.I.D, OPTEL remains a sophisticated technology searching for an application, rather than a cost-effective tool for training in family planning.** JHPIEGO's field installation of OPTEL, in Cairo, is rarely used and no one currently has time to develop an appropriate use.

Recommendations

1. Existing installations. JHPIEGO should try to find an appropriate cost-effective use for its OPTEL installation in Cairo. JHPIEGO should continue to share the teleconferencing facilities of the University of the West Indies and use evaluations from this system to assess its value.

2. Future installation. **OPTEL should not be extended to other countries until the usefulness and cost-effectiveness of this currently expensive communications method is evaluated more completely.** OPTEL should be installed in additional countries only when it can be demonstrated to have an important role in a larger, clearly articulated strategy in the proposed country. Ideally, this should be not only a JHPIEGO strategy

but a country training strategy. (For a greater impact, JHPIEGO should consider approaches whereby this technology could also be used for other A.I.D.-sponsored activities, whether bilateral projects or those of CAs.)

3. Current plans to install. Plans to install OPTEL in Turkey, Indonesia, and Morocco do not appear to meet the criteria in the recommendation above and should therefore be canceled or deferred. In the Philippines, JHPIEGO states that the installation of OPTEL is to be funded through a USAID/Manila buy-in and that USAID/Manila wants the equipment to be installed. In this case, it may be appropriate to proceed. Nevertheless, important questions should be answered first. Who would use the system? And for what purposes? Where would it be located? At the Fertility Care Center, where expertise and services are almost solely centered on laparoscopy? If there, what concrete purpose would it serve? Would others have access to it?

3. Pre-Service Education: Institutionalizing Family Planning in Medical, Nursing, and Midwifery Schools

3.1 Family Planning in Pre-Service Education: Overview

When international family planning efforts began in the 1960s, family planning was a new (and often resisted) idea and was generally not included in the basic education of developing country health care professionals: doctors, nurses, midwives, or others. The only way to train personnel in family planning was thus through in-service courses. For many years in-service training was the norm -- but it was increasingly recognized to be a very expensive norm.

A.I.D. concluded that costs of family planning training could be reduced by having family planning included in the basic education of doctors and nurses. It later made the same assumption with regard to midwives. JHPIEGO, along with INTRAH and possibly other CAs, was asked to make a major effort to put family planning into pre-service curricula. It is now part of the IT Division's Operating Principles and Objectives for Training to "Integrate family planning into the curricula of public and private educational institutions" and that "Family planning should be institutionalized in pre-service curricula" (see Appendix B). The Office of Population has no guidelines or strategy as to how this should take place, however, nor does it have any guidelines as to how much of the family planning training burden can be transferred from in-service training to pre-service education. This has been left up to the "training CAs."

In developing countries today, there is considerable variation as to whether family planning is included in pre-service education of doctors, nurses, and midwives. In some countries and in some schools, a good amount of family planning information is included. In others, family planning is there, but only marginally or superficially. In other countries, health care professionals graduate from their basic training with no understanding of family planning.

3.2 JHPIEGO: Pre-Service Activities but No Clear Strategy

The second part of JHPIEGO's mandate, as defined by A.I.D., is **"to institutionalize appropriate training in developing country medical and nursing schools, thus improving family planning service delivery."**[33] This appears also in JHPIEGO's mission statement (see Section 1.4.2). In the mission statement, however, midwifery schools have been added.

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[33] User's Guide to the Office of Population. Agency for International Development, 1991, p.21.

How does JHPIEGO work toward this goal? JHPIEGO has no documents which articulate a strategy for institutionalizing family planning -- neither in pre-service education nor in-service training. Nor is there a common understanding among staff as to exactly what is meant by "institutionalization." There is no clear statement about what is feasible, most efficient, or of exactly what knowledge or skills should be institutionalized. Often the term "integrate" or "incorporate" is used in place of "institutionalize." But there is not any clear shared vision either as to what the difference is between "integrate," "incorporate" and "institutionalize." What are the steps or basic components? Senior JHPIEGO staff have a sense of what is involved, but there are no project-wide guidelines to guide new staff, junior staff, or consultants, or even to facilitate decision-making by senior staff.[34] JHPIEGO occasionally refers to pre-service education as an efficient way to produce a "steady stream" of persons prepared to provide family planning services; this assumption is questionable.

Nor is "institutionalization" made clear in a way that allows A.I.D. to monitor or evaluate progress accurately. A.I.D. and JHPIEGO have also not established meaningful outputs and objectives for assessing progress. In the absence of clear definitions and meaningful targets and objectives, A.I.D. has no real way to evaluate JHPIEGO's effectiveness in this area.

Senior JHPIEGO staff can talk knowledgeably about why they pursued a given project in a given setting but, as in other program areas, JHPIEGO's approach to this task seems to be largely a "target-of-opportunity" approach. As one staff member stated (approximately): "When we find some institution that is interested in working with us, we would like to proceed. Why not?"

3.2.1 A Tentative Definition

Although JHPIEGO has not produced a consistent definition of the term, we might define institutionalization -- in the context of pre-service education -- as: "Incorporating basic family planning knowledge and values and, as feasible and cost-effective, training in family planning service delivery skills into the basic curriculum for the pre-service education of doctors, nurses, midwives, and other health care professionals."

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[34]For example, in February 1990, following an evaluation of the JHPIEGO-launched training center in Egypt (see Margolis et al. 1990), lively discussions took place between two members of this evaluation team and JHPIEGO senior staff. The JHPIEGO staff members were clearly intrigued by the subject of "institutionalization," and had multiple views as to what "institutionalization" might mean; but there was no consensus or even a basic definition, let alone a strategy for achieving it.

A framework for understanding the issues involved in institutionalizing family planning in pre-service education would begin with the clear recognition that two kinds of teaching and learning take place at the pre-service level. (This is true for any medical specialization, not just family planning.) These are: **didactic** learning (basic knowledge of a subject transmitted chiefly through classroom lectures) and **clinical** training (observing and learning how to perform surgical and other "hands-on" procedures). Didactic and clinical learning also take place in in-service training. In pre-service education, however, didactic hours occupy a much greater portion of the learning experience.

3.2.2 Typical JHPIEGO Pre-Service Activities

Despite lack of a clearly articulated strategy, there is a core set of activities that JHPIEGO employs for introducing/ integrating/ institutionalizing/ "strengthening" family planning in the basic education of doctors, nurses, and midwives. This is as follows:

1. Provide financial and technical assistance to faculty of an interested or "target" school, or schools, to review and revise the existing curriculum for either medical, nursing, or midwifery students. (This would obviously need to be preceded by policy dialogue to achieve the initial go-ahead.)

   In some cases, JHPIEGO may help faculty to develop a separate module on family planning and reproductive health. In other cases, the approach is to "integrate" family planning and reproductive health information throughout the entire curriculum (e.g., in discussions of maternal health, of child health, etc.). In some instances, both may be done -- as in the case of the Philippines nursing program (see Appendix K).

2. Once a revised curriculum has been agreed upon by the necessary authorities, "implement" the revised curriculum -- meaning, have faculty start using it instead of the old one. Subsequently, there may be evaluation to determine whether the curriculum is being used effectively.

3. Provide "academic skills courses" to key faculty members. JHPIEGO has recognized that a major deficit in medical education in developing countries is: large classes, impersonal didactic lectures, memorization, and limited clinical training experiences. To overcome this and make family planning/reproductive health courses effective, JHPIEGO offers "academic skills" training to the faculty teaching the family planning/reproductive health courses to enable them to be better teachers. JHPIEGO's "academic skills" courses focus on modern "adult learning" (i.e., interactive, participatory) techniques. The key faculty members may subsequently be

supported by JHPIEGO to teach this new approach to other faculty members.

The way this all occurs varies depending on the country and on whether medical, nursing, or midwifery programs are the target. For example, in Egypt, "academic skills" courses have not followed curriculum revision activities but have been offered to key ob/gyn faculty as a come-on. These Egyptian ob/gyn faculty were not interested in family planning per se, but had heard about or seen the new participatory methods that trainers at the Regional Center for Training in Family Planning were being taught by a JHPIEGO consultant, and wanted to get in on this exciting new approach. JHPIEGO's hope is that these ob/gyn faculty will subsequently be more interested in family planning and will want to incorporate it into their curricula in a substantive way.

3.3 Pre-Service Education for Medical Students

Physicians have traditionally been the key category of health care provider with whom JHPIEGO has worked (although there is a shift to greater numbers of nurses and also midwives under the "new" JHPIEGO). What family planning knowledge and skills should be included in a physician's pre-service education? What and how much **didactic** or how much **clinical** knowledge and skills are feasible objectives? Does "pre-service education" of doctors mean only what they get during their basic four to six years of medical school? Or does it also extend to include the year of post-medical school training (rotating internship) that is generally required?

The degree to which medical students are afforded opportunities to perfect **clinical skills** during their four to six years of medical school varies from country to country and from school to school depending on the number of students, the student-to-teacher ratio, and the clinical training sites available.

A year of post-medical school training (rotating internship) is generally required, for which the best students go to teaching hospitals. Between 5 and 10% of graduates go on to some type of ob/gyn specialty training. These post-medical school years are primarily clinical service and represent the ideal opportunity to link technical training to competence and then proficiency. These years could be considered pre-service training because the recent graduates are still supervised and not yet practicing independently. (JHPIEGO apparently includes the internship year in "pre-service.")

Over the years JHPIEGO has aligned itself with academic departments of obstetrics and gynecology in more than 40 developing countries. Initially it used training in laparoscopy as a common entree to the core group of experts in reproductive health in a country. Over time many of these individuals informed and

influenced policy and decision-makers. They also innovated, in some measure, at their institutions, which were viewed as change agents. Many of these ob/gyn professors remain at medical schools and are in a position to continue to work at embedding family planning education into the didactic portions of medical students' courses on reproductive health and related fields of medicine and surgery where applicable.

3.3.1 Recent Activities

Integrating Basic Family Planning Knowledge and Attitudes into Undergraduate Curricula: Colombia Example

JHPIEGO has recently completed a 3-year project in Colombia which illustrates JHPIEGO's approach to integrating basic family planning knowledge into undergraduate curricula. This involved more than 20,000 first-year medical and nursing students in 19 schools in Colombia. The students were taught a JHPIEGO-sponsored revised family planning curriculum aimed at knowledge, personal attitudes, and practices. These "Fertility Management Courses" of 15 hours (one hour per week) were designed for groups of 20 students and were conducted as part of the regular curriculum. The course was a combination of didactic and interactive sessions led by selected faculty who participated in the organization of their respective school's program. Deans' orientations, faculty workshops, and supervisory visits were made in the course of the 3-year project. The ultimate goal is to establish a basis for the adoption of a standardized user-oriented family planning course for first-year medical and nursing students within the regular curriculum of the participating schools. Results are yet to be evaluated.

Clinical Training for Medical Interns

In contrast to the Colombia model -- in which JHPIEGO has helped introduce basic family planning orientation (knowledge and attitudes) for first-year students, but no clinical experience -- Kenya and Zimbabwe illustrate the provision of family planning clinical training to interns.

Minilap Training in Kenya

In Kenya, all interns are now required to learn to perform minilaparotomies during their internships, in preparation for two-years of government service as medical officers. JHPIEGO's project here is designed to institutionalize training in minilaparotomy -- performed under local anesthesia ("minilap/LA") -- for medical interns at 13 teaching hospitals. Over the long term, JHPIEGO believes that the project will drastically reduce the need for in-service training, as it will supply the government with a steady and increasing supply of physicians trained in female VSC.

The potential for incorporating minilap training into internship training appeared to be good: The government is committed to increasing the availability of VSC and to training personnel to provide it. Despite the favorable conditions, however, accomplishing this task was not easy.

It proved difficult at the start to develop clinical skill levels that met international standards. Each intern was expected to perform a minimum of 10 minilaparotomies during the clinical portion of the training, a sufficient number to achieve competence. It turned out, however, that their trainers, the medical officers who were their supervisors, were themselves not performing the procedure to acceptable standards. To address this problem, JHPIEGO added a simultaneous in-service training-of-trainers project for medical officers and nurses. Even so, two 1990 evaluations highlighted substandard clinical work being done by both medical officers and interns. JHPIEGO appears to have turned this situation around (six of the seven major recommendations made in the previous evaluation have been successfully implemented).

To a large extent, the marked improvement in the project was possible because JHPIEGO's project director, an activist hands-on physician, personally took a leading role, making five trips to Kenya and spending about two months there during 1990 alone. Also helpful was the use of clinical preceptors trained to mentor and supervise their students (rather than centering on classroom teaching), management of a clinical practicum, and assessment of clinical skills. JHPIEGO refers to this as the "coaching" method (meaning, clinical training on a one-on-one basis). This approach has long been used informally in medical education, but was just being adapted, codified, and piloted (in Kenya) by JHPIEGO for its programs at the time of this evaluation.

Institutionalizing minilaparotomy training in the 13 teaching hospitals in Kenya is a significant achievement, but there is a question as to whether any one country program should absorb this high a percentage of the project director's time (see Section 5.1). This involvement might be justified if JHPIEGO is able to extract a set of lessons learned from the experience that can be transferred to similar situations in other countries and fed into the development of generic prototype materials and approaches. JHPIEGO has made a good start in this direction, but most likely more could be learned from this experience and, if appropriate, applied elsewhere.

Family Planning for Interns/Residents in Zimbabwe

Completed in October, 1990, was JHPIEGO's project, "Family Planning Curriculum for Interns/Residents" in Zimbabwe.[35] This project had two parts: one featuring hands-on minilap/LA training (adapted from Kenya) and IUD insertion; and a didactic portion which JHPIEGO has described as "innovative" and "unusual in several respects." The innovative features included self-paced learning and small-group case problem-solving conferences (rather than lectures). Implicit in this curriculum is the need for faculty with sufficient time to devote to the course and with training in modern teaching methods to carry it off.

3.3.2 Plans for Program Year 5

For Program Year 5 (1991-1992), JHPIEGO projected that 47% of its activity would be directed toward "institutionalization" of family planning. Approximately half of "institutionalization" (23% of total activity) is to be directed toward students in schools of medicine (including post-medical school training), midwifery, and nursing. Approximately 11.5% of "institutionalization" activities is to involve medical students.[36]

In Program Year 5, "medical student activities" are planned in 18 countries. In half of these countries, the planned activities are to train faculty in more effective teaching methods. The "target" audience is as follows:

- In 3 countries: undergraduate medical students,
- In 6 countries: interns/residents,
- In 9 countries: faculty training in modern teaching methods and/or curriculum development.

These figures indicate that: (1) half of JHPIEGO's planned pre-service activities for medical students focus on training faculty to be better teachers; (2) two-thirds of remaining activities focus on the level at which medical students can learn clinical skills; and (3) the lowest priority is helping beginning students acquiring basic family planning knowledge and attitudes. These figures may not tell the whole story. This needs to be made explicit, however, in a strategy document. Is this the best

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[35]JHPIEGO undertook this together with the Department of Obstetrics and Gynecology, University of Zimbabwe, and the Zimbabwe National Family Planning Council (ZNFPC). See: JHPIEGO, *Intern/Resident Family Planning Training Curriculum, University of Zimbabwe, Department of Obstetrics and Gynecology, and ZNFPC*, October 1990.

[36]JHPIEGO Annual Workplan, Program Year 5, June 27, 1991.

balance of effort? Does faculty training in teaching skills have a good pay-off? What evaluation has been done and what does it show?

3.3.3 Current Practice in U.S. Medical Schools

To understand what may be feasible in developing country curricula, it is instructive to bear in mind what happens in the U.S. -- recognizing, of course, that conditions always vary from country to country.

In the U.S. medical education emphasizes use of small group exchanges for problem-solving, rather than lectures, except where didactic material is presented. Students in their first year of medicine are oriented to reflective listening (basic counseling) and modern approaches to history taking. Reproductive Endocrinology and the principles of clinical family planning are taught in the second year and are associated with the students' need for personal knowledge as well as the rights of patients to know their choices. The technical use of contraceptive methods is restricted to observation and participation during the required under-graduate clerkships in the third year of a four-year course. This may be enhanced by actual practical hands-on work during electives in the 4th year when students are making career choices for residencies.

The steps which occur from the beginning of the sequence of orientation to proficiency are:

a) unconscious incompetence (entering medical students);
b) conscious incompetence (oriented students, pre-clinical);
c) conscious competence (post-graduate interns/residents trained and performing under supervision);
d) unconscious competence (the proficient resident who trains others in the course of his/her residency program and who operates in independent practice subsequent to leaving an organized program). (Some individuals in this final stage may have the abilities to become "master trainers" as currently defined by JHPIEGO.)[37]

Conclusion: Family Planning Education for Medical Students

In most countries it is probably not realistic to expect that medical students could be ready to work as family planning service providers immediately after medical school--that is, on completion of undergraduate medical training. (Classes are too big to allow for hands-on training, the tradition in developing country

[37]Observations and conclusions by Alan J. Margolis based on many years experience in medical education.

medical schools does not lend itself to such an approach, and it is almost certainly not cost-effective.) Rather the more realistic strategy would be: (a) for all undergraduates to be given basic knowledge in reproductive endocrinology and family planning, and (b) for smaller numbers to receive further training (especially technical training in clinical methods) closer to the time when they might actually become involved in providing clinical services (e.g, during internships, residencies or special elective courses for small groups).

3.4 Pre-Service Education for Nursing and Midwifery Students

The "new" JHPIEGO is placing increased emphasis on pre-service education of nurses and midwives (relative to doctors). These two categories of workers are often discussed together because of their similarities, but there are also differences. These are important to bear in mind when assessing issues related to training for family planning. The question also exists as to whether priority should be given to training nurses or midwives, and under what circumstances.

3.4.1 Activities and Accomplishments to Date

JHPIEGO has supported numerous activities related to pre-service education for nurses and midwives, but results have been limited to date. As of February, 1991, JHPIEGO reported only three countries where changes have been made in the pre-service curriculum for nurses and midwives: Ghana, the Philippines, and Colombia.[38]

Approach

JHPIEGO's pre-service work with nurses and midwives is not designed to produce nurses or midwives who are able, when they graduate, to provide competent family planning services without further training. Rather the primary focus has been to instill basic family planning knowledge and pro-family planning concepts and values among the nursing and midwifery students. This is well illustrated by the project in Mexico (first in the list below).

JHPIEGO's current approach for integrating family planning into the pre-service training of midwives and nurses seems to include a sequence of activities aimed at: (1) revising the curriculum; (2) orienting at least one member of the faculty of each school to the revised curriculum; and (3) training one or more members of the faculty of each school in effective teaching skills. This sequential approach is well illustrated by JHPIEGO's work in the Philippines (see below).

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[38]Listed in POPTECH's *Background Paper for Evaluation of JHPIEGO* (Friedman 1991, p. 11).

In many countries, however, JHPIEGO projects seem disparate -- not part of a sequence which follows through to evaluation of an implemented curriculum. This is illustrated by the following listing of activities launched to date during the current cooperative agreement.[39]

Latin America:

o In Mexico: Basic Reproductive Health Training for Nursing Students. One of JHPIEGO's biggest pre-service efforts to date consists of courses for first-year nursing students in 35 Mexican nursing schools. The course objectives are to develop pro-family planning concepts and values among the students - to enable the students to manage their own fertility and to be able to discuss family planning with their friends and patients. Significantly, a major impetus to the acceptance of this pilot program was the fact that 1 in 20 university students in Mexico dropped out of school because of a "pregnancy problem." JHPIEGO is currently evaluating this project (primarily, it appears, to determine whether the courses were "institutionalized").[40]

o In Costa Rica: A project to review and improve the family planning content of courses for pre- and post-graduate medical and nursing students at two universities.

o In Colombia: A project (similar to that in Mexico) to encourage adoption of a standardized user-oriented family planning course for first year students within the regular curriculum of 19 nursing schools . The purpose is to increase the knowledge of students as potential users of family planning, with hopes that this will influence their future practice as professionals.

Asia:

o In the Philippines: Three projects to strengthen family planning training in all Philippine pre-service nursing school programs. (See case study below.)

o In the Philippines: Plans are being made to assist the Association of Philippine Schools of Midwifery to strengthen the reproductive health curriculum of the midwifery schools and expand the educational and reproductive health training skills of their faculties. This project should have an important impact, since

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[39]This section is included to note what JHPIEGO says it has accomplished. It is not possible to estimate the impact of these accomplishments. The section is based on the evaluation team's case study of JHPIEGO projects in the Philippines, on the report of an evaluation of the course in Nigeria, and on very brief summative information in various JHPIEGO reports.

[40]JHPIEGO *Annual Workplan Program Year 5*, Section on Monitoring and Evaluation, pp. 20-21.

midwives are the primary providers of family planning care in the Philippines. (See case study below.)

Africa:

o **A regional 6-week reproductive health clinical update and teaching skills course for 15 tutors from nursing and/or midwifery pre-service education programs in Anglophone West Africa.** This course, conducted in Nigeria, was based in part on an evaluation of earlier nurse-tutor training which suggested that tutors without family planning clinical skills training were not as effective (even for didactic teaching) as tutors who had had such training. Four weeks were devoted to a reproductive health/family planning update, including a clinical practicum on patient assessment and management, IUD insertion, and clinic management. Two weeks were used to strengthen teaching skills. The trainees were members of teaching faculties or held administrative positions with teaching responsibilities at nursing and/or midwifery schools. Although experienced teachers, they had limited knowledge of family planning; only one had previous family planning training. The tutors were adept at learning the clinical skills. Following the JHPIEGO-sponsored training, an on-site assessment of each trainee's classroom performance and review of their lesson plans found some improvement in their performance as teachers, but a need for still more improvement.

o **Regional family planning skills and teacher training for nursing and midwifery tutors from Côte d'Ivoire and other countries in Francophone Africa.**

o **In Cameroon: A workshop to develop parts of a reproductive health module (family planning and pre-natal, intrapartum and post-natal care) for medical, midwifery and nursing schools.** During the last year of its current cooperative agreement, JHPIEGO plans to assist faculty of these schools to develop four more sections of the module (STDs, infertility, gynecology, and newborn care), and will conduct a three-week didactic and clinical reproductive health/family planning course (including IUD insertion) for 10 midwifery/nursing faculty members.

o **In Côte d'Ivoire: Curriculum development activities at the School of Midwifery and provision of technical assistance and educational materials to the medical, midwifery and nursing schools.** This is an ongoing project, with much still to be achieved. JHPIEGO hopes to institutionalize reproductive health training into the pre-service curricula of all of the health professional schools in Côte d'Ivoire within the next 4 to 5 years.

o **In Ghana: Provision of anatomic models, educational materials, and reproductive health/family planning training for tutors and nurse-midwives from 30 nursing and/or midwifery schools.**

o In Chad and Burkina Faso: Assessments of reproductive health/family planning training components of pre-service nursing and/or midwifery education programs, in 1990-91, requested by USAID missions.

o In Chad: A new project to develop and integrate reproductive health modules (including family planning) into the pre-service curricula of the schools of midwifery and nursing. JHPIEGO will assist with curriculum development training, clinical and didactic reproductive health training, counseling/IEC teaching skills training for nursing and midwifery faculty members, the development of clinical training sites, and provision of educational and audio-visual materials and anatomical models. The goal is to develop the information, education and communication skills of nursing and midwifery students and to prepare them to provide family planning services.

Near East/North Africa:

o A three-day regional conference on the development of curricula and educational modules on reproductive health for the pre-service schools of medicine, midwifery, public health nursing and social work. The workshop focused on the importance of family planning and how to incorporate it into the curricula of these schools. (Done with RONCO while it was implementing the PAC IIa project.)

Case Study: Improving Family Planning Teaching in Philippine Nursing Schools

The Philippines is one of JHPIEGO's most important countries (ranking second only to Egypt in anticipated expenditures [$1.4 million] for PY 5).[41] JHPIEGO's work in this country illustrates JHPIEGO's general approach to pre-service education. Since 1987, JHPIEGO has been engaged in pre-service activities for nurses, midwives, and physicians, in five projects, as follows:

1) Pre-Service Education -- Doctors. This project aimed at strengthening family planning content in the pre-service curriculum of the leading medical schools. It was suspended in 1989 after two years. Filipino physicians involved say they do not understand why, but still wish JHPIEGO would resume the project.

[41]JHPIEGO projects in the Philippines during the past three years represent the major types of country-specific activities that JHPIEGO has been engaged in globally since the late 1980s. Ongoing (6), recent (1), and pending (2) projects include the following kinds of activities: pre-service education for medical, nursing, and midwifery students; in-service training for doctors and nurses; VSC training and institutional support; laparoscope repair-and-maintenance center support; and training in Baltimore for selected individuals.

2) Pre-Service Education -- Midwives. This is a new project, just getting under way. Its goal is to strengthen family planning content in the basic midwifery curriculum. Funding is more than triple what was allocated to nurses training (approximately $500,000).

3) Pre-Service Education -- Nurses (three consecutive projects between 1987 and 1991). The first two were designed to strengthen the family planning content in the basic pre-service nursing curriculum of 126 nursing schools, the third was to improve teaching skills of the nursing school faculty who will teach family planning. Together, the budget for these projects was less than $150,000, a relatively low amount.

The most comprehensive effort was for nursing students. A case study of this experience is provided here because it illustrates: (1) JHPIEGO's general approach to institutionalizing family planning in pre-service education; and (2) generic issues in pre-service education. (A more detailed version of this case is presented as Appendix K.)

The Philippines has over 100 nursing colleges graduating approximately 26,000 nursing students annually. (The number is constantly growing because running nursing schools has become a lucrative business.) The curricula of the nursing schools is coordinated by the Association of Deans of Philippine Colleges of Nursing (ADPCN), thus making it in effect a national curriculum.

JHPIEGO Activities. JHPIEGO's work with pre-service nursing in the Philippines has taken place with the Association of Deans of Philippine Colleges of Nursing (ADPCN), an excellent counterpart organization. In 1984, the ADPCN launched a series of activities to design a new competency-based curriculum oriented toward primary health care and the role of nurses in the community. This new curriculum was put into effect nationwide in 1985. Subsequent evaluation showed the family planning component to be weak.

JHPIEGO began its first project with the ADCPN in 1987, its purpose being to strengthen the family planning content in this new pre-service curriculum. JHPIEGO provided financial and technical assistance to help the ADCPN analyze the existing reproductive health component and develop new modules (e.g., human sexuality).

A follow-on project ("Academic Skills in Reproductive Health for Nursing Faculty In the Philippines") was later designed. Its goal is to improve the teaching skills of the nursing school faculty who will teach the family planning and reproductive health modules. A core group of 40 key teaching faculty were to be trained in modern adult learning methodology. They in turn were to

conduct 120 academic skills workshops throughout the country to transmit the modern teaching techniques to all nursing faculty in the Philippines who would be teaching the family planning/reproductive health modules.

During the project, plans for developing the 40 key teaching faculty were changed. Only 20 were given the special skills training. However, instead of being trained only in teaching skills, they were also given training in clinical skills (chiefly IUD) and training to help them develop effective lesson plans.

Results. As a result of the JHPIEGO projects, the curriculum which guides teaching in these schools has been changed to encourage more open discussion of sexuality, to provide specific information about each family planning method, and to arrange for each student to visit and observe a family planning clinic. Nurses educated under the revised curriculum should be able to counsel patients about family planning and should understand the legal basis for family planning in the Philippines and the importance of informed consent. At least one MCH teacher from most of the nursing colleges has been oriented to the new curriculum and has had some training in how to teach reproductive health and family planning more effectively. Detailed lesson plans have been developed to make it easier to teach some parts of the curriculum. (Detailed lesson plans are important because there is a high turnover among teachers and new schools are being opened every year.) In addition, about 20 nursing faculty members have received training in clinical family planning skills.

Limitations. Philippine nurses will still need to take an in-service family planning clinical skills training course in order to be qualified to provide family planning clinical services. It may be possible to shorten the in-service family planning training course for nurses who have had the enhanced pre-service training, but this has not yet been tried. Whether the new teaching skills have been successfully transmitted down to all the nursing schools is questionable. Also, even though some nursing faculty have been trained in clinical skills, it is unlikely that they will be able to maintain these skills, and to train students in them, because nursing schools have no clinical base from which to provide out-patient services.

Analysis. JHPIEGO regards its Philippines nursing activities as one of its major successes, primarily because of its large multiplier effect. The nursing school system in the Philippines represented a particularly attractive target of opportunity for curriculum change, as all the nursing schools in the country are affiliates of the Association of Deans of Philippine Colleges of Nursing, which sets standards for the curricula for all schools -- in effect, a national curriculum.

Thus, changing this national curriculum should affect the training of all the graduates of all the schools.

However, although some 26,000 nursing students graduate each year, a large portion of these will never provide family planning services in the Philippines. Only about half (currently 48%) of the graduates pass the examination to become registered nurses (RNs); of these, a large proportion emigrate to other countries.[42]

JHPIEGO's needs assessment for these projects was weak and superficial. A more thorough needs assessment should have directed JHPIEGO's attention to midwives, who are the primary providers of family planning in the Philippines (not nurses). JHPIEGO did not begin a project with the midwifery schools until it had worked with the nursing schools for nearly four years. The midwifery schools do not have a uniform curriculum and therefore are not such a straightforward target for programming as are the nursing schools. There is, however, an organization that accredits the schools and JHPIEGO is now working with it, rather than on a school-by-school basis. In retrospect, a better strategy would have been to work with the midwifery schools first, or at least much sooner than has been done.

Nonetheless, training nurses was not a wasted effort. Even though relatively few nurses fill jobs that require family planning clinical skills, all nurses need to understand the benefits of family planning and be able to counsel patients and refer them for family planning care. Indeed, even transmitting family planning concepts, values and information to nursing school graduates who fail to become nurses has probably had value. They will most likely apply this training in unknown but positive ways in their own lives and in other roles they undertake in their society. In the Philippines, nurses fill many leadership roles in the health care delivery system, and nurses who go on to qualify as midwives (i.e., nurse-midwives), some of whom teach in the Philippine schools of midwifery.

Lessons Learned

1) This experience illustrates that sustained inputs, including more than one subproject, are necessary to integrate family planning effectively into a pre-service curriculum.

[42]Nursing has become the way up (in terms of status and income) and out (of the Philippines). Currently, 42 percent of the money sent back to the Philippines comes from nurses living abroad.

Continuity of effective technical assistance is an important part.[43]

2) This experience suggests that it is easier, and requires fewer resources and less time, to revise a curriculum than to improve teaching skills of faculty members.[44] It may be possible to encourage the more effective teaching methods by augmenting the curriculum with detailed, fully developed lesson plans (in particular lesson plans that direct the teacher to use specific teaching approaches).

3) In countries in which all schools follow a standard curriculum, it is cost-effective to direct efforts at strengthening the reproductive health/family planning content of the pre-service curriculum through curriculum revision. If possible, this should be augmented by the development of complete and detailed lesson plans.

3.4.2 JHPIEGO Plans for Program Year 5

In contrast to JHPIEGO's low productivity to date in pre-service nursing and midwifery education, plans for the final year of the project are extensive. JHPIEGO's Year 5 Workplan includes major new initiatives to strengthen family planning training in undergraduate nursing and/or midwifery in 13 countries (Egypt, Papua New Guinea, Bolivia, Ecuador, Tanzania, Niger, Senegal, Togo, Burkina Faso, the Central African Republic, Côte d'Ivoire, Algeria, and Morocco). Experience in the Philippines suggests that successful integration of family planning into pre-service education requires sustained inputs. JHPIEGO's fifth-year plans in this area thus appear unrealistically optimistic -- especially without strategies and guidelines to guide junior staff and consultants who would be asked to help carry out this work.

3.4.3 Nurses and Midwives: Similarities, Differences and Conclusion

Similarities between nurses and midwives are many. Globally, both are primarily women. They usually come from the same social strata. In most countries they are educated at the same level, often within the same training institutions. They

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[43]Technical assistance was provided chiefly by one JHPIEGO consultant, who the nursing school deans praised for her effectiveness and on-going support. The deans hope this consultant will return to help with evaluation and write-up of the experience. This should be very instructive, both for the Philippines and for other countries.

[44]Admittedly, in the Philippine nursing case, curriculum revision really meant only refining and strengthening a reproductive health curriculum that was already in existence. The lesson may still hold, however, even when family planning content is being introduced for the first time.

usually earn about the same amount of money and have about the same amount of authority and societal respect.

There are also significant differences. Higher proportions of midwives than of nurses work in: rural areas (as compared to cities and large towns), community-based settings (as compared to hospitals), and prevention-oriented care (as compared to curative care). Midwives are much more likely than nurses to have private practices. Nevertheless, midwives and nurses are more similar to each other than they are to either doctors or to community-based health workers.

Importantly, two different patterns of midwifery education should be noted. In some countries, midwifery is a specialty added by a nurse following her basic nursing education -- resulting in relatively highly educated "nurse-midwives." In other countries, midwifery is a separate career pattern in which students go directly from secondary school into midwifery school.

Conclusion. The focus on training of nurses and midwives is sound. In most developing countries, much of the direct patient care in family planning clinics is provided by midwives and nurses. Provision of family planning services fits well within the role of nurses and midwives, which features health education, counseling, a focus on prevention, and the management of common, non-acute health problems, especially among women. Studies have repeatedly found that nurses and midwives are interested in family planning, that they are more consistent than doctors in following family planning and STD protocols, and that they insert IUDs carefully and gently.

In many countries, however, midwives (not nurses or doctors) are the major providers of basic reproductive health care. They should be considered separately from nurses.

3.5 Assessment of Progress in Pre-Service Institutionalization

3.5.1 Difficulty of Assessing by Numbers or Cost

It is difficult to judge either the impact of JHPIEGO's work in the pre-service area, or how effectively JHPIEGO has moved to step up work in this area. Comparisons in terms of "numbers trained" in various categories are problematic and comparable cost data are not readily available either.[45] Nevertheless, the following data do give some sense of relative emphases.

[45]There are no figures for the first three and one-half years of the project that can be compared with those of the last one and one-half. For PYs 4 and 5 JHPIEGO has calculated pre- vs. in-service training in *dollar costs*; for the early part of the project, comparisons can be made only between *numbers* of participants in-service vs. pre-service courses. There are no dollar costs available for the early part of the project, and no quantitative projections for program years 4 and 5.

For the earlier years of the project, the only figures available that would show the relative emphasis on pre-service education vs. in-service training are numbers of persons trained (see Table J-1 in Appendix J). Both JHPIEGO and the Office of Population understand that the traditional presentation of "persons trained" is not very meaningful, as it does not convey anything about the ability of the "persons trained" to actually provide family planning services (see Section 6, Impact). On the other hand, comparison of total numbers of participants in JHPIEGO-supported activities in the two categories -- pre-service and in-service -- does provide a general idea of where JHPIEGO put its emphasis during the first three years of the project. These figures suggest that JHPIEGO placed less emphasis on pre-service education during the first three years of the project than it expects to during project years 4 and 5 (based on Workplan figures).

Figures for the first three and one-half years of the project show that approximately 21,000 nurses and doctors received JHPIEGO-assisted pre-service training in family planning, compared with about 8,000 nurses and doctors who participated in in-service training -- a ratio of nearly 2.5 to 1. This is misleading, however. Most of the pre-service participants are accounted for by one single project in Mexico in which 18,000 nursing students were slated to attend JHPIEGO-assisted classes.[46] The numbers of attendees in pre-service classes simply cannot be equated with numbers of participants in in-service training -- unless at least duration and content of the training are also described in detail.

With respect to physicians, the emphasis has clearly been on in-service training. A total of 4,000 doctors received in-service training under this agreement, or about four times the total number who attended pre-service classes.[47] At this time it is impossible to say what the figures for the last year and one-half years of the project will be.[48]

3.5.2 Issue: How Much Training Can Be Shifted to Pre-Service?

How much of the "training load" can actually be shifted from in-service training to pre-service education? JHPIEGO has not

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[46]See JHPIEGO's *Annual Workplan Program Year 5*, p. 12 and also Section 6 of this report.

[47]As of early 1991, some 2,270 physicians had received training in clinical techniques, compared to about 175 medical students and interns who participated in JHPIEGO-assisted pre-service education or training (most of being trained in Kenya in minilap). The ratio is more even with respect to didactic training: 1,535 doctors had received in-service training in a range of areas (reproductive health update, "education" skills, curriculum development), while about half that number (826) attended pre-service courses related to reproductive health. (See tables in Appendix J.)

[48]It would be surprising, however, if they could shift as radically as might be suggested from the dollar figures shown in the PY 5 Workplan.

assessed this systematically. JHPIEGO's Africa division, however, has tried to analyze the relationship of pre-service education to in-service training in terms of A.I.D.'s "stages of family planning program development" framework. The Africa staff outline a progression, with the stage of program development, from in-service, to pre-service, to continuing education, before reaching the long-term goal of institutionalization of reproductive health training. JHPIEGO states that, in Africa in particular, it is ineffective to begin institutionalizing pre-service reproductive health education before the government and the professional schools are politically and philosophically ready.[49]

JHPIEGO-Anticipated Results of Pre-Service Education

JHPIEGO's mission statement lists three anticipated results of pre-service education. It states that integrating basic reproductive health training in pre-service curricula should:

- Ensure a steady supply of qualified trainers and health professionals;
- Complement in-service training programs; and
- Decrease donor-dependency and reduce training costs.

The assumption that pre-service education will ensure a "steady supply of qualified trainers and health professionals" is not sound.[50] There are several reasons as to why pre-service training cannot or should not be expected to produce family planning clinical competency. First, a large portion of graduates will never go into work where they use clinical family planning skills, so it would be wasteful for the educational system to teach these to all students. Second, a large portion of students who might achieve competence in clinical family planning skills during pre-service years would lose that competence due to the time lapse between pre-service education and entering jobs in which the clinical skills are required. Third, in many countries, classes are too large and opportunities for clinical training are too few to permit medical, nursing, or midwifery students to gain competency in clinical family planning methods; and even if there were a sufficient client load, having inexperienced students "practice" on clients subjects many women to avoidable discomfort and in some cases risk. Finally, this also wastes clinical practice opportunities, which is the limiting factor for family planning <u>in</u>-service training.

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[49]JHPIEGO, *1990 Annual Report*, p. 12, and *Annual Workplan Program Year 5*, p. 2.

[50]JHPIEGO's mission statement actually makes a circular argument: the outcome (producing a steady stream of providers) is simply a restatement of the mission statement goal, "to increase the number of qualified health professionals...."

The second assumption in JHPIEGO's mission statement (that pre-service education complements in-service training) is clearly correct. The third assumption, that integrating family planning into pre-service curricula will decrease donor-dependency and reduce training costs is correct also -- but within limits. JHPIEGO regularly cites its 1989 Kenya experience, in which it found that training medical officers (in-service) in minilaparotomy cost six times as much per trainee as training interns (pre-service).[51] Widespread substantial decreases in either training costs or donor-dependency are not likely to occur in the immediate future unless much higher priority is put on pre-service education.

3.6 Conclusions and Recommendations

General (Pre-Service Education of Doctors, Nurses, and Midwives)

1. **Modest achievements; no clear strategy. JHPIEGO has some good achievements in pre-service medical and nursing education** (e.g., Kenya, Zimbabwe, Philippines). **However, many activities are disparate, without follow-through, and have not lead to institutionalization or documented impact.** JHPIEGO has not articulated clear priorities or a strategy for "institutionalization" of family planning in pre-service education. There is a general approach -- curriculum revision plus academic skills training for faculty -- but no program-wide guidelines as to how these activities should best take place, under what circumstances, or how they should differ for physicians, midwives, and nurses. Finally, JHPIEGO is unable to provide meaningful figures concerning cost-effectiveness of its pre-service efforts.

   Recommendation: JHPIEGO should articulate a "Strategy for Institutionalizing Reproductive Health and Family Planning in Medical, Nursing, and Midwifery Schools." This should be a "working paper" based on lessons learned and related analysis; many statements may need to be viewed as hypotheses and subjected to objective validation. The working paper should be revised as JHPIEGO's understanding grows of what works best. As with all JHPIEGO's standardization work, this should embody adaptation of a general approach to local circumstances; a strategy does not mean "cookie-cutter" imposition of a single model.

2. **Limited role of pre-service education. The assumption that pre-service education can "ensure a steady supply" of family planning trainers and service providers is not sound.** Pre-service education is an important complement to in-service training programs and may help decrease donor-dependency and

[51] Noel McIntosh and Judith Weinstein, *Kenya Trip Report*, May 31-June 11, 1989, p. 4. Still, given that only a portion (1 of 15?) of the trained interns will use the training, this may not be all that cost-effective.

training costs. But there are limitations as to what can be achieved in pre-service education. It is not feasible, and will probably never be cost-effective, for family planning clinical skills to be taught to all medical, nursing, and midwifery students during their basic education. The amount of clinical training appropriate during pre-service education varies with the type of provider (doctor, nurse or midwife) and the role each plays in family planning care in the individual country.

Recommendation: Ultimately, in all countries basic family planning and reproductive health care knowledge and values should be part of the pre-service curricula for all medical, nursing, and midwifery students. Inclusion of clinical training should be determined on a country-by-country basis in accord with provider roles in the country's family planning services.

3. **Sequencing of pre-service and in-service training at different levels of family planning program maturity.** In a low-prevalence country, priority in training and education must continue to be directed first to good in-service training carried out in conjunction with high quality services. As contraceptive prevalence rises, activities to include family planning in the pre-service curricula become more feasible and appropriate. It is necessary to have large-volume, well-run services for students in order for them to learn.

4. **Follow-through. A sequence of inputs is required for successful integration of family planning into pre-service education** (i.e., policy dialogue, changing the curriculum, developing lesson plans, training faculty in effective teaching skills [if this is to be provided], and evaluation).

5. **Setting priorities: Choice of providers. The relative emphasis that should be given to one type of provider or another (doctor [ob/gyn or general practitioner]), midwife, or nurse) should vary depending on the roles played by each of these categories of service providers in the individual country and specifically relative to the methods that each provides.** (For example, in the Philippines, because IUDs can be provided by MOH midwives, IUD training should focus on public-sector midwives. In Egypt, where there are no formally trained midwives and nurses are generally not permitted to insert IUDs, IUD training must focus on doctors.)

6. **Setting priorities: Choice of schools. In many cases it is not cost-effective to spend time trying to influence the curriculum of an individual school.** Ideally a training CA should try to influence all schools of each category (medicine, midwifery or nursing) in a country. In countries

in which all schools of a category follow the same curriculum, there is a clear multiplier effect from efforts to include or improve teaching related to family planning (as JHPIEGO did with nursing colleges in the Philippines.)

Recommendations: In countries without a uniform curriculum (which is the majority), JHPIEGO should work with leading schools able to influence others. Alternatively, or in addition, JHPIEGO should work with the organizations which accredit the schools (as it is doing with the Philippine midwifery schools) or with the organization which controls the national licensing or certification examination, where such exists.

JHPIEGO should give priority to schools whose graduates are most likely to fill positions that require the ability to provide family planning services. This will vary from country to country, but is more likely to include midwives and less likely to include nurses.

7. "Academic skills". Trying to improve the teaching methods of faculty in pre-service schools is an enormous job, in fact almost a Sisyphean task. There is little evidence of impact to date. It is much easier to revise a curriculum than to improve the teaching skills of faculty members. Nevertheless, family planning education would be much more effective if faculty used modern, interactive teaching methods. It may be possible to encourage the use of more effective teaching methods by building a variety of appropriate methods into the curriculum and by augmenting the curriculum with detailed, fully developed lesson plans.

   Recommendation: JHPIEGO should provide "academic skills" training only under certain conditions. It should evaluate its experience to determine whether, and when and how, "academic skills" training is cost-effective. A basic criterion should usually be that faculty members to whom "academic skills" are taught should each have a high proportion of students going on directly to work in family planning.

8. External advice on core knowledge and competencies. JHPIEGO should bring nursing/midwifery/physician educators, clinicians and service administrators together to identify "core knowledge" and "core competencies" that graduates of pre-service programs should have. Pre-service curricula should be based on a clear understanding of the roles, functions and tasks for which the students are being trained and the level of competence expected of new graduates. Tutors in pre-service educational programs need to understand the demands of the jobs their graduates will fill. Prototypic curricula for nurses, midwives, and physicians will all be

different. All must be adapted to each country. Specific suggestions appear below.

9. **Pre-service education of doctors. In most countries it is probably not realistic to expect that medical students could be ready to work as family planning service providers immediately after medical school**--that is, on completion of undergraduate medical training. (Classes are too big to allow for hands-on training, the tradition in developing country medical schools does not lend itself to such an approach, and it is almost certainly not cost-effective.) The more realistic strategy would be: (a) for all undergraduates to be given basic knowledge in reproductive endocrinology and family planning, and (b) for smaller numbers to receive further training (especially in clinical methods) closer to the time when they might actually become involved in providing clinical services (e.g, during clinical clerkships, internships or residencies).

   Recommendations: JHPIEGO should prepare a prototypic curriculum for medical students in their pre-clinical years. This should be done in conjunction with external advisors. Like all prototype materials, this would need to be adapted or used in each country through a process that instills a sense of ownership among the local counterparts. Prototypic family planning modules for medical students should include: rationale and indications for family planning; contraceptive methods; advice giving; gender sensitization; and introduction to clinical skills (IUD and Norplant insertion and removal, male and female sterilization).

   JHPIEGO should continue to explore training and use of clinical preceptors to mentor and supervise students (i.e., courses that do not center on classroom teaching but emphasize "coach"-type methods, management of a clinical practicum, and assessment of clinical skills).

10. **Nursing and midwifery education. JHPIEGO's work in this area has been limited and not designed to produce nurses or midwives who are able, when they graduate, to provide competent family planning service without further training.** In contrast, JHPIEGO's fifth-year plans appear unrealistically optimistic -- especially without strategies and guidelines to guide junior staff and consultants who would be asked to carry out part of this work.

    Recommendations: JHPIEGO should consider midwifery education separately from nursing. Relatively few nurses fill jobs which require clinical family planning service delivery skills. In contrast, most midwives are directly involved in providing basic reproductive health care to women. Thus, in

most countries it is desirable for midwives to become competent family planning service providers during their pre-service training. For pre-service training intended to provide family planning service competency, it may be worthwhile to try to improve the faculty members' training skills. However, it is probably not cost-effective for JHPIEGO to invest time and resources trying to improve the teaching methods of nursing school teachers.

11. **Pre-service education of nurses. All nurses should understand the benefits of family planning and be able to counsel patients about family planning and refer them for family planning care.** However, as relatively few nurses fill jobs that require clinical family planning skills, competence in providing family planning services should rarely be an objective of the pre-service education of nurses. Rather efforts to improve the family planning content of pre-service nursing education and training should be directed to:

- Providing accurate information about the effectiveness and mode of action of all traditional and modern methods of family planning used in the country;

- Providing accurate information about the laws and rules which regulate family planing service delivery in the country;

- Developing positive attitudes about family planning and its contribution to the health of women and children and the well-being of families and society;

- Developing competency in communication and counseling skills;

- Giving students some experience in counseling and/or client education regarding family planning, and

- Exposing students to positive models of nurses playing roles in the delivery of family planning services.

12. **Pre-service education and training of midwives. In countries in which most midwives take jobs that are directly related to reproductive health care, pre-service midwifery education should aim at producing competency in the direct provision of all temporary methods of family planning used in the country** (except any method which, by local law or custom, can only be provided by physicians). Training to produce such competency requires access to active, high-quality family planning services; students need adequate clinical experience and proficient role models.

Recommendations: JHPIEGO's mandate concerning pre-service education should explicitly include midwives. JHPIEGO should develop prototypic curricula in accord with principles recommended above.

13. Other health workers. It is desirable to provide accurate family planning information and an understanding of the importance of family planning during the pre-service education of most kinds of health workers. Pharmacists in particular should play an important role in providing family planning supplies and information.

Recommendations. JHPIEGO's mandate for pre-service education should be expanded to include pharmacists. During their pre-service training, pharmacists should be given information about family planning as well as learning experiences to help them develop pro-family planning values and IEC skills.

Support to include or strengthen family planning in the pre-service education of health workers who will not be providing family planning services should be limited to curriculum development and provision of carefully-selected teaching aids (e.g., videos, slide sets). A limited amount of training in effective teaching methods might be provided as an adjunct to curriculum development.

4. In-Service Training of Doctors, Nurses, and Midwives

4.1 Overview: What Does In-Service Training Include?

4.1.1 Types of In-service Training

"In-service" is a broad category that includes several types (and purposes) of training. It is important to understand and distinguish among these in order to evaluate outcomes -- as well as to set priorities and to facilitate sound decision-making. "In-service" includes the following.[52]

1) Training to enable health care providers with no prior experience in provision of family planning services to provide those services (initial basic family planning training);

2) Training to reinforce, update, improve or expand the knowledge and skills of health care personnel who are already providing family planning services:

   - general "update" or "refresher" courses,
   - training to provide a specific new skill (e.g., a new method of contraception, such as Norplant, or a new aspect of clinic management),
   - training to resolve specific family planning service delivery problems (e.g., frequent misdiagnosis of cervical abnormalities, inadequate counseling regarding VSC); and

3) Training to teach selected family planning service providers in how to train other health care personnel to provide family planning services ("training of trainers").

This kind of categorization permits an important conclusion about the extent to which in-service training can be reduced through institutionalization of family planning in the pre-service education of health care providers:

- It is the first type of in-service training -- <u>initial basic family planning training</u> -- for which need can be reduced somewhat through pre-service training. Inclusion of family planning knowledge in the basic education of all health care providers, and inclusion of clinical

[52]This framework was developed by this evaluation team in the course of trying to understand and then assess JHPIEGO's achievements. JHPIEGO has not made such distinctions; it is unclear which of these types of in-service training predominates.

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skills training for some, would minimize the amount of basic family planning that must be taught through in-service training.

- In contrast, training of the second type is essentially "continuing education" and must be provided in-service.

- Training of trainers (TOT) must also remain an in-service activity.

4.1.2 Methods Emphasized and Providers Trained: The Numbers

With regard to contraceptive methods emphasized during in-service training, JHPIEGO's focus is, of course, on the clinical methods. Among these, IUD training has predominated for all categories of service provider, followed by female VSC (minilaparotomy and laparoscopy) and then Norplant. Vasectomy has not been emphasized. Twice as many doctors have been trained in IUDs as in female VSC (1,373 in IUDs vs. 666 in VSC). In VSC, JHPIEGO has increased training in minilaparotomy as compared with laparoscopy (see Appendix D). As for nurses, between the start of the project and April 30, 1991, nearly three times as many nurses have received training in IUD management as in female VSC (1,203 trained in IUDs vs. 384 in female VSC. For nurses, VSC training consists only in providing operating room support). In addition to these figures are 153 nurses and 271 physicians trained in a combination (unstated) of skills (see Table J-3).

4.2 Current Approaches and New Emphases

JHPIEGO has not articulated a clear-cut strategy for in-service training nor presented any detailed overview of its program and achievements in in-service training. JHPIEGO's in-service activities are characterized, however, by several new "approaches" and "emphases" which are in various stages of evolution.[53] These cross-cut the training of individual categories of practitioners (doctors, nurses, midwives) and can be summed up as follows:

- Streamlining to improve efficiency of training;

- Reducing and customizing training in Baltimore while emphasizing regional/international training centers;

- Shifting from training of service providers to training of trainers (TOT);

[53]This emerges from interviews with JHPIEGO staff and brief statements in various JHPIEGO documents.

- More technical assistance, fewer generic courses;
- An evolving two-tiered approach to training;

4.2.1 Streamlining to Improve Efficiency of Training

Streamlining is a major emphasis throughout JHPIEGO's program. In the in-service context it means, first and foremost, **the use of standardized approaches to method-specific clinical training.** These are the approaches related to IUD, VSC, and Norplant training which are the heart of JHPIEGO's clinical training materials (described in detail in Chapter 2). This also includes other streamlining measures that JHPIEGO describes as **"removing inefficiencies in the training process."**[54] "Inefficiencies" have to do with factors that explain why so much training that is carried out (generally, globally) has had limited impact. JHPIEGO analysis in this area is just beginning, but is promising;[55] initiatives are underway in various projects.

Conclusion: JHPIEGO's efforts to streamline in-service training, while striving for safety and quality, are laudable. Such streamlining will be essential to meet the need for exponentially increasing numbers of trained service providers in the coming decades.

> Recommendation: JHPIEGO should refine its thinking about and develop clearer strategies for "removing inefficiencies" in-service training. This should be linked to improved needs assessment and country strategies.

4.2.2 Training in Baltimore: Customized Courses

In 1990, at A.I.D.'s suggestion, JHPIEGO changed its approach to training in Baltimore. From 1972 until then, JHPIEGO had offered a regular schedule of courses at a training center in Baltimore. These courses followed a uniform design directed at a certain category of personnel -- administrators, doctors, or nurses -- and centered on generic topics of concern to each category:

- Courses for administrators related to program planning, administration, and child survival.

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[54]JHPIEGO's *Annual Workplan for PY 5* lists as two important areas of emphasis "developing new, more cost-effective approaches" to family planning training and "removing inefficiencies in the training process."

[55]The "inefficiencies" are best articulated in a draft strategy paper written for Asia and the Near East by Dr. Clayton Ajello in 1991. (This further illustrates the point made in Chapter 1, that much good analysis lies buried in rather obscure country and region-specific documents.)

- Courses for physicians focused on infertility, sexually transmitted diseases, male fertility, teaching methods, and technical updates in obstetrics and gynecology.

- Courses for nurses concentrated on teaching methodology and curriculum development.

During the first three and one-half years of JHPIEGO's current cooperative agreement, the numbers of trainees brought to Baltimore averaged about 100 per year (364 total). Program administrators (142) were the dominant category, followed by physicians (110), and nurses (94). In most if not all cases, participants in a course came from multiple countries.

Since discontinuing these generic courses in 1990, JHPIEGO has developed a new approach to courses in Baltimore. Now far fewer courses are offered. Participants generally come from just one country and the course is customized to meet specific needs of that country's family planning program.

This change appears to have been appropriate. It is difficult, however, to assess the overall impact of the training that is still conducted in Baltimore (and JHPIEGO has not done so itself). Country visits during this evaluation showed contradictory results: positive results for Philippine participants in generic ("old model") Baltimore courses, but no evidence of benefit to the Moroccan program that sent participants to a customized ("new model") course.

The Philippine nurses and midwives who participated in generic curriculum development courses in Baltimore are playing significant roles in projects aimed at improving the family planning content of the pre-service nursing and midwifery curricula in the Philippines. They think of themselves and are referred to as "the Johns Hopkins people." Their sense of having had a special opportunity and of having developed special skills has led to their willingness and ability to cross agency lines and work together on course development for various JHPIEGO-sponsored projects. (It appears the training they received in Baltimore was first rate. One wonders whether this same beneficial outcome might also have been achieved had the course taken place in the Philippines.)

In contrast, a specially-designed course in 1990 intended to prepare Moroccan midwifery tutors as trainers probably will not produce the desired results. This was a TOT course whose purpose was to produce trainers for the Moroccan MOH's decentralized in-service family planning training centers. The course participants were 12 faculty members from Morocco's only professional-level midwifery school. The training itself may have been excellent, but the midwife tutors were sent to Baltimore in 1990, more than a year before the in-country training program was

going to start. Furthermore, because they are faculty of a midwifery school, the MOH has no control over their availability to teach in its in-service training program once that gets under way.

This problematic outcome is traceable to difficulties intrinsic to this model: it is difficult to plan training long distance, to select appropriate trainees, and to tailor information to current country needs. Although the course was supposed to be tailored to the particular needs of Morocco's family planning program, the result may well be that the course contributes little or nothing toward achieving the MOH objectives for which the participants were sent to Baltimore. If so, this will have been a very expensive failure (apparently a cost of about $7,000 per participant).

Conclusion: U.S.-based training can have a powerful effect -- if it is well-planned, if the right persons are sent for the training, if the training is of excellent quality, and if it offers something that is not available in the trainees' own countries. However, the perks associated with training in the U.S., and the logistical problems of trying to plan training long-distance, pose obstacles to effective planning and selection of trainees. U.S.-based training is also very expensive.

> Recommendation: In general, people should be trained as close to their own work environments as possible. An exception might be when training them at a distant site can expose them to family planning service delivery or training models that are not available in their own countries.

4.2.3 Regional/International Training Centers

JHPIEGO often refers to "JHPIEGO's regional training centers" (or, since 1991, its "international training centers"). How effective are these centers? What is their impact? How much effort (and resources) should go to them in the next few years? It is difficult to get a clear understanding of these centers -- JHPIEGO has no overview documents about them -- but the picture seems roughly as follows.

In the late 1970s and early 1980s, in response to A.I.D.'s call for shifting training to developing countries, JHPIEGO began to establish regional training centers (RTCs). The initial strategy was that these centers, most located in countries with relatively high prevalence rates in each region, should provide training in specific clinical methods to ob/gyns from neighboring countries that had not yet made such good progress in family planning (particularly in laparoscopy, JHPIEGO's prime clinical focus in those years). The training experience was also

intended to provide encouragement to participants to become leaders of family planning in their respective countries.

The sites designated "regional training centers" were usually based in or affiliated with a university department of ob/gyn. The directors have been ob/gyns, usually professors, often a former participant in JHPIEGO's Baltimore and/or laparoscopy training activities. Curricula, strategies, and relationships to the local national family planning program, and numbers of persons trained, varied considerably.

How Many Centers and Where?

The total number of sites designated as regional training centers has also varied over time, as some countries have been added and others deleted. (For example, Tunisia and Brazil were earlier called regional training centers[56] but are no longer included in JHPIEGO's latest listing.) Today JHPIEGO lists seven such training centers.[57]

Asia:

1. **Thailand:** Regional Training Center for Reproductive Health. Director is Dr. Kobchitt Limpaphayom, Professor in Dept. Ob-Gyn, Chulalongkorn University Faculty of Medicine.

2. **Indonesia:** Kilnik Radan Saleh. Director is Dr. Birhan Affandi, Head of the Division of Reproductive Health, Dept. Ob-Gyn, University of Indonesia Faculty of Medicine.

3. **Philippines:** Fertility Care Center (FCC) of Mary Johnson Hospital. Director is Dr. Virgilio Oblepias.

Near East:

1. **Morocco:** National Training Center for Reproductive Health (NTCRH). Director is Dr. Tahar Alaoui, Professor of Ob-Gyn and Dean of the University Mohamed V Medical School.

2. **Egypt:** Regional Center for Training in Family Planning (RCT). Director is Dr. Roushdi Ammar, former Chair of Dept. Ob-Gyn, Ain Shams University.

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[56]Derman et al.

[57]*Report on Workshop of JHPIEGO International Training Center Directors*, Jakarta, Indonesia, September 10-13, 1991.

Africa:

1. **Kenya:** Department of Obstetrics and Gynecology, University of Nairobi. Director is Dr. Samson Wanjala, Chair of the Department.

2. **Nigeria:** Department of Obstetrics and Gynecology, University College Hospital, University of Ibadan. Director is lecturer and senior consultant in the Department.

In September 1991, JHPIEGO changed its designation for these centers from "regional" to "international" training centers.

Issue: Effectiveness and Impact

Each of these centers has trained a substantial number of health care personnel from both their own and neighboring countries and have undoubtedly made significant contributions to family planning. JHPIEGO has abundant quantitative data on the numbers, and it has recently hired external consultants to evaluate other aspects of the programs of some of them (e.g., Egypt, Morocco, and Philippines). JHPIEGO has not, however, systematically tracked what has happened with trainees once they returned to their work sites. No summative data, nor even a summative description, on the impact or effectiveness of these training centers is available.

Admittedly, tracking the results of training, and especially third-country training, is difficult. JHPIEGO is not alone in this regard; other organizations share the problem. To its credit, JHPIEGO has made a few attempts to study what has happened to trainees once they have returned to their home countries. Results of these evaluations are illustrative.

Findings from regional training in Morocco. For several years JHPIEGO has supported training for personnel from African Francophone countries at the National Training Center for Reproductive Health (NTCRH) in Rabat. Training originally focused primarily on laparoscopy but has now shifted to IUD management. Courses follow a uniform design. An evaluation in 1989 was positive about the training itself, judging that the courses operate smoothly, that the trainers created a positive learning environment, and that trainees were given excellent opportunities to practice acquired skills in clinical settings.[58] On the negative side, the evaluation pointed out that no systematic needs assessment had been carried out in the Francophone countries to

[58]The current evaluation team was not asked to evaluate the training capability of this center, but the center certainly appeared capable of putting on good training courses. Even at this "flagship" facility, however, shortcomings in clinical procedure were observed. In particular, the physical set-up does not provide privacy for counseling the patients (and only minimal privacy for the pelvic examination); also a doctor observed taking care of two women requesting IUDs did not do an adequate assessment of abnormal appearing cervices.

ensure that the courses were meeting specific needs. "Functions relating to needs assessment and evaluation are not yet fully institutionalized," stated the evaluation.

Another evaluation, this one on training of Francophone physicians from sub-Saharan Africa at the NTCRH, also concluded that the training in Morocco had been very well implemented but found multiple problems on visits to the trainees' sites in Cote d'Ivoire. Few trainees were involved in family planning service delivery; few were inserting IUDs; little counseling was being done; and at several sites, no contraceptives were available. The evaluator concluded: "The majority of those who completed the training do not provide FP services in their institutions." The evaluator attributed the problem to pronatalist policy in Cote d'Ivoire, "...a lack of political will on the part of the leadership to integrate FP into the health care system." He concluded: "Despite their enthusiasm, the trainees are losing all their desire to provide services. They cannot do anything when faced with a situation in which their institutions lack both supplies and contraceptives."[59]

This sorry conclusion illustrates generic problems that prevail elsewhere too -- and that have broad implications for JHPIEGO. Much family planning training often has little impact because persons trained do not have the opportunity or the support to practice the skills they have been taught. The problem here is not poor training but poor planning. One can say that trainee selection was not careful enough. More fundamentally, the training was provided without being part of a country strategy and without any plans to enable the trainees to use their new training to provide services on their return.

JHPIEGO should have been aware of the general policy environment in Cote d'Ivoire and adopted one of two other strategies: either (a) training aimed at influencing the top leadership, or (b) training of well-placed service providers coupled to collaboration with a service delivery project which would provide the equipment and support to make service delivery possible in a few key sites. JHPIEGO, however, was not thinking strategically. This training was probably a waste of money. As JHPIEGO senior staff know well, unless trainees have means to use new knowledge and become competent in new skills within a short period of time after the training, the skills will be lost.

Issue: Whose Training Centers are These?

JHPIEGO's organization chart at the time of this evaluation (see Chapter 5) places the regional training centers under a box labeled "Overseas Programs." The notion that these

[59] Louissant (1990). *Trip Report to Morocco and Cote d'Ivoire.*

centers should all be considered programs of JHPIEGO illustrates a problematic philosophy and is not in full accord with reality.

Although JHPIEGO often refers to "JHPIEGO's regional training centers," these centers are not actually "JHPIEGO's." Many other organizations have contributed support. For example, Klinik Raden Saleh in Indonesia is also funded by WHO, The Population Council and AVSC.[60] In Kenya, programs of the Department of Ob/Gyn at Kenyatta University Hospital are likewise funded by many organizations -- FHI, The Population Council, Pathfinder, and others; the department chairman, who is designated "JHPIEGO international training center director," is by virtue of his post also director of all the other foreign-funded family planning projects. However good JHPIEGO's work may be, JHPIEGO is still just one supporter among many.

More important, all of these sites belong to the individual country. On this count, attitudes of the local personnel differ significantly. In Morocco, the NTCRH is so closely identified with JHPIEGO that Ministry of Public Health personnel refer to the center simply as "JHPIEGO." In Nigeria, training staff reportedly still display an old "JHPIEGO Regional Training Center" signboard, even though the center no longer receives JHPIEGO assistance. In Egypt, however, JHPIEGO is roundly criticized by USAID staff for taking a proprietary attitude with the center there. (USAID staff accuse JHPIEGO, for instance, of trying to send trainees from other countries to the Cairo training center without concurrence from USAID/Cairo and protest JHPIEGO's referring to the Egyptian center as "the JHPIEGO RCT.")

<u>Conclusion</u>: The regional/international training centers that JHPIEGO has supported have trained a substantial number of doctors and nurses from neighboring countries as well as their own; they have undoubtedly made significant contributions to family planning. There are also problems. JHPIEGO has not systematically tracked what has happened with trainees once they have returned to their work sites. No summative data or description on the operations or effectiveness of these training centers is available. Finally, it is misleading of JHPIEGO to designate all these centers as JHPIEGO centers, when many other organizations have contributed support and when they are more properly centers of the individual country.

<u>Recommendations</u>

> **JHPIEGO should carry out a systematic assessment of the strengths, weaknesses, effectiveness and impact of its efforts with the regional/international training centers it helps to support and base future activities on this analysis.**

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[60]One international expert judged it "presumptuous for JHPIEGO to identify itself as having proprietary rights over and being able to claim credit for the achievements of Raden Saleh."

Activities JHPIEGO seeks to undertake with these centers should be coordinated with country strategies and concurred in by the local USAID mission.

A designation such as "JHPIEGO-Affiliated Training Center" should be used in place of "JHPIEGO Training Center."

4.2.4 Training of Trainers

Another current emphasis is to shift, where possible, from training of service providers to training of trainers (TOT). As with other program areas, it is difficult to get useful statistics and judge how well JHPIEGO is doing. TOT seems to be the focus of only a small percentage of in-service training programs on-going at the time of this evaluation (e.g., in Morocco, Egypt, Tanzania, and Ghana), although a host of new TOT programs have been planned for PY 5 (e.g., in Turkey, Brazil, Ghana, Zimbabwe, Mali). Through December 1990, about one-quarter (721) of the nurses receiving didactic training were trained in the categories of education skills, training of trainers, and curriculum development (compared with 45 percent [1289] who were given "reproductive health updates" (see Table J-2).[61] JHPIEGO has not projected a comparable ratio for PYs 4 and 5 but a cursory overview of its in-service training projects during the earlier part of the project compared with its plans for PY 5 suggests that it plans considerably greater emphasis on training of trainers.

As JHPIEGO increases its focus in in-service training on training of trainers for all categories of service providers, it is grappling with how best these trainers can be produced.[62] Over time, JHPIEGO has developed a better understanding of what is involved, but as yet its strategies are incomplete and often do not accord with the realities of the field. Most recently, JHPIEGO set down in the PY 5 workplan some "lessons" related to training of trainers that it claims to have learned. These lessons, which are explored below, have not yet been built into JHPIEGO's program, however.[63]

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[61]Two-third of the nurses who received in-service training were given didactic training, compared with one-third who were trained in clinical skills.

[62]The terms "training of trainers" and "master trainer" are used in this report only for in-service training. The use of these terms may be considered inappropriate in a university context, where those teaching reproductive health or clinical skills have academic positions such as professor and would not consider themselves "trainers." JHPIEGO agrees with this distinction, but does not adhere to it consistently in its documents.

[63]The three lessons are as follows: 1) "A core group of these change agents (i.e. master-trainers) needs to be provided with program support and technical assistance for several years." 2) "Achieving competency as a service provider and as a trainer cannot be pursued in the same short course. A pre-requisite to being chosen for training as a trainer is that proficiency as a service provider has already been achieved." 3) "Not every proficient service provider is capable of being trained as a clinical trainer. Similarly, simply because someone is trained to be a clinical trainer, does not mean that such

Trainers of Clinicians (Service Providers)

JHPIEGO seems to hold that qualification as a trainer of clinicians requires two types of training and that "these cannot be taught in the same short course."[64] JHPIEGO has conceptualized very effectively the progression of clinical skills from acquisition, to competency, to proficiency and has a clear working definition of what proficiency entails: complete and correct knowledge, correct and proficient manual skills, good role modeling of interaction with clients, positive attitudes towards family planning, self-confidence in clinical role. It is also clear about what training skills involve: communication skills and knowledge and proficiency in a variety of learner-active teaching methods. JHPIEGO is less clear, however, about the best way to impart these skills.

Often in the past, teaching skills courses were held in Baltimore; now, they are usually to be given in the field, using consultants. Despite its statement about separating training in clinical skills from training in adult teaching methods, JHPIEGO also seems to believe that potential clinical trainers may assimilate adult teaching techniques during their clinical skills training and therefore that the teaching skills portion of training can be downgraded. Judging from the stage of development of its training materials, it is also fair to say that JHPIEGO probably has a better understanding of how to provide clinical than teaching skills training: development of the teaching skills manual has been a protracted process and the results have yet to be field tested (see Section 2.1.2).

Training of Trainers and "Master Trainers"

JHPIEGO uses the term "master trainers" and has attempted to develop master trainers in several countries (Egypt, the Philippines, Thailand, with plans to develop master trainers in Brazil for the MOH project and for Norplant in Indonesia). It has even developed a "master trainer" certificate, which carries the imprimatur and prestige of the Johns Hopkins University and which it has given to graduates of the Egypt, Philippines, and Thailand courses.

To some degree, there is consensus as what constitutes a master trainer. Those who were eligible for the certificate in Egypt went through three separate courses: a six-week course in Baltimore that provided basic knowledge in reproductive health and family planning services and, in Cairo, a clinical training course and a two-week participatory training methodology and skills

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an individual will necessarily be a proficient trainer."

[64]JHPIEGO, *Annual Workplan Program Year 5*, June 1991.

course, both taught by JHPIEGO consultants. Subsequently, the trainees designed a six-week curriculum and course materials for their training-of-trainers course (under direction of the JHPIEGO training skills consultant). In contrast, training in the Philippines for three persons who were to serve as master trainers involved quite a different approach. Training (at the Fertility Care Center of the Mary Johnson Hospital) lasted 14 months and consisted of two parts: several weeks of preparatory training and orientation followed by four six-week practicums, during which the fellows, serving as "master trainers," had a hands-on opportunity to develop a curriculum and teach courses. The fellows say they were given too little opportunity to learn curriculum development skills, however, and there was also a question as to whether four practicums were needed for the fellows to develop their teaching skills. Overall, the length of the 14-month course appeared to be a disincentive to attracting candidates.

On the whole, JHPIEGO seems to agree that master trainers for clinical courses should be grounded in the didactic disciplines of reproductive health and family planning; should be proficient clinical providers in their own rights; and should have mastered adult learning techniques. It has not, however, reached internal consensus about the importance of curriculum development skills for a master trainer. This is an issue that has bedeviled others in the training field as well. The case for including this skill rests primarily on the assumption that it is essential in the interests of both effective performance and sustainability.[65] The counter-argument is that this standard would unnecessarily and unproductively slow down and increase the cost of TOT and therefore limit and constrain training of family planning service providers. It may be that all master trainers (trainers of trainers) need at least minimal curriculum development skills. JHPIEGO, however, has not systematically thought through all the various ways that this plays out in order to reach a firm conclusion.[66]

Selection of Trainers

Identifying appropriate candidates for trainers of clinicians and as trainers of trainers has proved to be difficult for JHPIEGO. JHPIEGO is not entirely clear what categories of people, with what skills and characteristics, are the most suitable. Finding individuals with the right combination of skills

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[65]"Master trainers with responsibility for presenting courses need to know how to develop and up-date curricula and training materials. Clinicians who become master trainers will need to be taught these skills. This is important if trainers are to perform effectively, and it is essential for sustainability," as quoted from Pillsbury, B. and Stolba, S. "Training in Family Planning: Issues and Lessons Learned During Establishment of the Regional Center for Training in Family Planning in Cairo, Egypt." March 1991 (Draft.) See especially "lessons" 8 and 9.

[66]It is probable that INTRAH and DA have valuable insights on this issue. This would be one of several fruitful areas for consensus-building in an A.I.D. training strategy.

has been difficult and even those individuals who appeared qualified have often proved disappointing.

For example, in Africa, it has been difficult for JHPIEGO to find individuals who have the requisite qualifications. One of its "lessons learned" is that "a pre-requisite to being chosen for training as a trainer is that proficiency as a service provider has already been achieved."[67] In Africa, however, JHPIEGO has had to turn to persons who lack pre-existing family planning skills (much less proficiency) to train as trainers: i.e., to tutors in a school of nursing (as in Chad) or members of the MOH primary health care training team (as in Kenya). The question is whether such individuals can ever achieve an adequate level of clinical proficiency, especially when they work in non-clinical positions and therefore have little opportunity to practice skills learned during the training.

A similar problem arose with regard to the prospective master trainers hired for the RCT in Cairo. Recruitment took place through an ad in the newspaper and none of the three doctors and three nurses selected was really proficient in either family planning clinical skills or in training. Following initial training in Baltimore, two quit soon after while the other four required weeks and months of additional technical assistance in both training and clinical skills. It took nearly three years until JHPIEGO judged them sufficiently proficient to qualify for its Master Trainer certificate.

One option might be to merge the roles of trainer and supervisor. This was the format of the pre- and in-service minilaparotomy course in Kenya and, after a rough beginning, now appears to be working well. The potential advantages are many: supervisors probably understand the real demands of the jobs held by the people they supervise and are in the best position to follow up trainees, reinforce training, and identify performance deficiencies that should be addressed by further training. Despite its good Kenya experience, JHPIEGO has yet to assess formally the pros, cons, problems and best approaches to cross-training supervisors as trainers.

Conclusion. One of the most difficult areas for JHPIEGO has been training of trainers of clinicians (service providers) and training of trainers of trainers (TOT training). Uncertainty remains as to how best to train clinicians in teaching methods, as to how best to train a master trainer, and as to what sorts of providers make the best trainers.

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[67]JHPIEGO, *Annual Workplan Program Year 5*, June 1991.

Recommendations:

1) **JHPIEGO should reach consensus (at least preliminary consensus) on what needs to be included in the training of trainers of clinicians and of master trainers.**

- JHPIEGO should develop a definition of "master trainer." This should address the following questions: Does a master trainer need to be able to train clinicians, train other trainers (i.e., TOT), conduct training needs assessments, and develop curricula to address newly identified training needs? Does a person who is able to train clinicians and other trainers but does not have curriculum development skills qualify as a "master trainer"?

- JHPIEGO might consider a middle position with regard to the question of whether all master trainers should have curriculum development skills: namely, that a select few but not all of the trainers in each institution should be given these skills. This would permit institutionalizing a training capability without overburdening the training program for master trainers.

2) **JHPIEGO should develop a consensus regarding who should be recruited and developed as trainers.** This should explore whether it is better to:

- start with a proficient clinician and try to add training skills, or

- start with training proficiency (a good teacher) and provide technical inputs regarding the technical subject, or

- train a proficient trainer to teach the didactic aspects and use proficient clinicians as clinical preceptors (i.e., to supervise, teach, and mentor trainees during their clinical learning experience).

JHPIEGO should consider a strategy to develop as trainers selected supervisors of family planning and primary health care service providers (perhaps in combination with clinical preceptors).

4.2.5 An Evolving Two-Tiered Approach to Training

Many countries and USAID missions that call on JHPIEGO are eager, and even insistent, to have a substantial number of family planning service providers trained and out providing services in a very short time (Egypt having been a distinct case in point). This poses several dilemmas, especially in view of concurrent needs for institutionalization and sustainability. Part of the problem also has to do with IUD training.

Training in IUD insertion, management and removal significantly slows the production of trained family planning service providers because it is time-consuming and difficult to organize. Even with the use of anatomic models for beginning practice, the need for adequate numbers of clients who want to have IUDs inserted limits the number of service providers who can be trained.

To address this problem, JHPIEGO is experimenting with two-track (or two-tier or two-phased) approaches. One model is being tried out in a JHPIEGO-designed training effort in Papua New Guinea. There a relatively large number of service providers are being trained in relatively short "basic" courses that prepare them to provide pills and other non-clinical methods of family planning. A smaller number (perhaps selected from among those who prove to be especially interested and successful family planning service providers) subsequently receive additional training to develop competency in IUD insertion and management. JHPIEGO is apparently using this approach in Zimbabwe for nurses and midwives. A similar variant is evolving in Egypt, where JHPIEGO has recently concluded that its single six-week training course is not adequate for producing either trainers or proficient service providers and has now found itself splitting the training into a basic and an advanced course. It is not clear how explicitly JHPIEGO is using a two-track (or two-phase) system anywhere else, but the concept is creeping into JHPIEGO documents (at least those of the associate director for Asia/Near East).[68]

4.2.6 More Technical Assistance, Fewer Generic Courses

Increasingly, JHPIEGO seems to be moving away from a generic course approach and is instead providing more technical assistance to local personnel to develop their abilities to carry out an improved training program. As consultants work with local personnel (e.g., in curriculum revision), they can see where weaknesses exist and can respond fairly quickly and appropriately with technical assistance. JHPIEGO has in general used excellent trainers whose good work contributed to the success of many projects. In some of the best of cases, good technical assistance is combined with courses tailored to the specific needs of local participants (as during the start-up of the RCT in Cairo).

The pre-service nursing training in the Philippines is an excellent example of the advantages of good technical assistance (see Appendix K). JHPIEGO has also used this approach in a number of its in-service training efforts: basic in-service nursing in Kenya (see Appendix L), minilap training in Kenya, and the RCT in

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[68]For example, "Preliminary Training Needs Assessment for USAID/Islamabad," by Clayton Ajello, Saha Amarasingham, and Stephanie Foster. October, 1990, p.7.

Egypt. Like the Philippines pre-service education program, all these have relied to a large extent on technical assistance and have included both curriculum development and training of trainers or faculty. Like the Philippines, these projects should have a significant impact if followed through to the end (i.e., the new curricula being effectively taught).

4.3 In-Service Training of Physicians

JHPIEGO is revising its traditional approach to in-service training of physicians in several important ways. During its early years, when JHPIEGO's prime in-service focus was training in laparoscopy for ob/gyn specialists, training efforts tended to be small and limited to local sites such as a hospital, professional school, or specific region within a country.

During the current cooperative agreement, emphasis has shifted dramatically: 83 percent of the physicians who received clinical skills training were trained in IUD insertion, minilaparotomy, or some unstated combination of skills; only about 17 percent received training solely in laparoscopy (see Table J-3). This is a major change from the early days. Further, probably most physicians not receiving laparoscopy training are general practitioners, rather than ob/gyns. (In many developing countries, most ob/gyns focus on laparoscopy, leaving other family planning methods to be provided by generalists.) In addition to branching out to other methods and general practitioners, JHPIEGO also is attempting to:

- move from training of providers to training of trainers who will train the providers (as discussed above);
- develop training programs that will have a national, rather than an isolated local impact; and
- establish national standards both for training and for provision of a given method.

The hope is that these approaches will be more cost-efficient than training of service providers, and will have a greater, long-term impact leading to institutionalization of in-service training.

Although it is not possible to assess definitively the effectiveness of these new approaches, recent examples of in-service training in IUDs, minilaparotomy, and Norplant (described below) show how JHPIEGO is going about in-service training.

IUD Training in Egypt

The effort to institutionalize in-country capability for in-service training of doctors to provide IUDs was launched in Cairo through creation of the Regional Center for Training in Family Planning (RCT). Established in 1989 as a collaborative effort between Ain Shams University in Cairo and JHPIEGO, the center's long-term goal is to serve as a site to train physicians and nurses who will train field-level providers in all contraceptive methods at satellite locations throughout Egypt. Training in IUD insertion was emphasized mainly because the government was eager to expand and maintain a countrywide IUD program.

In Egypt, six service providers -- three ob/gyns and three nurses -- were recruited to be developed as "master trainers." Producing a core group of trainers who were not only proficient clinicians but also competent trainers turned out to be a far longer process than initially anticipated. A significant unanticipated development during their training and preparation to begin training others was the discovery that curriculum development could not proceed satisfactorily until consensus had been achieved about national standards for service delivery (see Section 2.2 and Appendix I). Having a set of national family planning service guidelines will help assure that those trained provide a consistent quality of services throughout the country.

Minilaparotomy Training in Kenya

Whereas in Egypt JHPIEGO efforts have been dedicated to a training center of its own creation, in Kenya JHPIEGO is working through a network of 13 MOH hospitals in a training effort over which, initially, it exerted little quality control (see Section 3.3.1). An early evaluation of medical officers' performance in providing minilaparotomy revealed a number of serious technical problems, leading JHPIEGO to reassess completely the approach being taken. A major initial deficiency had been that the physicians' superiors -- the ob/gyn supervisors -- had not been consulted about the training and that consequently there was no consensus about the appropriate techniques to be used.

JHPIEGO's solution was to call a conference, facilitated by a JHPIEGO consultant and the JHPIEGO project director, at which all the physicians aired their opinions as to how the procedure should be carried out and during which a consensus was reached as to the accepted medical protocol. This result was somewhat similar to that in Egypt, when the RCT trainers worked together with JHPIEGO technical assistance to come up with national guidelines for service delivery which would be part of any training effort. The lesson in both cases was that, although it may be a time-consuming process, involving host country personnel in working out

mutually agreeable procedures and protocols is an essential step in any successful training program. Although at the time of this evaluation, it was too early to judge how well the next round of trainees would perform on the job, the training itself looked good, from both a clinical and a pedagogic standpoint.

The Kenyan program resembled the Egyptian program in several ways. Most important, it was the first country-wide experience in institutionalizing clinical training in a specific method. In addition, the target groups were general practitioners; the training program in satellite hospitals was carried out by locally trained personnel; and the training was undertaken in response to a government initiative to increase the availability of a specific method throughout the country.

Norplant Training in Indonesia

At the time of the evaluation, a November 1991 conference for Norplant providers in Indonesia was being planned. It was to bring together Indonesian physicians to establish a standardized training-of-trainers curriculum and to carry out an initial training course for 10 Indonesian trainers. Like the Kenya experience, this training approach would use trainers who already had strong clinical experience: Indonesia was one of the first countries to undertake clinical trials of Norplant and all workshop participants would probably have already inserted and removed hundreds of Norplant implants. Despite this accumulation of experience, however, one of the main purposes of the conference would be to reach agreement on a standardized way to carry out and to train in this procedure. As in Egypt and Kenya, JHPIEGO's approach in Indonesia is to involve local practitioners to develop consensus regarding training approaches.

Conclusion. JHPIEGO has had some good successes with training for physicians that centers on a single contraceptive method (as opposed to training that covers all methods with the same relative degree of attention -- and thus requires more time to be taken off from work by the participating physicians).

> Recommendation: In developing new in-service activities, JHPIEGO should look for government or major private sector initiatives to increase use of a particular contraceptive method, understand through needs assessment which providers can have the greatest impact with regard to the method, and plan training as part of a strategy aimed at a countrywide impact.

4.4 In-Service Training of Nurses and Midwives

Whether JHPIEGO will have increased its emphasis on in-service training of nurses and midwives compared with physicians

during the remainder of the cooperative agreement is not clear. During the first three and one-half years, the numbers of nurses and midwives who received JHPIEGO-supported training were about equal to doctors. The background paper for this evaluation reports that JHPIEGO trained 4,641 nurses, midwives and "paramedics" in in-country and regional courses from May 1987 through December 1990.[69] That number is in addition to 2,316 nurse/midwife "clinical trainees". It is not clear how these categories differ. The total for both categories is 6,957 nurses, midwives and "paramedics" trained (see Table J-1). It is not possible to predict how many practitioners in any given category will be trained during the remainder of the agreement.

Furthermore, these numbers tell nothing about the nature, thoroughness or impact of the training. The listing of recent in-service projects is similar to that for pre-service projects (see Section 3.4.1) in that many workshops seem to be offered without an apparent linkage to a more comprehensive country strategy. It is difficult to assess what their impact may have been. One particular activity stands out.

Needs Assessment: Case Study from Kenya

One of JHPIEGO's most impressive in-service efforts has been a nine-month technical assistance activity to help the Division of Family Health (DFH) in Kenya strengthen its in-service clinical family planning training program for Ministry of Health nurses and midwives. This training program had existed for nearly a decade and was well institutionalized, but had become stagnant over time. In 1989, a candid evaluation by Kenyans involved in both training and service delivery revealed numerous problems, of a magnitude they had not previously comprehended. This careful, systematic evaluation necessitated much group processing of the findings and made it possible for the DFH training team to look at its own program more objectively and with a different perspective. It set the tone for taking a close and realistic look at training needs.

JHPIEGO assistance began with a two-week field-based task analysis, conducted jointly by DFH staff and JHPIEGO consultants. Two- or three-person teams visited service delivery points where they systematically assessed the tasks and responsibilities of family planning service providers and documented operational constraints to the provision of effective, high-quality services.

This exercise fed directly into a curriculum design workshop. In this, participants focused on defining the main elements of the job of a maternal and child health (MCH)/family

[69]Friedman, 1991.

planning service provider, drawing up a comprehensive, detailed job description and agreeing that the job description would serve as the focus for identifying the end-point competencies for the new curriculum.

A second workshop was held to identify the nurses' knowledge and competence prior to beginning the in-service course. These will be determined in large part by examining the learning objectives and content of their pre-service curriculum. The gap between the demands of the job (as per the new job description) and the pre-service education of the service providers defined the necessary content for the in-service training course.

JHPIEGO has provided technical assistance (consultants) for curriculum development and training of trainers. This is not noteworthy per se. What is unique is the degree to which the effort to re-design the in-service training curriculum has been based on systematic gathering and analysis of field-based data.

This Kenya project is one of JHPIEGO's better efforts. Considerable amounts of consultant time were needed to go through every step of the curriculum development process, but the result is that an opportunity was created for change and learning in a previously stagnant training program. The director of Kenya's national family planning program says he has now made this project his "top priority."[70]

JHPIEGO does not routinely carry out or base its training on such thorough data-based needs assessments as the above effort, funded by USAID, and carried out by Kenyans (with one expatriate advisor). In Morocco, for example, JHPIEGO is becoming involved in a training program that is part of an effort to "medicalize" family planning by increasingly training and using doctors, supplanting nurse-midwives, to provide clinical family planning services. It does not appear that this major change in direction is based on any intensive, systematic observation and analysis of the strengths and weaknesses of the current family planning program, which is managed mainly by nurse-midwives, or of alleged problems regarding IUDs.[71] Rather, family planning leaders in Morocco seem to have decided to "medicalize" family planning as part of a decision to provide employment for the relatively large number of physicians being produced each year. Although this decision belongs to the public

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[70]Statement in October, 1991, to this evaluation team. JHPIEGO has profited from hiring excellent trainers as consultants. The quality of consultants has been critical in the achievements of JHPIEGO subprojects. This is one example. For a detailed case study, see Appendix L.1.

[71]The IUD "problem" in Morocco does not seem to be related to excessive morbidity but rather to nurse-midwives' (and doctors') reluctance to insert IUDs in women whose cervices are red and appear inflamed, and the relative frequency of such cervical abnormalities.

health medical leaders of Morocco, JHPIEGO needs to conduct an adequate assessment of the situation before investing its resources in such a project.

Recommendations. In-service training should be based on objective data regarding the pre-service training, numbers, roles and general performance of the various categories of health professionals and other workers who might participate in the provision of contraception. It should also focus on strengths and weaknesses of current family planning service systems, including evidence of safety or lack of safety and evidence of effectiveness (i.e., contraceptive prevalence and method-specific continuation rates).

4.5 Strategies and Priorities: "Direct" Training or "Institutionalization"?

A major issue concerning in-service training is the amount of effort that is devoted to "direct" training of service-providers vs. measures designed to lead to "institutionalization." JHPIEGO tends to use the term "institutionalization" for pre-service education. It has not articulated priorities, a strategy or even a definition for institutionalization of in-service training.

A tentative definition of institutionalization in the in-service context might be: "The development, in an individual country, of an indigenous capacity to meet that country's needs for trained providers of family planning services; in a comprehensive sense, this includes not only the ability of indigenous personnel to function as proficient trainers, but also the capacity to plan, implement, manage, and evaluate the country's training program."

Although JHPIEGO has not articulated priorities or clear strategies, JHPIEGO is taking steps toward institutionalization of the capacity of some countries to carry out future training. For example, in about half of the countries (at least 8 of 17) for which JHPIEGO has plans for in-service training of midwives and nurses during PY5, those plans include activities designed to create or strengthen training capabilities within the host institution. For Pakistan, JHPIEGO has suggested a clear "two-track" strategy that would use in-service training to meet immediate needs for trained service providers able to provide non-clinical methods (a "fast start-up program"), while also pursuing an "institutionalization effort" aimed at institutionalizing clinical family planning training in both pre-service education and in-service training.[72]

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[72]Ajello, Amarasingham and Foster, p.9. See also Section 4.2.5 above.

The reality in the field to date, however, seems to be that direct training in clinical methods has taken priority over institutionalization. (The fact that there are no available data on institutionalization efforts per se is indicative.) This was probably unavoidable during the early transition from the "old JHPIEGO." Now greater emphasis on institutionalization is needed. This will almost certainly require management expertise that JHPIEGO itself does not possess (as illustrated by JHPIEGO's RCT experience in Egypt).

Conclusion. JHPIEGO has not articulated a clear-cut strategy for institutionalization of in-service training. Its efforts to move into training of trainers, to standardize approaches to training, and to tie into national programs, however, all hold promise of a greater impact and increased possibility of institutionalization. Nevertheless, as with other parts of JHPIEGO's program, an explicit strategy to guide decision-making (analysis of possibilities, pros and cons, and priority-setting) is almost certain to result in greater impact.

4.6 General Conclusion and Recommendation

Conclusion. In-service training addresses needs that will never go away: for basic training in family planning for new service providers who did not get it in their pre-service education; for skills upgrading, to strengthen specific skills (e.g., in counseling) of people who are already providing family planning services; for training for new skills (e.g., a new contraceptive method); and for training trainers.

The standardized clinical training materials and approaches that JHPIEGO has developed are a strong central part of its in-service work, specifically its "direct" training of both service providers and trainers. Needs for in-service clinical training by JHPIEGO are unlikely to decline in the near future, although the shift to training of trainers should reduce the numbers of service providers directly trained by JHPIEGO. The need to train general practitioners in clinical methods will continue to be an important component in the provision of family planning services. There may be a slight shift in emphasis among methods: training in IUDs may decline somewhat; training in laparoscopy will probably continue at its present level, while training in minilaparotomy will probably increase; training in Norplant will also increase.

Increased efforts to institutionalize in-service training capabilities are needed.

> Recommendation. While continuing to fine-tune its approach to clinical training, JHPIEGO should analyze its experience to date with activities aimed at institutionalizing in-service capabilities. It should consider development of a clear "two-

track" strategy -- "direct" training plus parallel systematic efforts at institutionalization.

5. Management Structure, Processes, and Issues

5.1 Management Structure and Processes in Baltimore

As with almost everything else at JHPIEGO, management structures and systems (including personnel arrangements) are in a state of evolution. The present staffing is thin at the leadership level and not really adequate to carry out the current program, let alone an expanded one. This is partly a consequence of A.I.D. concerns about capabilities and programs flowing from the "old" JHPIEGO. JHPIEGO recently, however, has expanded its staff and initiated laudable organization development activities that are intended to remedy management weaknesses. The changes under way seem positive, but it is too soon to predict the outcome.

5.1.1 Current Staffing

JHPIEGO has 53 positions (nearly all filled) at its Baltimore headquarters. Many of the staff have been hired in the last year or two. These new hires include both persons to fill new positions and replacement of staff who have left JHPIEGO during the transition from the "old" JHPIEGO program.

At the top level, four of the five Associate Director positions are currently filled. (The five posts include directors of regional programs -- Latin America; Africa; and Asia/Near East/Europe -- and associate directors for Education/Training and Monitoring & Evaluation.) (See Figure 1, JHPIEGO Organization Chart.) Two of the positions were only recently filled, the Latin America and the Monitoring and Evaluation associate directors. Still being recruited is an associate director for Africa. Currently, the JHPIEGO director functions as the acting associate director for Africa. In many other areas, most of the staff is new. For example, in the Latin America office at the time of this evaluation, the three support staff had been with JHPIEGO for only one-half year, three months, and two weeks respectively. In the Monitoring and Evaluation Office, the three senior staff were all new to JHPIEGO during 1991.

Staff competency varies. The four associate directors appear quite competent, although two are fairly new to their posts and one is spread too thin over a vast territory. Below these four, technical expertise thins out. Many of the staff are junior program coordinators who lack technical expertise, although they appear to do an effective job processing project paperwork. As is needed in family planning, the project director has sought to bring in competent women, and women are well represented on the staff.

JHPIEGO's director is rare as a American ob/gyn clinician who works in A.I.D.-funded international family planning delivery.

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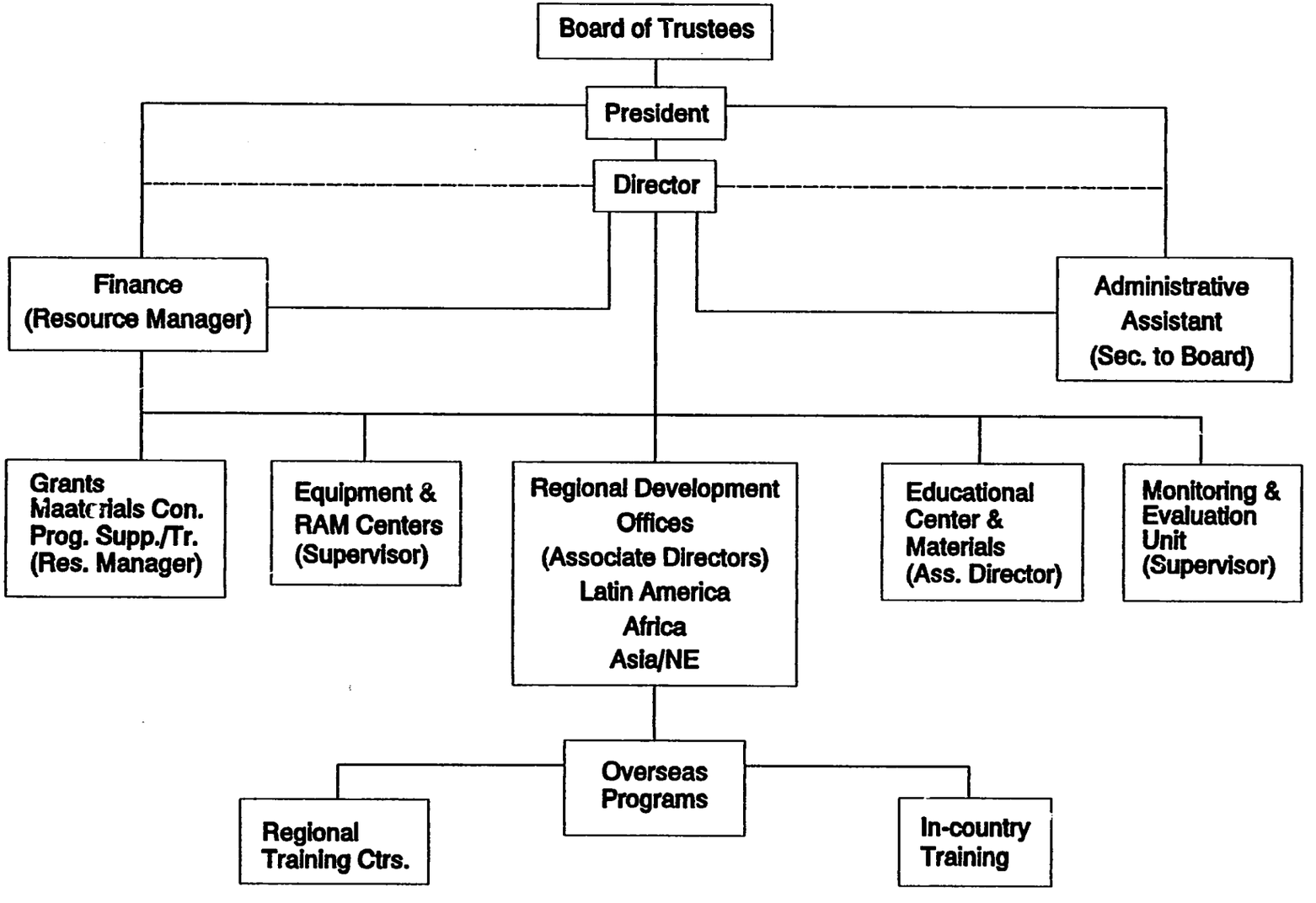
Figure 3

Current JHPIEGO Organization Chart



A.I.D., and international family planning, need more such people. In that capacity he serves as a role model for many doctors in developing countries. He is a good conceptualizer, does a prodigious amount of work and can be credited with a significant output -- including many of JHPIEGO's initiatives and achievements since his hiring.

The director is unusual in the amount of time he devotes to working at the grass roots in the field, away from the office. (In 1990, for example, he made five trips to Kenya, spending about two months in that country -- in addition to several visits elsewhere.) This is good for the field and for building JHPIEGO's clinical programs. His time away is also problematic, however, in that there is no one else with adequate decision-making authority to take over in his absence.

JHPIEGO has no overseas staff, no regional or country officers, advisors, or representatives in the field. For field operations, it sometimes hires U.S.- or field-based consultants on a temporary basis, but they represent a minor element in the overall operations.

5.1.2 Planned Reorganization

Since March 1990, JHPIEGO has been involved in an organization development process. An organization development consultant has been hired,[73] and she has been conducting one-on-one interviews with all the staff. This system-wide information gathering has revealed significant staff morale problems. It is to the credit of the director that he has given this potentially threatening process his full support.

The information gathered during this process suggests that JHPIEGO must institute a wide range of changes, affecting not only its organizational structure but also the modes of interaction and communication among staff within that structure. Specifically, the challenges facing JHPIEGO include

1) Clarifying and communicating a vision and strategic direction for JHPIEGO;

2) Instituting appropriate management structures throughout the organization;

3) Procuring management training for top-level managers;

4) Increasing communication and coordination up, down and across the organization;

[73] A similar effort had been launched earlier when the project director brought in an organizational psychologist to help resolve staff and transition issues.

5) Initiating a collaborative leadership and planning process for the top management group;

6) Developing mechanisms for increased communication within each unit and between each unit in the organization; and

7) Involving JHPIEGO staff in creating an organizational climate that supports equal attention to the product of JHPIEGO and the human side of the business.

As of September 1991, JHPIEGO had launched a number of initiatives to address the problems identified during the interviews. These include some reorganization, staff mechanisms to develop a plan of action for the entire organization, and unit-level discussions to identify problems and communication bottlenecks. Specific actions are as follows:

1) **Creation of the "Microcosm":** A group ("Microcosm") has been formed to generate recommendations for top management. It represents all levels and functions within the organization and is designed to ensure maximum commitment and participation organization-wide.

2) **Development of the top management group (director and associate directors):** This group is in the process of increasing its capacity to lead, plan, and coordinate.

3) **Redesign of the organization:** JHPIEGO is considering the addition of some new positions and the redefinition of existing positions. New positions include two deputies (one for Program Development, and the other for Organization and Human Resource Development, to be hired early in 1992) and the creation of a Clinical Support Services position. The deputy positions would enable the project director to continue engaging in clinical activities in the field while program planning and management receive needed strengthening on the home front. Some existing positions are to be redefined to support the future work of the organization, including Training Support Services and the entire function of the Monitoring and Evaluation unit.

4) **Organization development work within each functional unit:** Each unit manager is working with his/her group to assess needs in the areas of communication and coordination and is developing mechanisms to fill the needs identified. Some groups have initiated their own data gathering process.

5) **Organization development work between functional units:** This has involved clearing blockages in communication

between units. Causes of the blockage have often been the lack of adequate information. Mechanisms are presently being created between units to increase information flow.

6) **Third-party consultation and individual coaching:** The purpose of this work is to heighten awareness within JHPIEGO of the individual contributions to some of the challenges mentioned above. This involves a new focus on the human side of the enterprise.

Conclusion. JHPIEGO has begun the work of system-wide change and transformation. This transition appears critical for the future success of the organization. Future plans for sustaining the organization include increased attention to the personnel function (including measures to build staff morale). The proposed hiring of two deputy directors, one for program and one for internal management, is a much-needed measure.

Recommendation. The project director should not be obliged to change his modus operandi or to reduce the amount of time he spends in the field. However, there must be a deputy director with authority to make decisions in his absence. This deputy should remain in Baltimore managing operations and making decisions in the absence of the project director. If the two new deputy director positions are appropriately filled, this strengthening at the top level may prove a good formula for success. Follow-through of these plans must be monitored.

5.2 JHPIEGO'S Relationship to the University: the Board of Trustees and the Scientific Advisory Committee

5.2.1 The "Old" Relationship

The transition from the "old" JHPIEGO to the "new" has brought with it a significant shift in linkages and relationships with schools and departments within Johns Hopkins University.

From 1974 to 1988, JHPIEGO was directed from the Department of Obstetrics and Gynecology in the School of Medicine; funding passed through the Office of the Provost, with the Provost chairing a Board of Trustees that had responsibility for approving JHPIEGO projects and programs. With the resignation in 1988 of the then JHPIEGO Director (an eminent member of the Ob/Gyn Department), the previous close relationship with the Ob/Gyn Department attenuated.

The current JHPIEGO director came from outside the Hopkins community, bringing instead developing country experience. Since his arrival, JHPIEGO has developed a greater affinity to and emphasis on public health concerns as compared to current priori-

ties within the field of obstetrics and gynecology (which at Johns Hopkins, as throughout the U.S., have increasingly centered on sophisticated technologies that are not widely accessible in developing countries). In addition, JHPIEGO has also moved physically out of its old university quarters into new facilities located away from the university.

Finally, although JHPIEGO continues to benefit significantly from the Johns Hopkins name, few Hopkins professors are involved in its activities. Hardly any Hopkins professors perform overseas assignments for JHPIEGO. Trainees and other visitors from developing countries are often disappointed to find that their stays at JHPIEGO give them relatively little contact with the University. Many overseas visitors look forward to a clinical experience and contact with clinicians of Johns Hopkins -- and are often disappointed when this does not materialize in a substantial way.

JHPIEGO's response is that most Hopkins professors are not interested in, nor do they have expertise in, the substance of what JHPIEGO tackles overseas. Most American ob/gyns are interested in advanced techniques such as in vitro fertilization, not teaching minilaparotomy under local anesthesia in a rural African town.

5.2.2 Restructuring the Relationship

In 1990, a review of JHPIEGO and its relationship to the university was conducted[74] which addressed such issues as the following: Where should JHPIEGO be housed administratively? Should it be elsewhere than under the Provost's Office? Were the role, function, and composition of the Board of Trustees appropriate? Should there be a closer relationship with the School of Hygiene and Public Health? If so, how should this be achieved?

The reviewers recommended that JHPIEGO should remain under the Provost's Office, but that ties with the School of Hygiene and Public Health should be strengthened and technical input from its international public health faculty increased. To achieve this closer relationship, the reviewers advised that a Scientific Advisory Committee (SAC) be established with Hopkins faculty as members.

The Scientific Advisory Committee (SAC)

A Scientific Advisory Committee (SAC) was created in 1991. Its purpose is defined as

[74]Segal, Sheldon and M. Tahar Alaoui, *Report of Visiting Committee*, September 26-27, 1990.

> ...to promote the highest quality of programs through guidance in the initiation of new programs, and review and evaluation of major program areas and plans, and to serve as a bridge for JHPIEGO to Johns Hopkins University faculty who can contribute to those programs.[75]

The SAC presently consists of six persons, five of whom are Johns Hopkins University senior faculty. It is chaired by the chairperson of the Department of International Health and includes the chairpersons of the Departments of Ob/Gyn and Population Dynamics. (Both the Department of International Health and the Department of Population Dynamics are in the School of Public Health and Hygiene, whereas the Department of Ob/Gyn is in the School of Medicine.) Other members of the committee are a pharmacologist/senior associate dean of the School of Medicine, a professor of Health Policy and Management, and the Chair of the Department of Ob/Gyn at Francis Scott Key Medical Center (a teaching hospital affiliated with Johns Hopkins School of Medicine). Three have played important roles with JHPIEGO in the past; the others are new to JHPIEGO.

This committee has met once, in 1991, and is still attempting to get a clear picture of its function and involvement with JHPIEGO. Current plans for its functions are

- to take over the project review function formerly played by the Board of Trustees; and
- to be the mechanism through which JHPIEGO strengthens its relationship with relevant departments within the university.

Typically a scientific advisory committee contains top-level technical experts who can provide technical advice in the key areas in which the organization works. Although it may be an excellent means for strengthening ties to Johns Hopkins' Public Health program, JHPIEGO's Scientific Advisory Committee as currently constituted, does not appear to represent the technical expertise the program needs to flourish. In particular, the SAC seems weak in developing country family planning expertise. Another lack is that the Center for Communication Programs at Johns Hopkins is not represented. The Center (which is in the School of Hygiene and Public Health) manages Johns Hopkins' two other A.I.D.-supported family planning programs: the Population Information Program (PIP) and Population Communication Services (PCS) Project. Given the family planning expertise in each project, the Center's absence from the SAC is unfortunate. Both outside observers and

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[75] *Proposed Restructuring of the JHPIEGO Board of Trustees*, JHPIEGO Special Projects, November 4, 1991, p.1.

JHPIEGO's director have noted the need for greater synergism between JHPIEGO and these two projects.

The Board of Trustees

Typically a board of trustees plays a high-level policy, management, and fiduciary or financial oversight role. In the past, JHPIEGO's Board of Trustees also was required to make technical judgments about JHPIEGO projects. Because several of the trustees had little or no expertise in international health or family planning, it is questionable how effective they were in this area.

Now that the SAC has been created, a restructuring of the Board of Trustees is also under consideration. The thought is to add to the Board persons with international family planning and training expertise (such as directors of the JHPIEGO-affiliated training centers) as well as representatives from the private sector with interest in family planning.

A partial goal in this change would be to include persons who could help JHPIEGO diversify its sources of funding. Currently almost solely dependent on A.I.D., JHPIEGO would like to expand its program to include reproductive health activities that go beyond A.I.D.'s family planning mandate. For this, funds from other donors are needed.

Appointments of JHPIEGO Staff to University Positions

A related move for strengthening relationships between JHPIEGO and the University has been to arrange appointments for several JHPIEGO senior staff in appropriate Hopkins departments. During the summer of 1991, an advanced Kenyan graduate student from one of these departments was an intern at JHPIEGO. Vague plans exist for more such arrangements.

Technical Advisory Committees: A Frequent Element in Other R&D Projects

Many of A.I.D.'s cooperating agencies and centrally funded projects (in the Offices of Population, Health, and other sectors) find it valuable to augment their staff expertise by means of a group of outside technical experts. These are called, variously, a technical advisory group (TAG), senior advisory consultants, or something similar. Typically, these advisors have a greater sense of on-going concern and responsibility for the organization or project as a total entity than do consultants (although they may occasionally perform consultancies); at the same time, they often have more objectivity than is usually possible for full-time staff. In many cases, these are people who would be great additions to the staff, but who are not interested in working

full time for the organization (or who have a salary level the organization could not meet).

Given the thinness of JHPIEGO's upper management and technical staff, a TAG would seem a great boon for the organization, an appropriate means for augmenting technical capability without incurring a large on-going cost burden. It might have subcommittees (e.g., on training methodologies, on institutionalization of family planning in pre-service education, on clinical issues, on linking training to services, or on medical policy barriers) to which needed tasks could be delegated (e.g., an issues paper on removing medical policy barriers to contraception). Pro forma meetings would be down-played in favor of developing state-of-the-art working papers and helping in the standardization of efficient and cost-effective approaches. Most probably, however, JHPIEGO would not be enthusiastic about creating a second scientific/technical advisory group.

Conclusion. The recent establishment of a SAC and plans to restructure the Board of Trustees appear appropriate. The composition of the two bodies, as currently envisaged by JHPIEGO, does not, however, seem optimum for supporting JHPIEGO's technical needs (although the arrangement may be institutionally expedient within the University). Neither body has the expertise in technical family planning areas (training, education and service delivery) that JHPIEGO needs.

> **Recommendations**. JHPIEGO should develop a strategy to add to the SAC a group (or sub-groups) of technical experts knowledgeable in aspects of family planning education, training, and service delivery who can augment JHPIEGO's own staff in needed areas. This would require adding persons from outside Johns Hopkins University. Serious consideration should be given to including representation from the Center for Communication Programs on the SAC.
>
> Restructuring of the Board of Trustees should take place in concert with plans to bring additional technical expertise onto the SAC. International family planning experts should be chosen with great care. They should be in agreement with JHPIEGO's new directions and ideally should come from a major BIG country.[76]

[76]The BIG Country Strategy (BIG) of the Office of Population is designed to concentrate a greater portion of A.I.D's technical and financial resources in the world's most demographically significant countries. Initially, 17 countries worldwide have been selected for emphasis under this new strategy.

5.3 Use of Host Country Personnel

5.3.1 Project Directors/Country Directors

JHPIEGO often continues to select as its project directors the chairmen of the ob/gyn departments of a country's most prestigious local universities. Most are physicians; a few are deans of colleges of nursing. Often, the individual is also a "JHPIEGO fellow," i.e., someone who has attended a JHPIEGO training course in Baltimore. These persons tend to feel a close relationship to JHPIEGO and may remain directors of follow-on projects for many years. Sometimes the title of project director remains with the department chair when a rotation of duties occurs (e.g., in Kenya); at other times, the project director will remain project director, even if he changes jobs (e.g., in Morocco). These project directors are not considered members of the JHPIEGO staff.

Using such individuals has both its up and its down side. The pluses are considerable. In general, these are influential and effective individuals who, when they are committed to a job, are able to accomplish it. Moreover, most are familiar with JHPIEGO's goals for improved training and are interested in applying them. In countries in which family planning is not well accepted, using project directors who occupy an important local post and whose image is enhanced by their JHPIEGO connection has helped give credibility to family planning.

In some countries, the prestigious academic positions of these directors can help facilitate the work of effecting curriculum changes (e.g., in the Philippines, where the nursing school curriculum is being revised to include more family planning, the project director is both a JHPIEGO fellow and head of the Association of Deans of the Philippine Colleges of Nursing). The opportunity to relate to prominent academics has also given JHPIEGO high visibility, particularly in the typical developing country with few ob/gyn specialists.

On the negative side, these persons have many other responsibilities, limiting the time they have available for their responsibilities to the JHPIEGO project. Not only do their in-country jobs require a large portion of their time; some are also coordinators for other donors as well as for JHPIEGO, with numerous reports and grant applications to complete (as in the case of Kenya). Likewise, department heads may not have the management skills needed to run a JHPIEGO project (e.g., to carry out needs assessments or to undertake evaluation and re-programming), with the result that JHPIEGO staff must spend a considerable amount of time backstopping some projects, as in Kenya (see Section 5.4 below).

Another issue is that some of JHPIEGO's long-time associates may have agendas that do not necessarily coincide with current JHPIEGO and A.I.D. priorities. Persons affiliated with the government may be unwilling for political reasons to address medical barriers that inhibit use of some contraceptives (or, indeed, be themselves philosophically opposed to overturning these barriers). In other cases, a project director may put his or her own agenda before that of the national program. In retaining ties that date back many years, JHPIEGO may also be missing opportunities to develop relationships with younger, rising reproductive health professionals, especially those who can impart the woman's perspective of female clients.

A separate issue is that in countries with several projects, no one individual is charged with overseeing these efforts in aggregate. Interviews with project directors revealed that each director was pursuing his or her own agenda and was not conversant with other JHPIEGO projects being implemented in that country. JHPIEGO's Baltimore staff sometimes refer to one of the several project directors as the JHPIEGO "country director." In one case, however, the person so designated did not know that JHPIEGO thought of him as having this broader responsibility.

5.3.2 International Advisory Council (IAC)

JHPIEGO has made attempts from time to time to hold formal meetings that include the most prominent of its country directors. It has held Deans' Conferences and also once had an International Advisory Council (IAC) from which it apparently sought advice. (A.I.D. apparently opposed the IAC, and it no longer functions.) More recent meetings of "training center directors," however, now appear to serve the same function.

5.3.3 Lack of Development Philosophy

JHPIEGO shows no concrete evidence of having adopted the development philosophy that has at its heart ideas such as "empowering" and "enabling" developing country persons and institutions to take charge of their own programs, making well-reasoned decisions that lead to greater effectiveness and impact with less and less donor dependency. In many situations JHPIEGO does seek to build capabilities within various institutions or to achieve consensus among local experts on a clinical topic. But this varies. In other situations the general tenor of JHPIEGO assistance is said to be that "JHPIEGO is the expert and JHPIEGO knows best." There is no clear articulation of the standard development principles: Work collaboratively with local people, conduct joint needs assessments, transfer responsibility as well as technology and skills, and so on. In this regard JHPIEGO lags behind many other organizations involved in international development.

Some JHPIEGO staff and consultants do follow more of a development/empowering approach, but this happens on an ad hoc basis depending on the individual person. For example, in the Philippines the nursing school deans were very enthusiastic about the JHPIEGO consultant, pointing out her ability to facilitate their work, leaving many decisions to them, but giving them the technical and psychological support and subtle guidance to be able to make sound decisions. In contrast are incidents in which host country personnel feel they have been insulted by JHPIEGO staff, yelled at, and treated like children.[77] Obviously, JHPIEGO is supposed to bring high-quality technical expertise. The manner in which it is brought is equally important, however.

Conclusions. JHPIEGO's tendency to depend on ob/gyns, many of whom have had some training in Baltimore and with whom JHPIEGO has developed long-term relationships based on laparoscopy, has some advantages but seems to tie JHPIEGO to a too-narrow sphere of activity and inhibit innovation and effectiveness.

JHPIEGO has not yet adopted a development philosophy that might be summed up as "empowerment." Some of JHPIEGO staff and consultants embody this approach in their interaction with host country personnel, but it is not diffused throughout the organization.

> **Recommendations. JHPIEGO should examine each of its country programs in which there are two or more Project Directors, and in close consultation with the respective USAID mission, discuss the possibility of placing or hiring an in-country representative.**[78] The decision should be based on the need to facilitate coordination between JHPIEGO projects, the need to identify and remove medical or legal barriers to contraceptive use, and to focus the JHPIEGO country program and ensure that it complements the USAID country strategy.
>
> **JHPIEGO should articulate a development-oriented philosophy as a guiding principle for its work and then develop an approach as to how to implement this in its activities.** This would be an appropriate follow-on to the organization development work JHPIEGO has undertaken during 1991.
>
> JHPIEGO should look beyond the upper academic levels to identify younger, rising professionals who could broaden JHPIEGO's base of activities and help expand country commitment to improving reproductive health care.

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[77]Interviews in field and by telephone.

[78]JHPIEGO should look at the numbers of trips to Kenya or the Philippines taken by senior staff in 1990 and compare the cost of these trips and the days of country-specific technical assistance provided against the cost of hiring someone locally to work out of his or her home (perhaps on a part-time basis) to provide country-specific guidance to the projects and liaison with the USAID mission.

JHPIEGO should consider some strategy for bringing together developing country experts who can infuse the organization with greater developing country input and perspective. Something along the lines of the earlier International Advisory Council (IAC) might be the answer.

5.4 Communication and Cooperation with USAID Missions

JHPIEGO's relationship with USAID missions varies. Some missions are very positive in their assessment of JHPIEGO; others are very critical; the majority fall somewhere in between, with positive as well as negative views. Most of the smaller missions responding to the cable sent out for this evaluation were quite enthusiastic about JHPIEGO's efforts. Two of the larger missions, the Philippines and Egypt, had reservations or were negative; but in Kenya, another larger mission and country that has received considerable JHPIEGO inputs, USAID personnel were very positive (see Appendix E).

5.4.1 Mission Comments

This mixed pattern reflects in part JHPIEGO's own strengths: the organization seems to excel in smaller countries that are at the initial stages of family planning programs and in which its training efforts can both create family planning allies among the medical establishment and develop a cadre of skilled providers of female VSC. Mission comments on JHPIEGO's planning process support this observation. A good two-thirds of the missions responding were positive about JHPIEGO's planning process, drawing attention in particular to its collaboration with host country institutions. There was little discernible pattern in problems cited by missions that were less satisfied. One cited lack of objectives in the plan, another failure to plan for sustainability, a third, too great dependence on one individual. Overall the missions viewed JHPIEGO as a specialized organization whose purpose was to relate to specific host country institutions and, on balance, judged that it did this task well.

5.4.2 Relations with Larger Missions

For larger missions, which are increasingly concerned that CAs' activities fit into overall country population strategies, the concern is less with how JHPIEGO relates to host country institutions and more with how it relates to the mission's plans and goals. Both the Philippines and Egypt were less than positive on this score. In the Philippines, the mission reported difficulty in orchestrating a coordinated plan with JHPIEGO and with AVSC, pointing out that there had been some problems with both organizations in discussing how they should fit into the VSC network the mission was attempting to develop (see Section 1.5.3). In Egypt, USAID staff were critical of JHPIEGO for taking a too-

possessive role with the training center that JHPIEGO and USAID had worked together to create, and for attempting to proceed in ways that the mission did not support. On the other hand, in Kenya, JHPIEGO and mission professionals work very closely together and see eye-to-eye on most programming issues. USAID mission staff praised JHPIEGO for the thoroughness with which it tackled VSC training and addressed problems associated with service quality.

No doubt some of the differences in missions' perceptions can be traced to issues of personality. It is almost certain that JHPIEGO's excellent relations with the Kenya program reflect the personal attention given the program by the JHPIEGO director. During 1990, he spent nearly two months in Kenya to ensure that the VSC training being conducted by the University of Nairobi's Department of Obstetrics and Gynecology was consistent and of a quality sufficiently good to ensure maximum safety. Although this indicates how effective the director himself can be, it does not suggest a realistic pattern for JHPIEGO in other countries.

The generic issue, however, is that in many large programs (Philippines, Egypt, Morocco), the missions are paying for JHPIEGO's services through buy-ins (add-ons) to the cooperative agreement and therefore, have a stronger propriety interest in what JHPIEGO does. These missions tend to have professional health, population and nutrition (HPN) officers who are less likely than are the staff of smaller missions to defer to JHPIEGO's expertise in programming matters. As the Office of Population moves into its "BIG" country strategy, JHPIEGO will probably encounter this more critical programming environment more frequently.

5.4.3 Relations with Smaller Missions

Many of the smaller USAID missions have no or only one direct-hire HPN officer, and this person may have responsibility for more than one country. Even if the HPN officer covers only one country, many of the smaller missions in sub-Saharan Africa require the HPN officer to assist with food aid programs or other programs peripheral to family planning. Given the small amount of time this leaves for family planning, as well as the fact that most of the JHPIEGO activities in these countries (non-population bilateral programs) are centrally funded, small missions often have little understanding of what JHPIEGO is or is doing and tend to simply defer to the Johns Hopkins name, particularly when the ministry of health is positive about the work done by JHPIEGO.[79]

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[79]One HPN officer said; "I didn't know what JHPIEGO was really doing when I arrived at post and four years later when I left I still didn't know what they were really doing. It is Johns Hopkins and the Ministry people really liked their work with JHPIEGO."

5.4.4 Follow-Up Support

Missions, on the whole, have found JHPIEGO deficient in providing follow-up support to trainees. This was true no matter how they defined follow-up -- and the definition varied considerably, ranging from tracking project implementation and providing follow-up training to providing support to trainees who have completed JHPIEGO training. With regard to trainee support, missions were fairly positive regarding JHPIEGO's efforts to monitor training (see Chapter 6). Missions were less positive, particularly in Africa, when it came to JHPIEGO's ability to provide technical support visits, supplies and equipment, or even follow-up training.

This criticism, however, should be viewed in the context of JHPIEGO's overall global commitments. Like most training organizations, particularly those that operate worldwide, JHPIEGO has had neither the time nor the resources to support its trainees once they are back in their jobs. The instance of the Cote d'Ivoire physicians who returned from Morocco to find it impossible to provide family planning services is typical (see Section 4.2.3). As this example illustrates, even ample follow-up might not have worked. It is unrealistic to assume that any training institution can overcome local constraints to service provision. A wiser course would be to avoid unpromising situations in the first place through careful needs assessment and targeted selection of trainees in the context of a clear strategy for service provision.

> **Recommendation. For any courses it presents or supports, JHPIEGO should have good criteria for trainee selection,** i.e., criteria that relate training directly to service delivery or country strategies, **and seek to accept only trainees who meet these criteria.**

5.4.5 Routine Communication

JHPIEGO appears to communicate well with respect to **routine** administrative matters. In both Kenya and the Philippines, for example, the USAID mission was generally pleased with the communication from JHPIEGO headquarters and noted that JHPIEGO was responsive to their requests. The only problem area noted in the Philippines was the short timeframe of JHPIEGO's requests for concurrence for travel, both of participant trainees and of JHPIEGO staff visits. These late requests, however, appear to be no more than the normal administrative slip-ups that most international organizations experience.

5.5 Country or Regional Representatives/Advisors

The question of whether JHPIEGO should have country or regional advisors is a complex one. The answer depends in large

part on the kind of work being conducted or planned for the country or region. On the pro side, many functions and tasks can be accomplished better by someone who is persistently working and consistently available in the country. On the con side are the cost and possibility that some objectives may be better accomplished by someone coming in from Baltimore and Johns Hopkins.

Quite likely JHPIEGO could increase its impact in a number of areas by having in-country or in-region presence. Work to remove medical barriers is one of the most apparent; it is a delicate issue, and on-the-ground presence and ready availability would greatly facilitate any participation in on-going policy dialogue. A second area is institutionalization of family planning in basic curricula of medical, nursing, and midwifery schools; this also requires much back-and-forth deliberation and negotiation which is not easily achieved from Baltimore.

Other functions may be better accomplished by someone who is seen as coming from Johns Hopkins University itself. In addition, someone coming to a country from outside causes local people to focus on a specific agenda during the limited time that the person is in-country. JHPIEGO's entrance into host-country programs and decision-making is facilitated and its influence enhanced by the "halo" derived from Johns Hopkins University. It is unlikely that the halo could be transferred intact to a local-hire representative of the program.

The answer may depend in part on the role that JHPIEGO needs in a given situation. The choices are either to have someone who possesses high-level expertise in the technical aspects of reproductive health care and training skills, or, alternatively, someone to plan and facilitate the procurement and application of that expertise. Likewise, the answer may depend on the type of person available: if a high-level technical person is available, that might be right for certain regions or countries. In other cases, a mid-level coordinator (such as JHPIEGO's part-time consultant in Kenya) may be appropriate. In any case, it must be a person of sufficient stature or presence to be able to interact with department chairmen and deans of university medical schools.

Recommendation. JHPIEGO should consider, in consultation with local USAID missions, whether its impact could be increased by placing representatives in specific countries. A.I.D. should not force a country advisor or regional representative structure on JHPIEGO. If persons are to be hired for these positions, it is essential they have the appropriate combination of skills.

6. Impact and Evaluation

6.1 Overview: Good Potential but No Documented Impact

JHPIEGO has made some good starts and is uniquely positioned to have an impact in several specific clinical areas. These include activities related to making clinical contraceptive methods, especially the IUD, safer, more acceptable, and more widely available. This would contribute directly to an increase in contraceptive prevalence due to use of those methods and, possibly also, due to generally higher quality service provision.

It is not possible, however, to say with any certainty what the impact has been to date of the activities and new initiatives that JHPIEGO has undertaken since 1988. JHPIEGO has not sought to evaluate the overall impact or effectiveness of its work. Nor has it summarized its activities in a way that would permit evaluators, in the current time frame, to make any definitive judgments about impact. There is scattered evidence that numerous activities have been effective in certain regards. There is no clear documentation, however, about impact.

6.2 JHPIEGO Evaluation Activities

6.2.1 Quantitative Outputs

Much of JHPIEGO reporting has focused on quantitative outputs (e.g., numbers of training sessions, numbers of people trained). Little effort has been made to assess the impact of these activities -- let alone their effectiveness relative to cost. Various JHPIEGO documents and reports may contain evidence of impact scattered throughout, but no one in JHPIEGO has made the effort to extract and analyze this evidence. (In this regard, JHPIEGO is quite similar to other projects and programs involved in training, all of which are currently grappling with the challenge of how to measure the impact of training.)

At the time of the evaluation, JHPIEGO had not systematically documented the impact of any of its projects. Its most recent evaluation report, which summarizes activities through April 1990, focuses chiefly on fairly meaningless quantitative outputs.[80] For example, in some standard tables, it is hard to ascertain the total numbers of persons who have received some training. JHPIEGO's tendency to divide the total number of trainees into three basic categories is a case in point. These

[80]JHPIEGO 1990 Evaluation Report. Some of the data in the 1990 Evaluation Report also may not be correct; e.g., it shows 4,896 laparoscopies in Kenya during the fourth project year, whereas a trip report by JHPIEGO's laparoscopy maintenance specialist, Chung Ho, (June 1990), reported an annualized figure of 700. An evaluation for the fourth year, ending in April 1991, had not been prepared at the time of this evaluation.

included "professionals trained" (meaning in-service); "undergraduates trained"; and "clinical trainees." Even JHPIEGO staff, however, appeared confused as to whether clinical trainees were a sub-set of undergraduates trained, or a combination of both (see Table J-1).[81] In fairness to JHPIEGO, its cooperative agreement specified this kind of fairly meaningless outputs. When it was signed, A.I.D. itself viewed these as a major step in the right direction toward improvement over JHPIEGO's previous mode of operations. This kind of a cooperative agreement, however, contains no standards for judging impact or true effectiveness.

Another problem with quantitative outputs is the use of the word "trained" (as in "persons trained" or "nurses trained"). This term can be misleading. It implies that a certain level of competence or proficiency has been attained. What that level is, however, low or high, remains unspecified. All too often, the level may be quite low. In pre-service education (or "institutionalization"), for instance, "persons trained" may mean simply the number of nursing, midwifery or medical students who took one or more courses related to family planning. Depending on the school, these courses may teach actual skills or only give the student a superficial introduction -- hardly "training." As for in-service training, this may range from serious clinical training that produces proficiency, for example, in IUD or Norplant insertion, or it may consist only of a two-day familiarization seminar. The range of variation is immense. JHPIEGO understands that the traditional presentation of "persons trained" does not constitute any accurate statement of ability of the "persons trained" to actually provide family planning services. It has not, however, tallied up its trainees in any meaningful way.

JHPIEGO has been working together with other CAs (the IT Division's "Training Evaluation Working Group") to arrive at an understanding of what can and cannot be done in measuring impact. Good progress has been made to identify indicators, but no magic answers have been found.

6.2.2 Increased Emphasis on Evaluation

While JHPIEGO has a long way to go in designing for and assessing impact, it has this year made a major commitment toward improving evaluation, establishment of an office for monitoring and evaluation. Its intention to step up evaluation is expressed in its current annual workplan, which states:

[81]Staff stated that the category would be dropped in the 1991 annual report.

"The ideal organization would be self-evaluating. It would continuously monitor its own activities so as to determine whether it was meeting its goals or even whether these goals should continue to prevail."[82]

Course evaluation. JHPIEGO employs routinely standard approaches toward evaluation of courses it conducts and sponsors: pre- and post-tests to assess trainees' knowledge gains, and end-of-course assessments by the trainees. It is almost certain that better analysis of findings needs to be done, and appropriate modifications made. For clinical skills training, JHPIEGO emphasizes competency-based evaluation, an important approach.

Project evaluation. Recently, for a few key projects (especially large buy-ins), JHPIEGO has also undertaken some process evaluations.[83] These have been serious efforts, typically involving external evaluators.

Lessons learned. Senior JHPIEGO staff are increasingly focusing on "lessons learned." What JHPIEGO presents as "lessons learned" (e.g., as in its PY 5 workplan, Section 1.3.4) are not based on scientific documentation of evidence, however. Rather, these "lessons" are more accurately "insights," simple statements of what one or more staff member believe has happened.

Monitoring and Evaluation office. Perhaps most significant, during 1991 JHPIEGO established a Monitoring and Evaluation office, which has ambitious plans, including installation of efficient computerized monitoring. At present, however, this office is still unable to respond promptly to queries, even on quantitative outputs. When JHPIEGO was asked by this evaluation team to summarize the impact of its recent work, it had no summary to provide. Nor did it even make an effort to synthesize achievements (as many CAs do for an evaluation). Instead it provided to the team a stack of assorted documents which are essentially raw material from which considerable effort would be required before any conclusions about impact might be extracted.

One explanation for its inability to come up with answers could lie in the quality of data of the old computerized system (which makes it difficult for JHPIEGO to respond to questions that request quantitative outputs in categories different from JHPIEGO's own). Perhaps once all the groundwork has been established and

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[82]JHPIEGO, *Annual Workplan Program Year 5*, June 1991.

[83]For example, evaluations of the Regional Training Center in Cairo, Egypt (Anderson, Margolis, Pillsbury, and Wright 1990); the Medical Intern Minilaparotomy Training Program of Kenya (Bhatia, McIntosh, and Kamau 1990 and Bhatia, Dean, and McIntosh 1990); *An Assessment of In-Service Education in Reproductive Health for Nurses and Health Extension Officers in Papua New Guinea Using A Distance Learning Program Approach*, (Ajello and Kinzie, 1989); and the Philippine FCC Fellowship and Practicum Training (scheduled for November 1991).

proposed systems are in place, this office should enable JHPIEGO to become the "self-evaluating organization" it aspires to become and should be able to describe adequately to A.I.D. at any point in time the impact that JHPIEGO activities are having. It will be important to assess this ability.

6.3 Team Assessment of Impact

While firm conclusions are not possible, the following impressionistic conclusions can be offered based on field visits, interviews, and document review by this evaluation team.[84]

6.3.1 Impact on Quantity and Quality of Services

Quantity

For most countries, it is virtually impossible to make any judgments about whether or by how much JHPIEGO has contributed to an increase in the quantity of services being provided. This is partly because of internal inconsistencies of some of the data. This is also because it is difficult to track the impact of workshop participation on the actual provision of services. In Egypt, however, where JHPIEGO was the lead agency helping to establish the Regional Center for Training in Family Planning (RCT), it is widely acknowledged that the RCT has contributed to a significant increase in the number of trained service providers. During this same period there has also been a substantial increase in contraceptive prevalence. A recent UNFPA evaluation team judged the increase was due in large part to A.I.D. inputs, including those of the RCT and JHPIEGO.[85]

Quality

The quantitative data, and outcomes of activities, are not described well enough (e.g., x number of nurses taught) to conclude anything about the positive impact on service quality. It appears impressionistically, however, that JHPIEGO's moves to standardize and upgrade the quality of clinical training should lead to significant improvement in the safety and quality of services. In particular, JHPIEGO's work on GTIs and infection prevention should have an important impact on improving and extending IUD and VSC services. This would appear to be the case in Kenya and Egypt, for example.

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[84]The Scope of Work for this evaluation posed the questions: "What impact have JHPIEGO courses had on the quantity of services provided? On the quality of services provided?" Although data does not exist to answer definitively, it appears that JHPIEGO courses in and of themselves do not necessarily have a great impact. Thus, the question about "impact of courses" is not wholly "on target."

[85]Personal communication, Jose Rimon, project director, Population Communication Service Project.

Demographic Impact

It is not easy for any training project to evaluate its activities in terms of demographic impact. It may be possible in some cases (for example, Egypt) but not all. One family planning professional stated that JHPIEGO could claim to have contributed to modern contraceptive prevalence rate in the Philippines through VSC activities. This individual also suggested: "JHPIEGO needs to develop agreed upon algorithms for attributing percent of prevalence and to view these as achievements in light of program costs."

JHPIEGO has been working together with other CAs (the IT Division's "Training Evaluation Working Group") to arrive at an understanding of what can and cannot be done in measuring impact. Good progress has been made to identify indicators, but many issues remain unsolved. This group's efforts may represent some of the best thinking to date on the linkage between training and demographic impact.

Impact in Institutionalizing Family Planning

Potential is great, but the work is just beginning. (See Chapters 3 and 4.)

6.3.2 Impact on Improving Host Country Medical Policies

This has not been a focus of JHPIEGO (nor part of its formal mandate). JHPIEGO has not articulated any strategy for removing medical or legal barriers to contraception and whatever it may have achieved in this area was probably a by-product of other activities. JHPIEGO would seem eminently suited to tackle the issue, given its Johns Hopkins prestige. Policy work, on the other hand, may require an on-the-ground presence in specific countries -- which JHPIEGO does not have. It seems unlikely that JHPIEGO could make much headway in this area with its present Baltimore-based staffing.

6.4 Opinion in the Professional Community

A sampling of eminent family planning professionals, American and international, as well as representatives of other A.I.D. cooperating agencies, was interviewed (see Appendix A, Major Contacts). In addition to being asked about training needs during the coming decade, each was asked: "What have been JHPIEGO's main impacts, strengths, and weaknesses?" The following responses are illustrative:

1) "The main effort and impact has been laparoscopy training for ob/gyns."

- Many saw this as having had a positive impact, namely influencing eminent opinion-leading ob/gyns to be supportive of family planning.

- Others saw this as a negative impact, having benefitted elitist university professors rather than overall family planning programs.

- Some mentioned that this had been done in a way that focused inappropriately on targets. (For example, one ob/gyn professor said JHPIEGO required recipients of laparoscopes to sign an agreement that they would perform x number sterilizations in a given period).

2) "The new orientations since [the current project director] arrived have been a good improvement." Specifically mentioned were: broadening JHPIEGO's focus; work on IUDs, GTIs, reducing infection, improving quality.

3) "Governmental constraints (e.g., Philippines, Egypt) have significantly affected JHPIEGO's programs at times.

4) "Host country professionals need to have more input into what they want from JHPIEGO's menu."

5) "JHPIEGO lacks experience in program management and transfers little administrative knowledge to its project directors and their staffs."

6) "JHPIEGO should become less insular and more collaborative with its peer CAs; it should also pay more attention to training of trainers for midwives and nurses--the frontline providers of services."

7) "JHPIEGO should emphasize spacing methods to expand its program beyond VSC and the laparoscope."

8) "If JHPIEGO is really concerned about reproductive health, it should consider a training module directed at the management of incomplete and septic abortion."

One quote captures what many family planning professionals commented about JHPIEGO:

> "...[the project director] is a field-oriented activist whose full-time attention to the organization has given it more visibility and credibility in the field of international family planning. But three years have not been enough to change completely its parochial image of an elitist program attending only to academic medical departments via its relationship with the Department of Obstetrics and Gynecology at Johns Hopkins Medical School."

Conclusions

Good potential. **JHPIEGO has made some good starts and is uniquely positioned to have an impact in several specific clinical areas. It is not possible, however, to say with any certainty what the impact has been to date of the activities JHPIEGO has undertaken since 1988.** Data and documentation do not currently exist.

Strategies and Impact. At present it is difficult to demonstrate the impact of training. The present cooperative agreement with its target numbers of people to be "trained" does not provide the guidance needed in achieving impact. What will be necessary for guiding resource investment will be better and clearer strategies. Embodied in such strategies must be criteria for choosing among the many opportunities for investment of time and resources. Finally, it is also important that strategies be open to change as circumstances change and knowledge accumulates about what works best.

Recommendations:

A.I.D. and JHPIEGO need to develop new indicators for project effectiveness and impact (beyond simple figures such as "numbers of courses" or "numbers of people trained"). Expected program outputs should be phrased not only in terms of quantities; achievements must have qualitative measures as well.

JHPIEGO's Monitoring and Evaluation staff should have a major role in helping set priorities and articulate strategies for JHPIEGO's program and its various components. Design and evaluation should go hand in hand. An immediate task for the office should be to finalize its preliminary framework for evaluation and begin pulling together data and descriptions in a way that facilitates program decision-making.

7. Recommended Future Mandate, Strategies and Activities

Most of the recommendations listed below are extensions or syntheses of recommendations that have already appeared in this report. A few respond to questions posed in the scope of work that had little prominence in the report.

7.1 Mandate for JHPIEGO, Strategies, and Activities

Mandate

JHPIEGO's future mandate should be to participate, on a country-by-country basis with the USAID missions, the government, other CAs, and as appropriate, local private sector organizations, in implementing a national training strategy aimed at the following objectives:

- institutionalizing an efficient family planning in-country training capability; while also
- meeting immediate needs for improving the ability of service providers to provide better family planning and reproductive health services;
- working to institutionalize basic family planning knowledge, and as appropriate skills, in pre-service curricula of health care providers; and
- identifying and seeking to remove medical barriers and other rate-limiting factors impeding the expansion of family planning services.

Priority should go to working in BIG countries in which a significant demographic impact can be expected, but also to smaller countries in which the political leadership is eager to provide family planning services but lacks trained service providers. This means that JHPIEGO should not waste resources trying to train providers in small countries in which the environment is not conducive to initiating services.

Strategies

- Whatever mandate and objectives are finally adopted, JHPIEGO should develop a set of clearly articulated strategies for achieving these in a cost effective way.
- JHPIEGO should develop an approach to counseling as part of its overall approach to training (although it need not develop its own materials; many good materials are already available, e.g., those produced by AVSC).

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- Any courses JHPIEGO presents or supports should be based on thorough and objective needs assessments. In addition, JHPIEGO should have good criteria for trainee selection which relate training directly to service delivery or country strategies, and it should seek to adhere to these criteria.

- JHPIEGO should articulate a development-oriented philosophy as a guiding principle for its work and then figure out how to implement this in its activities. This would be an appropriate follow-on to the organization development work JHPIEGO has been going through during 1991.

Activities

- JHPIEGO should not be restricted to working with any single category of provider (doctors, midwives or nurses); with either pre- or in-service training; with either the public or the private sector. Rather, the emphasis in any country should depend on a strategic approach to country planning by A.I.D. The Office of Population should be able to provide guidance to the missions on how to develop a training strategy that involves a needs assessment carried out by host-country training and family planning service personnel, with external technical assistance as needed. From this should come an identification of the host-country institutions with which JHPIEGO and other CAs can have the greatest impact.

Some specific guidelines follow:

Types of providers (doctors, midwives and nurses). The relative emphasis that should be given to one type of provider or another (doctor [ob/gyn or general practitioner], midwife, or nurse) should vary depending on the roles played by each of these categories of service providers in the individual country and specifically relative to the methods that each provides. With respect to doctors, JHPIEGO and A.I.D. should distinguish clearly between ob/gyns and general practitioners, as the latter are more numerous and widespread throughout a country, including in rural areas.

Private vs. public sector. The distinction between the private and the public sector is relatively unimportant as a categorical imperative for programming and should be downplayed. The distinction between private vs. public sector practitioners is in many cases an artificial one (e.g., many public sector doctors have private practices).

Training of trainers vs. service providers. In the next cooperative agreement, JHPIEGO should focus mainly on training-of-trainers/"master-trainers"; training of service providers should be the exception rather than the norm.

7.2 Recommendations to A.I.D.

The exponential increase in demand for family planning services that will occur over the next decade will be accompanied by a similarly large increase in the need for service providers. A.I.D. needs to recognize the crucial role training plays in bringing about higher levels of continuing use of family planning. In all its training activities, A.I.D. must find ways to make training more effective and efficient. A.I.D. will need to develop a more systematic concept of what works and better thought-out strategies for systematically and efficiently training the right categories of personnel to allow for the greatest possible dissemination of services.

1) **Training strategy for the Office of Population.** The Office of Population should have a strategy for increasing the effectiveness with which it programs its training resources during the coming five to ten years. The goal of such a strategy should be to help the Office, and the IT Division, to design, monitor, and evaluate its training programs with greater ease and success. To this end, the IT Division should consider convening a "Training Strategy Working Group" with representation from the IT Division's training CAs as well as other CAs with substantial training components. This is especially important for maximizing the contribution of training to the Office's BIG Country Strategy (or any similar effort).

2) **Specific mandates for CAs.** The Office of Population should consider giving mandates related to specific methods to its CAs. AVSC should continue its focus on VSC, Georgetown University on natural family planning, and JHPIEGO should have lead responsibility on the IUD, a role it has unofficially assumed in recent years. This could involve extending its efforts to address issues of supervision and quality assurance, both of which interact with training. Consideration should also be given to giving a CA responsibility over the pill -- perhaps INTRAH or DA, which could work with FHI, which has done important research on pill compliance, to develop and evaluate approaches to improving the training and supervision of providers. The goal would be to improve continuation and effectiveness rates. In cases in which individual CAs have been supported by A.I.D. to develop expertise in certain areas (e.g., AVSC for counseling, DA for materials development, and JHPIEGO in IUD management), the fruits of these efforts should be shared among relevant CAs.

3) **Design of a follow-on project with JHPIEGO.** The new JHPIEGO project should be designed in the context of an overall training strategy in such a way that A.I.D. can use JHPIEGO to its greatest comparative advantage. JHPIEGO has certain historical emphases and strengths on which A.I.D. should

capitalize. Although JHPIEGO has emphasized certain areas, it has ignored others (e.g., the pill, supervision, development of locally suitable training materials to meet local needs, working with certifying and accrediting bodies). This is acceptable, so long as there are other organizations focusing on the other aspects. JHPIEGO should focus on what it is starting to do well; it may be appropriate to expand its scope somewhat, but JHPIEGO should not be expected to meet all family planning training needs.

4) **Country training strategies.** In each country in which A.I.D. supports family planning activities, there should be a clearly articulated country training strategy. The Office of Population should have guidelines as to what belongs in a country training strategy and how it is developed. This should be part of the overall training strategy recommended above. It should probably also include some principles as to how the various CAs are to define their roles in the country training strategy as well as the particular role of the specialized training CAs, both vis-a-vis bilateral projects and other CAs. These guidelines should then guide both project design and evaluation as concerns training.

Appendix A

Methodology: Description of Assignment

Appendix A

Methodology: Description of Assignment

This evaluation of the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) was to be primarily forward-looking. Specifically it was "to help define the need for and role of training in A.I.D.'s population program during the next decade and JHPIEGO's role in that training." The evaluation was also to provide a basis for a new cooperative agreement for JHPIEGO. The team was directed that the most important focus was to be JHPIEGO's future direction over the next 5-10 years; evaluation of JHPIEGO's current work was to be a secondary purpose (see Attachment 1, Scope of Work for this evaluation).

This report also is the standard final evaluation for this project, whose current Cooperative Agreement (#DPE-3045-A-00-7004-00) ends April 30, 1994. The project was originally to cover the period May 1, 1987 to April 30, 1992, with a project budget (ceiling) of $55,182,000. A two-year extension became effective as of May, 1991.

The team was directed to focus on the work of JHPIEGO only since the hiring of its current director, in August 1988 (thus only the past three years [approximately] of the project. The team was explicitly directed (1) to exclude from consideration the earlier activities of this project, and (2) to focus on the future rather than on the quantifiable outputs that were objectives in the Cooperative Agreement. The basis of this directive from A.I.D. was both the recognition that the JHPIEGO program has changed significantly since the advent of the current director and also the growing recognition that quantifiable outputs (such as numbers of persons trained) are in and of themselves not good indicators of program effectiveness or impact.

The evaluation was arranged through the Population Technical Assistance Project (POPTECH) and carried out by four persons, with a fifth individual assisting in the report writing effort. Team leader was Barbara Pillsbury, Ph.D., anthropologist and evaluation specialist. Team members included consultants Alan J. Margolis, MD, professor emeritus, Obstetrics/Gynecology and Reproductive Science, University of California, San Francisco; Judith P. Rooks, MPH and certified nurse midwife; and Gary Leinen, MPH, Office of Population staff member. Report coordinator was Dorothy B. Wexler, POPTECH. Several team members had earlier exposure to the work of JHPIEGO: Dr. Pillsbury and Dr. Margolis conducted for JHPIEGO the December 1990 evaluation of the Regional Center for Training in Cairo; Dr. Margolis and Ms. Rooks were part of the team that carried out the AVSC mid-term evaluation in May 1991. Dr. Margolis had also participated in A.I.D.'s evaluation of Indonesian Voluntary Surgical Contraception program (November 1989). Ms. Rooks had evaluated A.I.D.-sponsored training projects in Africa since the 1970s.

The evaluation took place during a four-week period (September 23, 1991 through October 21, 1991). The first week consisted of meetings with Office of Population staff in Rosslyn, Virginia (one day) and with JHPIEGO staff at its headquarters in Baltimore (three days). Four members of the team spent from September 29 through October 19 in the Philippines, Kenya, and Morocco observing JHPIEGO activities and meeting persons involved in JHPIEGO work. The fifth team member joined the team in Morocco. Debriefing for the Office of Population and JHPIEGO took place on October 22, again in Rosslyn.

Conclusions are based on information from the following sources:

- In each of the countries visited, team met with most of the persons who are (or had been) project directors and project coordinators of JHPIEGO projects; USAID population staff; host country personnel responsible for or knowledgeable about the country's family planning program; representatives of A.I.D. Cooperating Agencies; and others knowledgeable about JHPIEGO activities or their context in the national program (see Attachment B, Major Contacts).

- To elicit input from USAID staff in countries not visited during the evaluation, a cable had earlier been sent to all USAID field missions asking for their assessment of JHPIEGO strengths and weaknesses. Responses from 18 missions were reviewed by the team (see Appendix D).

- Several sets of interviews were conducted with persons outside the countries visited. Their purpose was to elicit opinions concerning JHPIEGO effectiveness (strengths and weaknesses) and impact as well as views on what is needed in the future. Interviews, some in person and some by telephone, were conducted with a sampling of eminent international family planning professionals, American and international (see Attachment B, Major Contacts); representatives of other A.I.D. Cooperating Agencies involved in training; and with USAID/Cairo population staff as well as the Executive Manager of the JHPIEGO-supported Regional Center for Training in Cairo.

- The team also reviewed numerous documents including JHPIEGO training materials and trip reports (see Attachment C, Bibliography). A separate evaluation had earlier been conducted of JHPIEGO work in Brazil. The report of the Brazil evaluation became available to the team during the preparation of this report.

Appendix A — Attachment 1

Scope of Work

I. JHPIEGO'S MANDATE AND STRATEGIES

A. JHPIEGO's Current Mandate and Strategies at the Central Level

What is JHPIEGO's operational definition of its mandate? What are JHPIEGO's present strategies for meeting its mandate? How has JHPIEGO changed its strategies over the last few years? Why?

B. Fit with the IT Division's Operating Principles and Objectives

How well do JHPIEGO's strategies and activities fit with the IT Division's operating principles and objectives?

C. Overlapping Mandates

USAID has training cooperating agencies with overlapping mandates. Have there been problems with overlapping and duplicate efforts (e.g. curricula or other training material) at the field level? How can these problems be alleviated?

D. Planning and Strategies at the Field Level

How does JHPIEGO develop country strategies and plans? (E.g. do they have a useful needs assessment guideline?) Are pre-service education projects planned with enough attention to continuation after the end of the project? Are small scale projects planned with enough attention to later expansion to a broader scale? How well does JHPIEGO integrate missions' and national population strategies in their plans? How can these areas be improved?

II. JHPIEGO's Training Activities:

A. Appropriateness of Clinical Training Materials and Methods

How appropriate are JHPIEGO's clinical training materials and methods? E.g., how appropriate are JHPIEGO's clinical training manuals for the various target groups? Are they suitable for use or adaptation in all countries in which JHPIEGO works despite different approaches to training in different countries and institutions? What can be done to improve the materials and methods?

B. **Appropriateness of Training of Trainers Approaches**

How appropriate are educational training manuals? Are educational training manuals suitable for use or adaptation in all countries in which JHPIEGO works despite of different approaches to education evident in these countries? What curriculum development strategy has JHPIEGO used in introducing family planning in medical and nursing schools? What improvements can be made in the future?

C. **Follow on Support**

Is JHPIEGO providing sufficient follow-on support to its trainees and education projects? How can this be improved?

D. **Target Audience and Institutions**

Is JHPIEGO targeting the appropriate pre-service educational institutions? Is JHPIEGO targeting the appropriate in-service training institutions? Is JHPIEGO targeting the right personnel groups for training? How much emphasis should JHPIEGO put on the different types of health care personnel?

III. Impact of JHPIEGO Activities

What has been the impact of JHPIEGO's educational and training activities in institutionalizing family planning educational and training capabilities in the countries in which JHPIEGO works? What has the impact been on quantity and quality of service? What has been the impact on improving host country medical policies? What do evaluation studies indicate? Where are these results documented and how are they used? Have the results been disseminated? How can evaluation be improved in the future?

IV. MANAGEMENT STRUCTURE, PROCESS AND ISSUES

A. **Management Structure and Processes**

What is JHPIEGO's current management structure, staffing patterns, management systems and communication processes? What are the main strengths and weaknesses in the present system?

B. **Use of Host Country Project Personnel**

How does JHPIEGO use its project directors and coordinators? What are the strengths and weaknesses of the present system? How can it be improved?

C. Communication with and Cooperation in the Field

1. Is communication between missions and JHPIEGO effective? Have there been problems? How have they been solved? What problems remain? How can communication be improved?

2. Is communication between host country institutions and JHPIEGO effective? Have there been problems? How have they been solved? What problems remain? How can communication be improved?

3. How well has JHPIEGO been cooperating with other cooperating agencies centrally and in the field? How has this cooperation been done and what results has it produced? What improvements can be made in the future?

V. FUTURE DIRECTIONS

A. Future Training and Education Needs of Population Programs

What will be needed in family planning education and training over the next decade? Are there other needs besides family planning education and training that would be appropriate for population training projects? What should the role of training be in family planning programs over the next decade (e.g. should it play a leadership or support role)?

B. Recommended Future Mandate, Strategies and Activities

What should JHPIEGO's future mandate be? What should their strategies be for achieving this mandate? What activities need to be added or changed? Which strategies and activities need to be emphasized? Which strategies and activities need to be de-emphasized?

C. Management and Programmatic Implications

What changes are needed in JHPIEGO's current management structure, staffing pattern, management system and communication process to enable it to meet its proposed future mandate and strategies?

Appendix A - Attachment 2

Major Contacts

JHPIEGO

Headquarters Staff

Noel McIntosh, Director and Acting President, Executive Office
Susan Saudek, Distance Learning Coordinator, Executive Office
Liliane Toumi-Metz, Associate Director for Technical Services, Executive Office

Terri Dean, Program Officer, Africa
Anthony Nathe, Program Officer, Africa

Clayton Ajello, Associate Director, Asia and Near East
Mary Segall, Assistant Director, Asia and Near East . . .

Sandra Buffington, Associate Director, Latin America

Adam Lisiewicz, Associate Director, Monitoring and Evaluation
Lynne Gaffikin, Assistant Director, Monitoring and Evaluation
Donna Eddy, Computer Systems Specialist, Monitoring and Evaluation
Charles Maringo, Fellow, Monitoring and Evaluation

John O'Connell, Resource Manager, Resource Management Office

Ronald Magarick, Associate Director, Education Office

Board of Trustees and Scientific Advisory Committee

Dr. M. Gordon Wolman, Professor and Chairman, Environmental Engineering, JHU; (former Chairman, JHPIEGO Board of Trustees)
Dr. Jared Cohon, Vice Provost for Research, (interim Chairman, JHPIEGO Board of Trustees)

Dr. Robert Black, Chairman, Department of International Health, School of Hygiene and Public Health, The Johns Hopkins University; (Chairman, Scientific Advisory Committee)
Dr. George Huggins, Chairman, Department of Obstetrics and Gynecology, Francis Scott Key Medical Center, Baltimore; (Member, JHPIEGO Scientific Advisory Committee)
Dr. Theodore King, President/CEO, Family Health International; (former President, JHPIEGO)
Dr. W. Henry Mosely, Chairman, Department of Population Dynamics, School of Hygiene and Public Health, JHU; (member, JHPIEGO Board of Trustees)

Consultants

Elaine Lowry, consultant on resource management
Gary Bergthold, training consultant
Richard Sullivan, training consultant
Jonalynn Mandlebaum, consultant for Philippines
Soheir Sukkary-Stolba, consultant for Egypt

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Appendix A — Attachment 3

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Appendix B

Information and Training Division
Operating Principles and Objectives for Training

Appendix B

Information and Training Division
Operating Principles and Objectives for Training

Operating Principles:

1. Education and training have more impact when **closely linked to service delivery.**

2. Training activities should **flow from a comprehensive strategy** based on the needs, resources, and stage of development of the country being assisted.

3. Family planning should be **institutionalized in pre-service and in-service curricula.**

4. Training is more efficient and effective, and has more impact on job performance and service delivery, when it is **competency-based.**

5. Training activities should be designed to have **an effect beyond the specific activity or intervention** supported. The outcome and multiplier effects of these activities should be **documented and evaluated.**

Objectives:

1. Develop a sustainable **national training capability** in all AID-assisted countries.

2. **Integrate family planning into the curricula** of public and private educational institutions.

3. Strengthen institutional capabilities to **measure the effectiveness of training and its impact on service delivery.**

4. Build institutional capabilities to **assess needs**, design, produce and distribute low-cost, locally relevant **training and reference materials.**

5. Develop **national service delivery policies and plans, standards, and method protocols** as a framework for training, quality assurance and supervision of service delivery.

6. Develop a **model for projecting required human resources to achieve planned service delivery goals.**

Appendix C

Overlapping Mandates and CA Collaboration: Considerations for Project Design

Appendix C

Overlapping Mandates and CA Collaboration: Considerations for Project Design

JHPIEGO and PAC IIb[1]

The main distinction between the JHPIEGO and PAC IIb mandates is that JHPIEGO has chief responsibility for training doctors along with nurses and midwives whereas PAC IIb focuses on community workers and secondarily on nurses, with doctors to be included only in special instances. To respond better to this mandated division of labor, JHPIEGO, in 1989, discontinued its only training of community health workers (in the BEMFAM project in Brazil). Nurses and midwives, however, are still trained under both JHPIEGO and the PAC projects.

A second difference between these projects relates to contraceptive methods taught. JHPIEGO supports training in long-term methods that require sterile techniques -- IUDs, voluntary surgical contraception (VSC), and Norplant -- whereas PAC IIb focuses on pills, condoms, and counseling. A third difference concerns the relative emphasis on pre-service education vs. in-service training (although firm data are not available).

Both PAC IIb and JHPIEGO also are charged with developing training materials, PAC IIb explicitly, JHPIEGO implicitly. JHPIEGO's vigorous efforts in this area have surpassed initial expectations, so that now both projects are actively engaged in developing both materials and curricula. In yet another convergence of mandates, INTRAH has traditionally been perceived as good at working with ministries of health whereas JHPIEGO initially focused on academic faculty. In many countries, however, JHPIEGO now also works with ministries of health (while INTRAH and Development Associates have also worked with universities).

JHPIEGO and AVSC[2]

With AVSC, the overlap is significant, too. The main area of overlap is VSC. VSC is AVSC's primary mandate (although AVSC is expanding into other clinical methods), whereas it is only part of JHPIEGO's mandate, albeit an important one. The main distinction is that AVSC puts most of its resources into VSC service provision whereas JHPIEGO's thrust is VSC training. Thus, AVSC has put a greater emphasis on counseling and the coordination of large-scale VSC service delivery programs, whereas JHPIEGO has focused on standardization of clinical training materials and approaches for the surgical procedure itself (see Appendix C for further discussion).

Like other service delivery CAs, however, AVSC devotes an appreciable -- and growing -- part of its budget to training. In 1990, it allocated 13 percent of its estimated expenditures -- or nearly $1.2 million -- to training. (Around 60 percent was allocated to service delivery.) Although most AVSC trainees receive training in non-surgical topics (primarily counseling), about 225 physicians were trained by AVSC in surgical

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[1]The PAC IIb mandate, as described in the Office of Population's 1991 Users' Guide, is "to strengthen and develop the capacity and capability of developing country institutions and agencies to design, implement and evaluate a program of training activities so that various PAC IIb workers will be able to provide family planning services. Main objectives are 1) to train providers, supervisors and other service personnel in order to rapidly expand the availability and improve the quality of family planning and health services and 2) to develop training materials and publications that meet rigorous instructional design standards and that are adaptable and replicable in multiple cultural and program settings."

[2]AVSC's mandate: to make high quality voluntary surgical contraceptive (VSC) services available as an integral part of developing country health and family planning programs. Its main areas of emphasis are 1) expanding access to services, with emphasis upon institutionalization and sustainability; 2) rigorous and systematic attention to voluntarism, and 3) maintaining and enhancing the safety and quality of services. Source: John Marshall et al., "Midterm Evaluation of the Association for Voluntary Surgical Contraception (AVSC) Cooperative Agreement."

techniques in 1990; this was about half the number (approximately 450) trained by JHPIEGO in program year (PY) 4 (May 1, 1990 to April 30, 1991) in laparoscopy, minilap, IUD insertion, or a combination of these skills (see Table D-1 in Appendix D).[3]

If AVSC were involved only in minilap, the method in which it has specialized, and JHPIEGO only in its original area of concentration, laparoscopy, there would be no overlap. However, both organizations now give primary attention to minilap. AVSC provides training almost exclusively in minilap.[4] Under its current director, JHPIEGO has also been placing higher priority on training in minilap. Between May 1, 1987 and April 30, 1991, JHPIEGO trained almost equal numbers of doctors and nurses in minilap (617) as in laparoscopy (609).[5] Between May, 1990 and April, 1991 (PY 4), JHPIEGO trained twice as many providers (137) in minilap as in laparoscopy (55) (see Table C-1). JHPIEGO now supports laparoscopy training in only a handful of countries (e.g., Kenya, the Philippines and Morocco). At the same time, a considerable proportion of the VSC procedures supported by AVSC are laparoscopies: During the period 1988-1990, 43 percent of the total 383,000 VSC procedures supported by AVSC were laparoscopies.[6]

A larger and very important question relates to the relative appropriateness of the minilap vs. laparoscopy procedure. Although both JHPIEGO and AVSC are still involved in laparoscopy, both share a stated preference for minilap. It is generally agreed that minilap is more appropriate in countries with less a sophisticated medical infrastructure and that use of minilap will allow for quicker spread of female VSC services. A.I.D., however, has no general guidelines that would assist programmers on a country-specific basis to decide whether laparoscopy or minilap (or both) should be supported or whether AVSC or JHPIEGO (or both) should provide that support (see Appendix C).

Collaboration with PAC IIb and AVSC

At Headquarters

Given the considerable overlap and the competition this fuels, relationships among the CAs are remarkably good. At the headquarters level, the CAs have made a strong effort, particularly in recent years, to keep each other informed of one another's activities, sharing trip reports and annual workplans on a regular basis (the latter an effort initiated by JHPIEGO two years ago), discussing plans informally, and participating in conferences and working groups. JHPIEGO expects cooperation to improve further as training needs increase.

A major point of contention relates to JHPIEGO's having developed training manuals based on materials prepared by other organizations (e.g., JHPIEGO's Norplant package was based in part on PATH's prototypic curricula). Some CAs have viewed this as "pirating." JHPIEGO, however, maintains that its purpose is to make the materials widely available in a form tailored to training needs and that it gives full credit to the originators of the materials. An organization's proprietary interest in materials developed is natural. Nevertheless, JHPIEGO's additional input to tailor existing materials to training needs is an important contribution.

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[3]Marshall et al.

[4]Between May 1, 1987 and April 30, 1991, AVSC trained 737 physicians in minilaparotomy and only 1 in laparoscopy; 329 other health workers were trained to support of minilap procedures as opposed to 6 in laparoscopy. (Source: AVSC.)

[5]In this time period, another 433 providers received training in an unspecified combination of skills, including laparoscopy, minilaparotomy and IUD insertion.

[6]Marshall et al.

At the Field Level

At the field level, the potential for duplication of effort, turf battles, and inconsistent training is considerable. JHPIEGO is active in 11 countries in which there are also PAC IIb projects, and in 20 countries in which AVSC also has projects (see Table C-1). The challenge is to ensure that activities complement each other. JHPIEGO strives to do this and there are multiple examples of specific countries in which JHPIEGO has worked with other CAs to coordinate activities.

Inevitably, there are also instances in which coordination could be improved. For example, in Kenya INTRAH has a resident regional director based in Nairobi to coordinate all PAC activities for Anglophone Africa. JHPIEGO also is involved in several training activities, pre-service and in-service, in Kenya. Yet it is reported that JHPIEGO's director (also JHPIEGO's acting associate director for Africa), despite many visits to Kenya, has never paid a visit to INTRAH's regional director in Nairobi.

Table C-1

Country Overlap Between JHPIEGO, PAC IIb and AVSC

JHPIEGO Overlaps with	PAC IIb	AVSC	JHPIEGO Overlaps with	PAC IIb	AVSC
AFRICA			**ASIA**		
Burkina Faso	■		Indonesia		■
Cameroon	■		Papua New Guinea		
Central African Republic			Thailand		■
Cote d'Ivoire			**EUROPE/NEAR EAST**		
Ghana		■	Morocco		■
Kenya	■	■	Philippines	■	■
Mali		■	Tunisia		■
Rwanda	■	■	Turkey	■	■
Senegal		■	Egypt		■
Tanzania	■	■	**LATIN AMERICA/CARIBBEAN**		
Togo	■		Brazil	■	■
Zimbabwe		■	Colombia		■
Uganda	■	■	Guatemala		■
Subtotal Overlap	7	9	Subtotal Overlap	4	11

Sources: JHPIEGO, AVSC, DA and INTRAH.
Note: Shading indicates program is operating in this country.

JHPIEGO's and AVSC's relationship at the field level ranges from harmonious to relatively non-communicative. On the plus side, AVSC credits JHPIEGO with having made an important contribution in opening the doors to medical schools, enabling AVSC then to work with JHPIEGO-trained medical leaders in introducing service programs. In AVSC's eyes, the ideal situation exists in Morocco, where JHPIEGO

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supports initial training to government doctors and AVSC provides the follow-up technical support. Likewise, in Kenya, both AVSC and JHPIEGO are have very productive programs, with JHPIEGO supporting a successful university-based program to train medical interns in minilaparotomy, using an adapted version of AVSC's draft minilap curriculum, while AVSC supports a successful program providing minilap services. In contrast, in the Philippines, the USAID mission has had some difficulty linking AVSC and JHPIEGO into a joint strategy with the Department of Health to re-initiate VSC services in the country.[7]

Management Expertise: Overlap in Management Training

JHPIEGO has *not* sought to develop expertise in management, either on its staff nor in its projects. It has also had little communication on this topic with the many CAs that have either principal or other peripheral expertise in this area. Rather, JHPIEGO's emphasis has been on training for clinical skills, not for clinic management, program management, or any other sort of management. For example, as JHPIEGO worked intensively to establish the Regional Center for Training in Family Planning (RCT) in Cairo, it paid virtually no attention to organizational management issues. When management weaknesses were revealed in the otherwise positive 1990 evaluation of the Cairo RCT, the response from JHPIEGO was that it had been premature to worry about management as the infrastructure was still in its beginning stages. Two years after its start-up, however, the need for resolution of management issues had become acute.

Whether JHPIEGO should develop expertise in management, or leave it to other CAs, is a question to be determined. JHPIEGO remains weak in this area, but as it becomes increasingly concerned with institutionalization, management will require additional attention.

Gaps

In addition to questions of overlap, there are also some gaps: areas which no CA is tackling as a priority. For example, while many CAs are working on Norplant, no one is focusing on the pill. Even though not among the long-lasting clinical methods which A.I.D. tends to favor, the pill nevertheless plays a crucial role in the contraceptive method mix.

[7]The plan calls for minilap training to be provided in district and provincial hospitals. The role of laparoscopy in the hands of gynecologists at the larger hospitals is not yet clearly defined.

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Appendix D

Issues in Voluntary Surgical Contraception: Laparoscopy and Minilaparotomy

Appendix D

Issues in Voluntary Surgical Contraception: Laparoscopy and Minilaparotomy

Background

After initial studies and evaluation in Europe in the 1960s, laparoscopy as a procedure to provide voluntary surgical contraception for women began to be widely used in the U.S. in the 1970s. The elegance of the technique and its utility in many conditions were quickly recognized by gynecologists. Not only is it a safe method of conducting a tubal ligation; it is also an excellent method of making a diagnosis of an acute condition (e.g., ectopic pregnancy) or a chronic one (e.g., infertility due to obstructed tubes).[1] Laparotomies can be life-saving in the former circumstance and avoided, if needless, in the latter.

During the same time period, the concept of minilaparotomy was promulgated in Europe and Asia as a safe means of tubal ligation for use in less complex surgery units which existed in greater numbers in the countries where there was a very large demand for sterilization. Despite its simplicity, minilap requires its own attention to meticulous technique if it is to be performed safely and with a minimum of discomfort.

Both procedures require the same careful infection control, anesthesia practices, and high quality counseling to be safe and well received. Laparoscopes require a greater investment to purchase and more maintenance.

Both procedures are now being done worldwide, laparoscopies by ob/gyn specialists and minilaps primarily by generalists, in both cases with an operative mortality comparable to that experienced in the U.S.

Division of Labor Between JHPIEGO and AVSC

Within A.I.D.'s universe, two large, worldwide organizations -- JHPIEGO and the Association for Voluntary Survical Contraception (AVSC) -- are involved in VSC, and although historically, laparoscopy has been JHPIEGO's sphere of influence and minilap, AVSC's, in truth both are associated with both methods, with the overall trend increasingly favoring minilaparotomy.

From approximately 1974 to 1986, JHPIEGO was responsible for the dissemination of laparoscopes through its attention to and connections it sought with departments of ob/gyn in the premier medical schools of developing countries. More recently, it is turning its attention increasingly to training in minilaparotomy. AVSC, although not avoiding supporting the laparoscopic technique in countries with relatively large cadres of specialists (43 percent of the 383,000 VSCs supported by AVSC during the period 1988 to 1990 were laparoscopies), mainly espouses the minilap approach as it can be used at more service sites in many countries -- the primary mandate for AVSC as a service organization.

With both JHPIEGO and AVSC following seemingly different routes to the same important goal, it would appear that competition for recognition and appreciation were unavoidable. On the whole, perhaps because AVSC is primarily a service delivery organization and JHPIEGO a training operation, they have instead often worked cooperatively. This is demonstrated in a number of countries in different stages of VSC development with different medical systems and varying numbers of specialists and generalists available for service delivery.[2] These include

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[1]The major use for the laparoscope in Kenya is the diagnosis of infertility based on tubal obstruction from chronic salpingitis and the determination of whether a major surgical procedure would be helpful in its cure.

[2]These countries were visited by members of the JHPIEGO evaluation team and their findings are contained in the AVSC midterm evaluation, May 1991; Egypt RCT internal evaluation for JHPIEGO, December 1990; and A.I.D. evaluation of Indonesian VSC program, November 1989.

- Indonesia: VSC was begun by ob/gyn specialists in the heavily populated islands using laparoscopy very successfully in programs sponsored by AVSC and JHPIEGO. Emphasis is now shifting to minilap as attention is directed to the outer islands and to generalists to deliver services there.

- Egypt: Due to religion-based resistance to sterilization in any form, VSC by specialist laparoscopy has been very slow to be accepted and minilap procedures are not done.

- Philippines: After a 3-year hiatus in VSC activity in the public sector (part of the general hiatus in family planning), the Department of Health's Family Planning Division is reviving the program for minilap done in district and provincial hospitals. Training and retraining is about to begin in a program which places roughly equal emphasis on interval minilap and post-partum minilap. The role of laparoscopy in the hands of gynecologists at the larger hospitals is not clearly defined at the moment. The division of responsibilities between JHPIEGO and AVSC for the various parts of the Philippine VSC program is still under consideration by the Philippine government, USAID/Manila, and the two CAs themselves.

- Kenya: A very successful program in minilap services is being managed by AVSC, whose regional office is in Nairobi. A very successful program in intern and general officer training in minilap is under way under the aegis of the Department of Ob/Gyn at the University of Nairobi with the intense support of JHPIEGO (including frequent visits by the JHPIEGO director). Laparoscopy has been incorporated into the training of residents within the past two years and is used in public hospitals for infertility diagnosis to avoid needless laparotomies if tubal damage is too extensive to warrant surgical repair. In Kenya with its high incidence of infertility, this service is considered important for the credibility of efforts in reproductive health under the rubric of which VSC is performed.

- Morocco: The National Training Center for Reproductive Health at Rabat is widely recognized as both a national and a francophone regional resource for family planning training. It performs approximately 1,000 VSCs per year --approximately 20 percent of those done in Morocco, all by laparoscope. There is a satisfactory number of ob/gyns in the country and the surgical facilities are adequate for the safe performance of laparoscopy. Currently the Ministry of Health and USAID/Rabat are seeking to move toward training in minilap on the ground that it should be available as a back-up to laparoscopy in the event of equipment failure. This component of VSC will be handled by AVSC while JHPIEGO continues to support the training activities of the NTCRH (which is a part of the ob/gyn department of the medical school and is directed by a highly influential professor who is now dean of the medical school).

Laparoscopy or Minilap: Complementary or Competitive?

The above description of country programs points up another issue: do any clear-cut guidelines exist as to whether minilap or laparoscopy is the more appropriate procedure to support in any given country setting? In the country examples, both minilap and laparoscopy have played and are playing significant roles in the activities of reproductive health. The sum of both is greater than either alone. Their sites of activity and their impacts are not competitive or mutually incompatible. Each has a niche which is different in each country depending on its situation in the academic, public and private sectors.

On the other hand, it seems clear that minilap should be the preferred method in situations in which general practitioners are responsible for providing care in small- to medium-sized facilities that are geographically widespread throughout rural areas or even a large urban or suburban area. Nevertheless, in certain countries, and in sections of others, ob/gyn specialists are available who are trained or capable of being trained in laparoscopy and who can provide high-quality VSC services using the laparoscope technique.[3]

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[3]"Voluntary Female Sterilization: Number One and Growing." Population Reports. Series C, No.10. Nov 1991.

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Recommendation: **JHPIEGO and AVSC should prepare a position paper outlining the pros and cons, costs and benefits, advantages and disadvantages, and situations in which laparoscopy is an indicated or acceptable procedure and in which minilap post-partum/interval is the procedure of choice. A mutually agreed upon statement of principles and guidelines would do much to dispel the implied antagonism between procedures and organizations which continues to exist despite the best efforts of both groups to come together.**

An alternative would be for the organizations to examine the situation with each "Big Country" mission to fully understand the host country's family planning strategy. Each country will be in a different stage on the continuum from emergent to mature. At each stage of development along this typology the training needs, as well as types of services offered by location and method mix, will change. Having assessed the current situation and the desired composition for the national program, an agreed upon strategy can be promulgated. Sites of services, and their staffs and capabilities, can be ascertained and enumerated to facilitate surgical training requirements. Also, long-term reliable clinical methods (such as the IUD or Norplant) can be provided when and where appropriate for couples who have misgivings about permanent surgical methods.

RAM Centers: A Small, Important Investment in Institutionalization

JHPIEGO currently supports seven repair and maintenance (RAM) centers (in Ghana, Kenya, Morocco, Nigeria, Philippines, Tunisia and Turkey), the last of a series of centers that JHPIEGO has supported during its earlier emphasis on training in laparoscopy. In JHPIEGO's year-5 Workplan, 2 percent of its expenditures are earmarked for support of these centers.

In countries such as Korea, Taiwan and Indonesia, repair and maintenance of laparoscopes has been institutionalized along with the laparoscopic technique itself. In these countries, governments or hospitals have assumed total responsibility for laparoscope repair and maintenance. JHPIEGO justifies continued support of five centers on the grounds that they are essential to the operations it is otherwise supporting. Total abandonment of laparoscopy might also alienate individuals who have been active in the initiation and expansion of services over the past two decades and who could play a key role in teaching minilap in the future.

Recommendations:

1. JHPIEGO should continue to support certain RAM Centers in the short term in order that the institutionalization of the technique of laparoscopy is not jeopardized.

2. In the medium/long term, institutionalization of RAM centers should be encouraged.

3. Evaluations should be conducted for all the major laparoscopy programs under A.I.D. auspices (whether through JHPIEGO or AVSC). These should examine both equipment maintenance and utilization. This information should be incorporated in the Laparoscopy-Minilap Consensus report recommended above.

Appendix E

JHPIEGO's Involvement in Reproductive Risk Assessment

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Overview of JHPIEGO Work in Reproductive Risk Assessment

In Latin America an approach JHPIEGO is using is that of "reproductive risk assessment." JHPIEGO's 1990 Annual Report documents its involvement in a series of reproductive risk assessment projects in Brazil. JHPIEGO is supporting the Sociedade Civil Bem-estar Familiar no Brasil (BEMFAM), a Brazilian non-governmental organization, to develop and implement a program to integrate a reproductive risk classification and referral system into commmunity-based health services in three states.

JHPIEGO is collaborating with Family Health International (FHI) in several studies to evaluate aspects of these projects. JHPIEGO developed a risk assessment tool for use in the projects and trained physicians and paramedics to conduct assessments using the tool; clients are followed-up to see the effect of the risk assessment after six months. This project also includes a "KAP" (knowledge, attitudes and practices) survey of paramedics 8 months after their training in reproductive risk assessment. JHPIEGO and FHI are working together on a study to compare risk assessments conducted by paramedics to risk assessments of the same women conducted by physicians. FHI is gathering data to allow cost analysis of these projects. JHPIEGO presented a symposium on reproductive risk as part of the Second Latin American Family Planning Conference.

JHPIEGO's Workplan for Program Year 5 includes plans to help the Mexican Social Security Institute (IMSS) to share its reproductive risk assessment methodology and materials with other Central and South American countries. JHPIEGO's 1990 Annual Report also mentions an interest in exploring a reproductive risk training project in Guatemala, although no such plans appear in their fifth year workplan.

Origins of Reproductive Risk Assessment

The concept of maternal risk screening began in the late 1950s, when epidemiologic studies found associations between certain maternal characteristics and a higher-than-average incidence of poor maternal and child health outcomes. This led to the development of increasingly formalized efforts to predict poor outcomes through "risk assessment," to organize different intensities of care to meet the needs of women with different levels of risk, and to guide individual women into the kinds of care that they have been predicted to need. More recently, some family planning programs have begun to use risk assessment as a way to identify individual women who are "most in need of family planning," to urge "high-risk" women to contracept in order to protect their health, and to direct family planning program efforts towards women with certain "risk factors," often including parity and age. **The risk approach makes contraception more acceptable to some health professionals and politicians by accentuating the health benefits of family planning.**

The Mexican Social Security Institute (IMSS) is probably the largest provider of family planning services in Latin America and the Caribbean. During the mid-1980s, the IMSS introduced a quasi-experimental reproductive-risk screening program in one Mexican state and tried to measure the effects of the program by comparing reproductive health care and outcomes in the experimental state with those in another (noncomparable) state without the special program.

What were the results of the IMSS' experiment with reproductive risk assessment? The most significant changes that occurred in the experimental state during the first 17 months of the reproductive risk program were a significant increase in the number of IMSS physicians who offered family planning to

their patients and an increase (from 47% to 61%) in the percent of women who accepted a contraceptive method during hospitalization following childbirth or an abortion.

Although this increase was greater in the experimental than in the control state, extreme differences between the states as measured during a pre-intervention survey make it impossible to draw conclusions regarding the impact of the risk assessment program on contraceptive use. Moreover, the reproductive risk program was not associated with a greater increase in contraceptive use among women seen in IMSS clinics, and the increase in contraceptive use among hospitalized women in the experimental state was greater for low-risk women than for women who had been told that they were at high-risk. The IMSS program increased the number of physicians who were willing to play an active or supportive role in family planning and the IE&C and outreach components of the program led to greater use of contraception. However, **it is not clear what, if anything, the risk assessment process per se contributed to this increase.** It should also be noted that more than half of the women screened through this program were classified as high-risk.

The reproductive risk approach is now being implemented at IMSS facilities throughout Mexico; it has elicited great interest in many other Latin American countries, and it has the support of WHO. Nevertheless, a 1990 Population Council seminar to review studies and experience with use of reproductive risk assessment in maternity care and family planning programs found a dearth of data to support its effectiveness. By focusing on health outcomes and on a technical, quantitative methodology consistent with a medical orientation, risk assessment may indeed make family planning more interesting and attractive to physicians. Giving family planning a medical imperative may make it more acceptable and promotable in some Catholic or Islamic countries.

However, this potential benefit may come at a very high cost. The risk approach consumes energy, attention and resources which could otherwise go to expanding services and making them more acceptable to all women, causes family planning service providers to focus on only a small segment of the women who need and want contraception, and may endanger access to family planning by giving physicians a larger gate-keeping role. Also of concern are the social and psychological costs (and ethical implications) of having the health-care system tell large numbers of developing country women (more than half of those screened in Mexico) that they are at "high-risk" if they become pregnant. The numbers of women who want to use contraception to avoid pregnancy is very large, and very few developing countries are meeting the needs of those women. Therefore, the Population Council seminar concluded, the "use of formalized maternal risk assessment in family planning programs makes sense only where local policies or scarcities make it impossible to offer family planning to everyone."[1]

Conclusion: JHPIEGO has played an active role in projects intended to incorporate reproductive risk assessment into the family planning service delivery structure in three important Brazilian states. It has undertaken no new reproductive risk initiatives except for plans to help the IMSS (in Mexico) share its reproductive risk assessment experience with other Central and South American countries, and, most importantly, plans to evaluate the work in Brazil. JHPIEGO participated in the 1990 Population Council seminar on this subject and appears to be acting with appropriate caution. Results from the JHPIEGO/FHI/BEMFAM studies should make an important contribution to an area in which implementation and enthusiasm are far ahead of research.

Recommendation: Given the limitations of the reproductive risk assessment approach, JHPIEGO should not invest any great amount of energy in elaborating the approach. At the same time, where countries embrace it, JHPIEGO must respect this.

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[1]Rooks, J. and B. Winikoff, A Reassessment of the Concept of Reproductive Risk in Maternity Care and Family Planning Services. The Population Council, New York, 1991 (in press).

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Appendix F

A Training Module for the Management of Septic and Incomplete Abortion: Saving Lives and Gaining Family Planning Acceptors

Appendix F

A Training Module for the Management of Septic and Incomplete Abortion: Saving Lives and Gaining Family Planning Acceptors

Overview of the Problem

The complications of septic abortion are responsible for one third of all maternal deaths in developing countries.

Many women suffering from this condition have consciously attempted to terminate an unwanted pregnancy or have unconsciously ignored an unexpected or unwanted pregnancy and not taken care of themselves, thus exposing themselves to a serious pregnancy complication.

Treatment of septic abortion cases absorbs large amounts of hospital staff time and often occupies up to half the beds on a gynecological ward. In addition, scarce hospital materials and antibiotics are consumed -- to the detriment of other patients requiring them.

There is a simple treatment for most cases which would be efficient and life-protecting. This treatment -- manual vacuum aspiration (MVA) -- has not yet been introduced, however, in the busy over-crowded hospitals of most countries.

In Kenya, a site visit during this evaluation to a large district hospital near Nairobi (Machakos) found the women's ward crowded with seriously ill patients, most of whom were post-operative for a variety of conditions. The chief of ob-gyn reported that she had been able to demonstrate to the hospital administrator the cost-savings of a simplified plan to treat cases of septic incomplete abortion which previously crowded the limited surgery space and time, in addition to monopolizing bed space which could be allotted to other clients in need. As a result, the simple aspiration equipment needed was obtained and a room off the ward was assigned for sole use to treat these women and for safe storage of the equipment. This gynecologist had data to show that prior to the change the average septic patient spent 4 days in the hospital, while now the stay is one day or less. An added benefit is that with less crowding the other patients are receiving better care from the over-worked staff.[1]

Moreover, many women who have recently had a serious life-threatening complication from a poorly timed pregnancy will be highly motivated to accept family planning, or to use it more effectively, as has been demonstrated by studies in both the U.S. and developing countries.

Recent testimony by A.I.D. before Congress has clarified that the Mexico City policy guidelines allow: provision of training and equipment to treat septic and incomplete abortions (including illegal abortions); and post-abortion counseling and services, including contraceptive services.[2]

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[1]In Nairobi, abortion is the leading cause of admission to the emergency gynecological ward at Kenyatta National Hospital; more than one half of all cases are reported to have serious complications, such as sepsis (Aggarwal 1980; Aggarwal and Mati 1982, Ajayi et al 1991).

[2]"U.S. Government Clarifies Mexico City Policy Abortion Restrictions: Some Abortion Related Activities Permitted." Washington D.C.: Population Crisis Committee, 1990.

Conclusion: Treatment of septic and incomplete abortion by manual vacuum aspiration is an approach that is appropriate for most developing countries. It can be fairly easily implemented, it saves lives and contributes to greater and more effective contraceptive use, and it fits the training mandate of JHPIEGO.

Recommendation: JHPIEGO should prepare a training module for the emergency treatment of septic and incomplete abortion. (In Kenya, this should be used with the curriculum already being evaluated for instruction of interns/residents.) Wherever possible, this clinical training should be planned and carried out in conjunction with activities (including those sponsored by other organizations) to provide post-abortion contraceptive counseling and services.

Appendix G

Screening for Cancer of the Cervix in the Absence of Facilities for Cytology or Colposcopy: an Adjunct to IUD/GTI Activities

Appendix G

Screening for Cancer of the Cervix in the Absence of Facilities for Cytology or Colposcopy: an Adjunct to IUD/GTI Activities

Overview of the Issue:

Cancer of the cervix is the malignancy which most often causes death in women in developing countries. There is general agreement that cancer of the cervix is a sexually transmitted disease. Late cases of cervical cancer are difficult to treat and have a very poor prognosis. They require radiation therapy, which is often not available in developing countries. Early diagnosis allows easier treatment and better survival.

Cytologic screening ("pap smears") is widely used in developed countries for the detection of pre-cancerous conditions as well as very early cancers of the cervix. It is a laboratory method which is beyond the capacity of most developing countries to employ on a mass-screening basis. It will thus not be available in developing countries on a large enough scale to meet the need in the foreseeable future.

A recent article in Lancet[1] suggests that more than 50% of cancers of the cervix can be identified by visual inspection in a relatively early stage when treatment will be easier and results more satisfactory.

Identification of the abnormal cervix is within the abilities of anyone being trained in pelvic examination, who also can be taught cervical biopsy technique. Development of standardized procedures for screening for cancer of the cervix (in the absence of facilities for cytology or colposcopy) would be an important adjunct to JHPIEGO's IUD/GTI activities. What is proposed here is not more complex than other current activities of JHPIEGO (in fact, is simpler than some), and can be handled with clinically simple methods, at least in pilot projects.

Conclusion: If confirmed, this observation lends itself to an addition to the GTI training module now being advocated by JHPIEGO for the diagnosis of infections and the better management of candidates for IUD insertion. This would be an important reproductive health initiative with significant potential for saving women's lives while, at the same time, contributing to higher quality family planning services.

> **Recommendation:** JHPIEGO should evaluate, by clinical research or pilot project(s), the value of gross inspection in the early diagnosis of cancer of the cervix using the facilities of a university department of OB-GYN and an associated department of pathology in a country where the incidence of cervical cancer is high. Subsequently, if proven advantageous, gross screening of the cervix for suspected cancerous lesions can be added to the GTI manual (which needs enhancement of its section on the evaluation of the cervix in general).

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[1]Sehgal, A., V. Singh, S. Bhambani, et al. 1991. "Screening for cervical cancer by direct inspection." Lancet, vol. 338, p.282.

Appendix H

JHPIEGO's Role in Reviving the IUD

Appendix H

JHPIEGO's Role in Reviving the IUD

One of the "new" JHPIEGO's major areas of emphasis has been the IUD. JHPIEGO has worked hard to make this method, which has fallen into disfavor in many countries, safer and more acceptable. JHPIEGO's recent IUD initiatives constitute important groundwork which, with continued follow-through, could have a major impact in increasing the contribution that the IUD makes to contraceptive usage throughout the world.

Background: Backlash Against the IUD

In the early 1960s, IUDs surfaced as an important method of contraception after a small international conference reviewed data on the hitherto unheralded clinical use of the IUD in Japan and Israel between 1940 and 1960 and a series of small studies on plastic IUDs of different shapes which had recently been carried out in the U.S.

Introduced to South Asia by A.I.D. and others, the widespread use of IUDs foundered in the late 1960s and early 1970s. Reasons were primarily insufficient and inaccurate client information and education as well as fragile medical infrastructures which could not cope with the follow-up and reassurance of the large numbers of women who had been recruited to the method. Meanwhile in the United States, in the early to mid-1970s, the IUD was utilized widely by unmarried, childless women. This group of women had excess complications in part because of their increased risk of genital infections and in part because of the use of an IUD which had not been completely clinically evaluated.

Developments such as the above diminished the enthusiasm and acceptance of the IUD within the medical community as well as with women. Despite this, second-generation IUDs were being evaluated. The finding that copper added to the device increased its effectiveness and tended to decrease bleeding complications maintained interest in IUDs despite general pessimism.

Current Status and Potential

Important facts about the IUD today are as follows:

1) After more than 20 years of use throughout the world, the IUD has gone through several generations of technical refinement and is considered an important modern method of family planning.

2) The IUD has its lowest rates of complications and failure in multiparous women in monogamous relationships. This is a large group of potential clients demanding reliable contraception.

3) IUDs can be successfully inserted and clients can be satisfactorily followed by appropriately trained nurses, midwives or physicians.

4) To avoid the past problems that led to disaffection with the IUD, large-scale national training programs require attention to:

a) a detailed outline of client information and education;

b) uniform methods of insertion by service providers;

c) knowledge and accurate diagnosis of genital tract infections, which are important contraindications to IUD insertion; and,

d) awareness of up-to-date principles of infection prevention so that insertion techniques will be safe for clients.

JHPIEGO's Initiatives: Findings and Conclusions

JHPIEGO has recognized the great value and potential of the IUD in its current form -- the copper T 380 -- which has a very low pregnancy rate and a modest complication rate. JHPIEGO has moved in the following important ways to reinvigorate and extend IUD programs for developing countries:

1) A training manual has been prepared to standardize and detail each step in the process of informing the prospective client, examining her, and inserting the IUD -- what JHPIEGO refers to as "safe and gentle" IUD insertion and removal;

2) An anatomic pelvic model has been developed and introduced to permit a "humanistic approach" in IUD insertion training. This has the advantage of avoiding the usual situation in which completely unskilled trainees practice IUD insertion on female clients to gain initial skills.[1] It also has the important advantage of reducing the need for a large volume of IUD clients in order to train service providers in IUD insertion;

3) An IUD training package, as well as courses for service providers and trainers-of-trainers, has been prepared in detail and includes an important emphasis on teaching methods;

4) Specialized information on genital tract infections and infection prevention has been brought together in complementary reference manuals so that complications directly related to IUD insertion can be minimized;

5) A regional training center has been established in Egypt whose first goal was to extend the newly inaugurated national IUD program in a uniform and replicable way and thus expand its chances for success; and

6) Consistent standards have been established so that quality control visits can effectively be carried out by a number of examiners in different parts of a country expecting uniform outputs in terms of client teaching and clinical use of the IUD.

Lessons learned in the process of codifying and creating uniformity in training and implementing IUD services will have far-reaching effects in the advancement of other contraceptive methods such as Norplant. In addition, there will be important spin-off effects on techniques of training medical professionals in developed as well as developing countries.

Recommendations

1. JHPIEGO should continue to play its key role in reviving the IUD and promoting its widespread availability and acceptability. It should clarify lessons it has learned in the process of standardizing IUD training and services and use these for advancement of other contraceptive methods such as Norplant.

2. JHPIEGO should encourage its physician director to continue his interest in applying the model described above and align his administrative and other responsibilities to permit his "hands on" involvement with programs in the field so they may continue to evolve and improve.

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[1]JHPIEGO has found that both IUD and Norplant training can be completed in less time with better results through use of anatomic models . For example, WHO currently recommends 15 actual IUD insertions, on clients, as a minimum standard for IUD training. JHPIEGO recently completed a study comparing time and insertions needed in an IUD insertion course for Thai midwives with and without anatomic models. In the course that used models, the time was shortened from 6 weeks to 1 week with competence achieved after 1.6 insertions following practice on models, in contrast to the 6.5 insertions on clients previously required.

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3. A paper which reports results from the Thai study (which documented IUD insertion competency after only a few insertions in actual clients by trainees who had used anatomic models for acquisition of initial skills) should be submitted to The Lancet or another highly respected and widely distributed medical journal. In the meantime, JHPIEGO and its Thai colleagues should present results of that study to WHO and ask WHO to collaborate in a study which attempts to replicate the Thai findings elsewhere. If findings prove similar, JHPIEGO should ask WHO to revise its IUD insertion training standards and methods.

Appendix I

Developing National Family Planning Service Guidelines: Case Study from Egypt

Appendix I

Developing National Family Planning Service Guidelines: Case Study from Egypt

This case study is important for several reasons. Egypt was the first (and to date only) country in which JHPIEGO has played a major role in developing national guidelines. Second, this is a process which JHPIEGO believes should be carried out (hopefully in a less intense manner) in all countries. Finally, this was the basis for the prototype guidelines that JHPIEGO is now sharing with others.

In 1988, USAID/Cairo asked JHPIEGO to help establish a center for family planning training in Cairo. Family planning demand was increasing rapidly in Egypt but there were too few service providers able to meet that demand with quality services. USAID/Cairo wanted to increase rapidly the numbers of competent service providers and to do so established a buy-in to JHPIEGO. In late 1988, JHPIEGO and a senior Egyptian Ob-Gyn and family planning pioneer began hiring staff and putting together the training center, sited at Ain Shams University in Cairo, now called the Regional Center for Training in Family Planning (RCT).

When JHPIEGO and the RCT staff began to plan its courses, there were no agreed-upon family planning clinical standards in Egypt. Some doctors and nurses followed various protocols which were often contradictory or incomplete; others did things in their own idiosyncratic way. Where references were available, they were often also contradictory or out-of-date. The Ministry of Health had concluded earlier that national guidelines were needed to improve the quality of family planning services in Egypt and had been trying for several years to develop such guidelines.

In spring, 1989 USAID/Cairo asked JHPIEGO to expedite the process. Eventually it was agreed that the RCT staff would take the responsibility of pulling together various protocols existing in Egypt and, with technical assistance from JHPIEGO and inputs by Dr. Robert Hatcher, produce a draft National Family Planning Guidelines appropriate to the Egyptian cultural setting.[1] Although this would divert the RCT trainers from other activities essential to preparing for their first training course --activities which they were under pressure to proceed with at a rapid pace--it was decided that the Center itself needed such a set of standards for its own training purposes.

Thus the trainers took on and worked intensively at this task, alongside the other start-up activities. By April 1989, they had produced a rough draft. JHPIEGO's Clayton Ajello, with Dr. Hatcher, then assisted substantially in refining the guidelines. The resulting draft was reviewed by the MOH, USAID/Cairo, and several emminent medical school faculty members in September and comments incorporated. By late 1989, several thousand copies of the *National Family Planning Guidelines for Egypt* had been printed and were being distributed by the MOH.[2]

All major family planning organizations in Egypt are now using some form of these guidelines for training and service delivery. Contraceptive prevalence has increased significantly since 1988. RCT-provided training is judged to have contributed substantially to this increase. An important element in the training, and in the increase in contraceptive use, has undeniably been the development and adoption of the national standards -- in which the RCT and JHPIEGO played a lead role. This experience thus shows how training can be linked to service delivery, and how training can have an impact on contraceptive prevalence.

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[1]Robert A. Hatcher, M.D., senior author of the authoritative Contraceptive Technology: International Edition (Atlanta: Printed Matter, 1989).

[2]Reference: RCT 1989 Annual Report for Project Year 1, pp. 3, 27.

It is clear from the Egypt experience that a training center must have a set of standards that it imparts to trainees. These must be culturally appropriate and also appropriate to the resource level of the trainees' daily work. Developing standards for clinical practice is beyond the capability of a training center, however. It is a much larger task, one requiring national consensus and, in many countries, technical assistance, as was provided by JHPIEGO.

Clearly it would have been easier for the RCT trainers to prepare themselves to start offering courses had they not simultaneously had the additional burden of developing national guidelines. Nevertheless, in the absence of appropriate agreed-upon standards, it was necessary for the RCT trainers to devote time to this task. In no case should it be expected, however, that trainers can produce standards single-handedly.

JHPIEGO has found that the guidelines produced for Egypt represent a good starting point for other countries. Each country must develop its own guidelines, however, given the variation that exists among countries both in clinical practice as well as in the cultural and political milieu.

Conclusion and recommendation: A set of agreed-upon and appropriate standards of family planning clinical practice ("practice guidelines" or "national family planning service guidelines") must exist to serve as the basis for all clinical work, both in the classroom and in the family planning clinic. Implemented properly, national standards can link training to service delivery and increase contraceptive prevalence. If guidelines don't exist, they should be developed.

JHPIEGO played a significant role in the formulation of Egypt's National Family Planning Service Guidelines. The RCT in Egypt is psitioned to act as a regional consultant for the Middle East if called upon by other countries desiring family planning guideines.

Appendix J

Participants in JHPIEGO-Supported Courses: Tables

Appendix J

Participants in JHPIEGO-Supported Courses: Tables

Table J-1

JHPIEGO In-Service Training in Clinical Skills
National and Regional Training
(May 1, 1987 - April 30, 1991)

Type of Training	Participants	Participants (PY 4) May 1, 1990 - April 30, 1991	Total Participants May 1, 1987 - April 30, 1991
Laparoscopy	Physicians	29	387
	Nurses	26	222
Minilaparotomy	Physicians	39	279
	Nurses	49	162
	Interns	49	176
Clinical Combination of Skills[1]	Physicians	121	271
	Nurses	12	153
	Interns	9	9
IUD Insertion	Physicians	260	1,373
	Nurses	400	1,203
	Instructors	37	165
	Medical Students	0	18
GTI/STD	Physicians	14	85
	Nurses	0	88
Infertility/GTI/STD	Physicians	16	47
Anesthesia	Physicians	0	39
	or Nurses	7	108
Laproscopic Microsurgery	Physicians	0	17

Source: Friedman
Note: Numbers in boldface are referred to in the report.
[1]Minilaparotomy, laparoscopy and IUDs

Table J-2

Total Training Conducted at all JHPIEGO Education Centers
(May 1987 - December 1990)

Category	PY 87 - 12/31/90
Participants	**30,384**
U.S.	346
National and Regional	30,038
Professionals Trained	**9,182**
Physicians	3,915
Nurses, Midwives, Paramedics[1]	4,641
Administrators	576
Social Workers	50
Undergraduates Trained	**21,202**
Medical	660
Nursing/Midwifery	20,202
Interns	340
Clinical Trainees[2]	**4,045**
Physicians	2,316
Nurse/Midwives	1,729
Interns	156
Medical Students	18

Source: Friedman
[1]The "paramedics" category has been phased out, in recognition that the PAC IIb contract has responsibility for training non-clinical categories. About 1,000 paramedics were trained between PY 1987 and PY 1989, all in Brazil through the BEMFAM project.
[2]These are a subset of "Professionals Trained."

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Table J-3

National and Regional Training Summary: Didactic Training
JHPIEGO
(May 1987 - December 1990)

Category of Training	Number of Courses	Targeted Audience	Total Participants PY 1987 - PY 1990
In Service			
Reproductive Health Update	5	Administrators	31
	19	Physicians	207
	51	Nurses	1,289
Perinatal (Child Health)	4	Physicians	88
Neonatal (Child Health)	3	Physicians	24
	3	Nurses	34
Laboratory GTI (STD)	3	Physicians	7
	1	Nurses	4
	1	Technicians	4
	1	Scientist	1
FP Update	1	Physicians	12
	1	Nurses	5
Education Skills[1]	14	Physicians	169
	19	Nurses	329
Trainer of Trainers[1]	9	Nurses	187
Curriculum Development[1]	1	Physicians	109
	1	Nurses	205
Information, Education and Communication	2	Social Workers	50
Program Planning	1	Administrators	1
	1	Physicians	9
	1	Nurses	6
Conferences, Workshops, and Seminars	27	Administrators	402
	50	Physicians	910
	45	Nurses	745
	2	Health Officers	9

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Pre-Service			
Reproductive Health	27	Interns	184
Update	6	Medical Students	642
	912	Nursing Students	20,202

Source: Friedman
Note: Figures in boldface are used to illustrate points in text.
[1]These are assumed to be training of trainer skills.

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Appendix K

Integrating Family Planning into the Pre-Service Training of Nurses: Case Study from the Philippines

Appendix K

Integrating Family Planning into the Pre-Service Training of Nurses: Case Study from the Philippines

Integrating effective family planning into the pre-service education and training of midwives, nurses and physicians is a principle of the Information and Training Division of A.I.D.'s Office of Population and a priority for JHPIEGO.[1] These statements of principle and priority are based on the assumption that incorporating family planning into the pre-service training of health care workers is an effective way to produce a steady supply of family planning service providers, that it is more cost-efficient than in-service training, and that it may reduce needs for in-service training.

JHPIEGO has conducted a series of projects to strengthen the family planning training provided in pre-service nursing schools throughout the Philippines. This case-study is presented as a means to examine these assumptions. It describes and analyzes the background circumstances, implementation and likely outcomes of three JHPIEGO projects with the Association of Deans of Philippine Colleges of Nursing (ADPCN) -- two projects over a 3-year period (1987-1990) to strengthen the reproductive health content of the basic pre-service nursing curriculum and a 2-year project (1989-1991) to improve the teaching and lesson planning skills of faculty responsible for teaching the reproductive health content in pre-service nursing schools.

NURSING EDUCATION IN THE PHILIPPINES

In the Philippines, unlike almost all other countries, including the United States, all professional nurses are prepared in 4-year ("baccalaureate") nursing education programs. Prior to 1984, there were also shorter (3-year) nursing education programs. Graduates of the latter programs are now referred to as "Graduate Nurses" (GNs), and only the graduates of the 4-year programs are designated as professional registered nurses (RNs). Because of the relatively high standard of nursing education in the Philippines, combined with world-wide nursing shortages, Filipino nurses can qualify for practice in many other countries, including the U.S. As a result, nursing has become the way up (in status and income) and out (of the Philippines) for large numbers of ambitious Filipinos. There is now a great demand for nursing education.

There are now 149 schools of nursing in the Philippines, of which only 10, each associated with a public university, are government-funded. The others are basically run as businesses. The "president" of the "college of nursing" is often a businessman, and it is a lucrative business. The financial basis of the schools is tuition. Last year 26,000 individuals graduated from Philippine schools of nursing. Less than half of the graduates pass the national examination for entrance into nursing practice. Currently about 13,000 new nurses are licensed each year.

Currently 42% of the money sent back to the Philippines from Filipinos li[illegible] [illegible]oad comes from nurses. This makes a major contribution to the Philippine economy.

Quality of Nursing Education

The Association of Deans of Philippine Colleges of Nursing, Inc. (ADPCN) oversees all nursing programs in the Philippines. In 1983 the ADPCN convened a Technical Committee on Nursing Education (TCNE). The TCNE includes leaders from the ADPCN and representatives from the Board of Nursing, nursing service administrators, the Department of Health (DOH), the Philippine Nursing Students Association, the Philippine Nurses Association, and the Department of Education, Culture and Sports

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[1] IT Division, *Operating Principles and Objectives for Training* (see Appendix B); and *Scope of Work for Continuing Family Planning Training Support in the Philippines*, JHPIEGO, September 1990, p. 1.

(DECS). This means the committee members are not only nursing educators but also representatives of the agencies responsible for regulating nursing education, nursing students, and nursing service administrators (who employ the graduates of the schools). The involvement of this committee was a key component in the ADPCN effort to create and implement a new and improved nursing curriculum throughout the country.

With the support and involvement of the TCNE, in 1984 the ADPCN conducted a series of workshops to define the roles, functions and tasks required of nurses in the Philippines. Based on that analysis, the ADPCN developed a manual to guide the curricula of all Philippine schools of nursing (*Enrichment of Nursing Courses: A Guide*). It is a competency-based curriculum oriented toward primary health care (PHC) and the role of nurses in the community. The goal of the curriculum is to prepare a generalist nurse with a community orientation who, with appropriate orientation, in-service training and supervision, can work effectively in any situation. The first year of the 4-year curriculum is general education with an emphasis on the social and physical sciences. Students enter the nursing schools at the beginning of their second year (Level II), which focuses on normal individuals and the family. The third year (Level III) focuses on illness and other abnormal conditions or disruptions in health. The last year (Level IV) focuses on people in their communities and the potential for a better quality of life. The ADPCN document is an excellent guide based on a sophisticated analysis and understanding of the complex and rapidly evolving role of nurses and the principles of modern curriculum development. The new curriculum was implemented nationwide in 1985. Nurses graduating since 1988 have been prepared completely under the new curriculum.

Despite this excellent curriculum guide, the quality of nursing education was uneven. This is not surprising given the economic pressure to open new, for-profit schools of nursing. Some of these schools have extremely large numbers of students. It is impossible for many of the schools to provide adequate clinical/practical learning experiences for so many students. (The De Ocampa Memorial College of Nursing in Manila, for instance, admits 600 students per year and thus has a total of approximately 1,800 students.)

The ADPCN conducted an evaluation of the new curriculum in 1989; family planning was identified as a weak area. The evaluation also found that the curriculum needed to be strengthened in primary health care.

Quality of faculty: The Philippines does not have an adequate number of appropriately prepared faculty for so many and such large schools of nursing. Nursing faculty are supposed to have masters degrees (since they teach students who will earn baccalaureate degrees). However, most do not have advanced degrees. Those who do not have master's degrees are expected to be working toward them, although this is possible only for those who live in cities with universities. A 1988-1990 survey of faculty at 82 nursing schools (59% response rate) found that the baccalaureate of science in nursing (BSN) was the highest degree for 86.6% of the faculty (not including the deans); only 13.1% had masters degrees, and 0.3% had doctorates. In addition, many faculty members are quite young and inexperienced; 28% had been teaching for one year or less. Faculty turnover is high; many leave to go abroad; there is competition between the schools for the remaining good faculty members. The better schools use complicated formulas to calculate and justify increased salaries to attract and retain their teachers.

Facilities, equipment and supplies: Nursing schools generate significant income (through tuition), which is potentially available for investments to improve and support the education of their students. Although private owners want to minimize expenses in order to maximize profits, they have to support their schools well enough to make them attractive to students. The one nursing college visited during the JHPIEGO evaluation had adequate, though not generous facilities, equipment and supplies. The library subscribed to some of the more important journals and contained a relatively large collection of books. However, many of the library's holding are contributed by the college's U.S.-based alumnae. Many of the books are old and obsolete; journal collections are incomplete. There is much room for improvement.

Government regulation of nursing school quality: There is great variation in the quality of the nearly 150 nursing schools. The Department of Education, Culture and Sports (DECS) is the government agency with responsibility for accessing and maintaining the quality of educational institutions. DECS categorizes schools as "A", "B", "C", "D" or "E" based on their facilities, instructional standards, faculty, and the performance of their students on the national Nursing Board Examination. Only 5% of the schools are graded "A"; most of those graded "A" are the government-supported universities. Some schools which would be graded A on the basis of their facilities, instructional standards and faculty, end up with lower grades because they are unable to be selective in admitting students. Students not fluent in English are less likely to do well on the national Nursing Board Examination, even though they may be relatively competent. DECS plans to close some of the schools. In addition to the quality indicators, DECS takes the supply and need for nursing education in a particular part of the Philippines into consideration.

The key to the quality of nursing education resides in the commitment and competence of the deans. Strong deans can make stronger demands for support from the owners of their schools. The dean and faculty members at De Ocampa Memorial College of Nursing, for example, appear competent and committed. However, the dean of this school is a member of the ADPCN leadership group, and she may represent a higher level than the norm. The De Ocampa school has been graded as B or C by DECS.

Characteristics of Nursing Students

Nursing students must pass the national college entrance examination. In fact, because of competition for entrance into nursing colleges, their students must score higher than the minimum standard for entry into college. The exams are given in English, and those without English proficiency are less likely to do well.

It is difficult for persons from low-income families to enter nursing. Four-year tuition fees at De Ocampa Memorial College of Nursing come to about 32,000 pesos; total costs, including room and board, books, uniforms, et cetera, come to about 100,000 pesos (US $3,846 for the 4-year course). Fees at the 10 government-supported university nursing education programs are lower, and these programs accept a few scholarship students. Approximately 70% of the students are women; 30% are men.

Supply and Demand for Nurses to Work in the Philippines

Most positions for nurses in the Department of Health (DOH) are filled. However, nursing leaders say that the government has not created enough posts (i.e., that there are not enough nurses in government service because of an inadequate number of positions). The number of nurses in DOH posts is about the same as the number of physicians, which is unusual; in most countries there are several times as many nurses as physicians.

Salaries for nurses seem to be appropriate for their place in the Philippine health care system. Entry level nurses make about 4,000 pesos/month, which is a little more than beginning teachers. Nurses at the highest level can make up to 15,000 pesos per month. Faculty at De Ocampo College of Nursing were making about 7,000.

Although many nurses are employed in the private health-care sector, very few have private independent nursing practices.

An easing of the nursing shortage in the United States seems to be reducing employment opportunities for Filipino nurses in the U,S. This could eventually lead to an over-supply of nurses in the Philippines.

Continuing Education for Nurses

Nurses are required to have a certain number of hours of continuing education each year in order to continue to be registered. However, few nurses have access to continuing education courses; it is not clear that there is a mechanism to monitor and enforce compliance with this rule.

JHPIEGO INPUTS

JHPIEGO has had three subcontracts with the ADPCN, beginning in 1987 (thus three years after the ADPCN began its curriculum revision work).[2] The purposes of these projects have been to strengthen the reproductive health content of the basic pre-service nursing curriculum and to improve the lesson planning and teaching skills of nursing faculty responsible for teaching the reproductive health content.

The definition of "reproductive health" used in these projects includes: management of pregnancy, delivery and the post-partum period; care of the newborn; family planning; breast feeding; protection of children against childhood diseases, parasitic and diarrheal diseases; child nutrition; genetics; cancer detection; human sexuality and its disturbances; sexually transmitted diseases; endocrinology; and management of high-risk pregnancy.

Needs assessment leading to the development of the first two projects: JHPIEGO's needs assessment document, dated June 1988, reflects only a superficial assessment of nursing education in the Philippines. **It also did not address the fact that midwives, rather than nurses, are the cadre designated to provide most of the family planning care.** However, the Project Paper for the third of JHPIEGO's three contracts with the ADPCN (TCA-37) states that research conducted by the Philippine Commission on Population found the poor understanding of reproductive health concepts among newly graduated nurses to be a problem and constraint to the Philippine family planning program. The early evaluation of the revised BSN curriculum also identified family planning and primary health care (much of which relates to reproduction) as weak areas.

Development of the Reproductive Health Syllabus and Resource Units

Reproductive health content comes into the Philippine BSN curriculum mainly in the second year and fourth years (Level II and Level IV). The Level II syllabus was revised first (in 1988); the Level IV syllabus was revised in 1990. The syllabus for each level specifies conceptual and informational content; teaching methods and learning activities, including the types of clinical experiences and facilities that should be used; printed references and audio-visual and other resources to be used by the teachers and by the students, and suggested means to evaluate student learning. For each level the process included the following steps:

---A five-day workshop during which 10 Filipino nursing experts developed a detailed syllabus to help nursing faculty incorporate learning experiences related to reproductive health concepts, information and skills in the specified level of the curriculum. JHPIEGO provided up-to-date, complete and accurate technical information to support this process and an excellent nursing education consultant to support and facilitate the work of the Filipino nurses.

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[2]Two projects (both titled "Strengthening Reproductive Health Content of the BSN Curriculum in Philippine Colleges of Nursing") took place over a 3-year period, 1987-1990. (The cost was $93,044 for one project, TCA-15; costs for NCA-117 are not specified in the JHPIEGO documentation). The third project, "Academic Skills in Reproductive Health for Nursing Faculty In the Philippines," was designed to improve the **lesson planning and teaching skills** of the nursing school faculty who will teach family planning. This two-year (1989-1991) project was to enhance the teaching skills of faculty responsible for teaching the reproductive health content in pre-service nursing schools ($53,735 for TCA-37).

--A one-day meeting to orient members of the Technical Committee on Nursing Education (TCNE) and the Board of Nursing to the new syllabus and to obtain their feedback.

--A second five-day workshop during which 8 Filipino nursing experts (including many who had participated in the original workshop) made plans for a two-week training-of-trainers (TOT) course to prepare selected nursing faculty to train other nursing faculty to use the new reproductive health curriculum.

--A 2-week TOT course for 30 selected nursing faculty, including at least one from every region of the country.

--Faculty trained in the TOT course taught other maternal and child health (MCH) faculty in their own college of nursing and in other schools within their regions how to use the syllabus.

At the end of this process, at least some of the MCH faculty from virtually all Philippine nursing colleges had received some training in use of the new reproductive health curriculum. However, approximately 20 new schools have opened since this process was completed; it is not clear to what extent the training of faculty has been extended to those schools.

Nurses who graduate in 1993 will be the first to have been trained according to both Level II and Level IV of the new reproductive health curriculum.

The Board of Nursing, which develops and administers the licensing examination, expressed satisfaction with the reproductive health curriculum and planned to incorporate questions from it into the national examination.

Evaluation of the first two projects. The evaluation plans built into these projects called for: (1) documentation of the number of faculty members trained at each school, (2) site visits to observe actual teaching of reproductive health in 50 colleges of nursing, and (3) three regional conferences involving MCH faculty from all nursing schools to follow up the training and discuss their ongoing implementation of the reproductive health syllabus. Natural disasters (earthquakes, floods and volcanic eruptions) have delayed the site visits, which are now scheduled to be conducted in November 1991 by a three-person team including the Project Director, Project Coordinator and a representative from DECS. However, the project budget to support site visits is only $1,149, an amount probably inadequate given the difficulty and cost of travel to these far-flung schools. Guidelines to structure observations during the visits have been developed and pilot tested.

Plans are being made to hold the evaluation conferences in March of 1992. The plans are not very specific yet. Only people who have been trained will be invited to the conferences. (This seems a limited approach, like trying to figure out a rate when looking only at the numerator, i.e., with no information on the denominator. Project personnel, and JHPIEGO, might learn more about the impact of the project if they invited key MCH faculty from each school, whether or not the individual had participated in the training.) The project budget includes nearly $26,000 for the conferences.

The JHPIEGO consultant[3] who provided technical assistance earlier in these projects has won the trust and confidence of the ADPCN leaders, who expect her to participate in the evaluation conferences. Her participation will provide important continuity. Her Filipino counterparts also anticipate her assistance and joint authorship in preparing an article to describe the process and outcomes of this project. Such an article would contribute to an important sharing of this experience and lessons learned with other countries.

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[3]Dr. Jonalynn Mandlebaum.

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Needs assessment for JHPIEGO's "academic skills" project. The evaluation activities summarized in the previous paragraph have not yet been completed; nevertheless the follow-on project ("Academic Skills in Reproductive Health for Nursing Faculty in the Philippines," TCA-37) states that evaluation of the previous projects (NCA-117 and TCA-15) identified three factors which limit the effectiveness of the teaching of reproductive health in the Philippine BSN programs. These are: (1) Nursing faculty have very limited teaching skills and rely almost totally on the lecture method; (2) nursing instructors assigned to teach reproductive health content voiced inadequacy in their level of knowledge about reproductive health issues, and (3) nursing educators feel that Western textbooks have limited value for addressing the reproductive health needs of the Philippine population and want to develop their own references.

JHPIEGO-supported activities to improve teaching skills of nursing faculty responsible for teaching reproductive health. The Project Paper for the Academic Skills project called for the development of an academic skills curriculum and training 40 "master trainers" who would then conduct approximately 120 "echo" training-of-trainer (TOT) courses throughout the country. It is not clear to what extent this plan has been or will be implemented. The project seems to have evolved over time in response to needs and opportunities identified or developed in conjunction with other JHPIEGO projects. At this point it seems difficult to disaggregate activities related to the two ADPCN curriculum development projects and the project for improving teaching skills; one set of activities flows into the other. The following are some of the activities which have occurred under the Academic Skills project:

-- Three one-day workshops were given to provide reproductive health updates to all nursing school deans and interested faculty, students and in-practice nurses. These were used in part to identify people with a particular interest in reproductive health in order to select the persons to be trained as "master trainers" for this project. Criteria for selection of persons to be prepared as master trainers included having a masters degree, an interest in reproductive health, and a commitment to continue to teach nursing for at least three years after the training.

-- The group revising the reproductive health component of the Level IV curriculum decided that each nursing college should offer a clinical family planning skills "elective" to senior nursing students who want a career in family planning. In order to begin to move in that direction it was decided that at least one member of the faculty of each nursing college should be trained in family planning clinical skills.

-- A need was identified for fully developed, step-by-step lesson plans which are clearly keyed to the curriculum. Such lesson plans include specific objectives and content and suggest which teaching/learning methods to use, how much time to devote to each lesson, and how to evaluate the extent to which students achieve the learning objectives. Lesson plans make quality teaching easier and help to assure a certain standard; new teachers can use the syllabus to teach thoroughly, with little need for preparation.

-- To begin to meet these needs, approximately 20 nursing college faculty members have taken a 6-week course given by the Mary Johnson Hospital Fertility Care Center (FCC). This course was initiated with JHPIEGO support in 1990. It included 2 weeks of clinical skills training, plus training in training skills and the development of lesson plans.

-- JHPIEGO supported purchase of teaching materials needed at each school.

It seems that the original plan to develop a TOT curriculum, train 40 master trainers and conduct 120 echo TOT sessions to improve teaching skills of all MCH nursing faculty has been delayed or abandoned. This seems to have been replaced by a series of one-day family planning update seminars and 6-week family planning clinical skills and TOT training course at the FCC for 20 faculty members. The latter also yielded a set of lesson plans to augment the new curriculum.

Probable Impact of the Series of Three Projects

These projects are on-going and have not been evaluated yet. However, some of the objectives have already been achieved. The following is a summary of the probable final results in regards to preparing new nursing graduates for a role in family planning:

-- The curriculum which guides teaching in all Philippine colleges of nursing has been changed to encourage more open discussion of sexuality, to provide specific information about each family planning method, and to arrange for each student to visit and observe a family planning clinic. Graduates of the nursing colleges should be able to counsel patients about family planning and should understand the legal basis for family planning in the Philippines and the importance of informed consent. At least one MCH teacher from each of most of the nursing colleges has been given some orientation to the new curriculum, and some training in how to teach reproductive health and family planning more effectively. Detailed lesson plans have been developed to make it easier to teach certain parts of the curriculum. These are particularly important, since there is a high turnover among teachers, and new schools are being opened every year.

-- About 20 nursing faculty members have been trained in clinical family planning skills; others may also be given this training. This will almost certainly increase their ability to teach students about family planning.

-- All of the nursing college deans and some of the faculty have attended one-day seminars to update their technical knowledge regarding family planning and other aspects of reproductive health.

-- Some (probably not all) of the schools have an improved collection of books and other reference materials related to family planning and other aspects of reproductive health.

-- The curriculum calls for the development of a family planning clinical skills elective for senior nursing students. A great deal of additional effort and resources would be necessary to implement this plan.

Conclusions

1. **All nurses need to understand the benefits of family planning and be able to counsel patients and refer them for family planning care. However, relatively few nurses fill jobs which require clinical family planning skills.** In the Philippines, half of the nursing graduates do not pass the examination to become RNs. Of those who do become RNs, a large proportion leave the Philippines to practice nursing in other countries. Of the RNs who practice in the Philippines, most work in positions which are not directly related to reproductive health. **Most of the health-care positions which require family planning skills are filled by midwives.**

2. **A pre-service educational program in which family planning concepts are integrated into a broad array of learning experiences is probably a very effective way to transmit accurate information about family planning and to develop lasting pro-family planning concepts and values. It is *not* an effective way to provide the skills and judgment required for competent family planning practice.** Reasons include:

   o Inadequate clinical practice available for large numbers of pre-service students;

   o Students who achieved competence but not proficiency would lose that competence due to the time lapse between pre-service training and entering jobs in which the clinical family planning skills would be required;

   o It is wasteful because only a small percentage of all graduate nurses will ever be in positions to use clinical family planning skills; and

o It is wasteful because only a small percentage of all graduate nurses will ever be in positions to use clinical family planning skills; and

o It is inappropriate in a curriculum designed to prepare a generalist practitioner.

3. **Graduates of Philippine nursing colleges with improved reproductive health training will still need in-service family planning clinical skills training to be qualified to provide direct family planning clinical services.** It remains to be seen whether or to what extent the Philippine Department of Health in-service family planning course (3 weeks for "basic" family planning service delivery and 5 weeks for "comprehensive" family planning service delivery, i.e., including IUDs) can be shortened for nurses who have had the improved pre-service training.

4. **It is probable that a combination of pre-service education, which leads to the development of pro-family planning concepts and values, followed by short-term in-service training leading to competence in clinical skills will produce nurses who are more effective family planning clinicians than nurses trained through in-service courses alone.** This is a testable assumption.

5. The enhanced reproductive health training in Philippine colleges of nursing will transmit the concepts, values and information which lead to approval of family planning to large numbers of people, mainly women, who will never be in a position to provide family planning services in the Philippines. Nevertheless, the enhancing of reproductive health training in Philippine schools of nursing should make important contributions to family planning in the Philippines and, perhaps, in other developing countries:

   o Transmitting basic family planning concepts, values and information to 13,000/year Filipino female and male college graduates who fail to become nurses is not without value. They will apply this training in unknown but presumably positive ways in their own lives and in the other roles they will undertake in their society.

   o Many of the Filipino nurses who leave the Philippines go to North African/Middle Eastern countries which could benefit from the nurses' better understanding of the importance and role of family planning.

   o Nurses fill many leadership roles in the Philippine health care delivery system, and some nurses go on to qualify as nurse-midwives and teach in the Philippine midwifery schools.

   o It may be possible to shorten the current in-service family planning training course for nurses who have completed the new pre-service nursing curriculum with its enhanced reproductive health content.

6. **It is much more difficult and requires more resources and time to improve nursing school faculty teaching methods than to influence their teaching through curriculum revision and the development of detailed lesson plans.**

Recommendations:

Concerning pre-service nursing education in general:

1. In countries where all nursing schools follow a standard curriculum, it is important and cost-effective to direct efforts at strengthening the reproductive health/family planning content of the pre-service nursing curriculum through curriculum revision augmented by the development of complete and detailed lesson plans. In most countries, the appropriate objectives of such efforts should be:

o To develop positive attitudes about family planning and its contribution to the health of women and children and the well-being of families and society;

o To provide accurate information about the effectiveness and mode of action of all traditional and modern methods of family planning used in the country;

o To provide accurate information about the laws and rules which regulate family planning service delivery in the country;

o To develop competency in communication and counseling skills and to give students some experience in counseling and/or client education regarding family planning, and

o To expose students to positive models of nurses playing roles in family planning service delivery.

2. Competence in the provision of family planning services should rarely be an objective of the pre-service education of nurses.

Regarding JHPIEGO pre-service efforts in the Philippines:

3. JHPIEGO and the ADPCN should postpone or abandon plans to develop family planning *clinical skills electives* in nursing colleges. Graduates who want to have a career in family planning can take the DOH in-service comprehensive family planning course.

4. JHPIEGO should *not* direct additional resources toward improving teaching skills of faculty members of the Philippine nursing colleges, except through the development of additional detailed lesson plans.

* * *

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Appendix L

A Model for Needs Assessment: Basing Training on Systematic, Objective Data about Family Planning Service Providers, the Demands of Their Jobs, and Family Planning Deficiencies Observed in the Field

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A Model for Needs Assessment: Basing Training on Systematic, Objective Data about Family Planning Service Providers, the Demands of Their Jobs, and Family Planning Deficiencies Observed in the Field

I. CASE STUDY FROM KENYA

Introduction and Significance

This case study reports the evolution and progress of a project which is unusual, perhaps unique, in the degree to which it is based on a systematic gathering and analysis of objective data. The objectives of the project -- revising the curriculum for in-service family planning training in Kenya and building curriculum development skills in the group of trainers responsible for Kenya's in-service family planning training program -- are not exciting in themselves. But this particular characteristic of the project -- the extent to which it is based on objective data (its "data-basedness") -- has created an opportunity for change and learning in a previously stagnant training program. It has also caused the director of Kenya's national family planning program to declare this project his "top priority."

Many are impressed by this project. A JHPIEGO consultants in Kenya, a highly regarded American nurse-midwife trainer with extensive international experience, remarked on the power of the process being used in this project, and said that it was new to her. JHPIEGO's Director has asked the lead consultant to discuss the curriculum development process being used in this project during a continuing education session for JHPIEGO staff in Baltimore. In addition, the evaluation team has based one of its broadest recommendations in part on the importance of the data-based approach in this project.

Background Information

Since 1982, Kenya's Ministry of Health (MOH) has been providing family planning services through the Integrated Rural Health and Family Planning Program, in which antenatal care, well-baby care (e.g., growth monitoring, immunizations), treatment of sick babies and family planning are all provided in the same clinical facility, called a Service Delivery Point (SDP). (Most "SDPs" are dispensaries and health centers, although some are clinics in hospitals.) The main service providers in this system are Enrolled Nurses (ENs), Enrolled Midwives (EMs) and Enrolled Community Nurses (ECNs), the latter whose training includes midwifery. Together they are responsible for providing maternal and child health (MCH) services, including family planning, in MOH dispensaries and health centers. They are supervised by Kenya Registered Nurse-Midwives (KRN/Ms), public health nurses (PHNs), or older and more experienced ECNs. Those who work in health centers are also supervised to some degree by Clinical Officers (COs), who manage the health centers.

The pre-service training of ENs, EMs and ECMs is not designed to give them competency in the provision of family planning services. In order to become "MCH/FP service providers" they must take a special 7-week in-service course, which prepares them to provide all of the temporary methods of contraception. The "MCH/FP certification course" is managed by the MCH/FP Training Programme of the MOH's Division of Family Health (DFH) and is conducted through 11 Decentralized Training Centres (DTCs). More than 5,000 FP service providers were trained through this course between 1972 and 1990, more than half of them since 1985. It has been estimated that the MOH would need to train at least 7,000 more FP service providers between 1990 and the end of 1994.

This MCH/FP Training Programme is managed by a group of 6 senior nurse trainers, who work at the DFH headquarters in Nairobi; altogether there are 40 - 50 trainers, including those at headquarters and those at the DTCs. The DTCs are actually training teams comprised of MOH nurse/midwives who have been

designated as trainers. Most of the DTCs do not have permanent physical training facilities; hotel facilities are often used as classrooms. A variety of SDPs in the vicinity of the training location are used for clinical training. In addition to the basic 7-week course, the MCH/FP Training Programme teaches three other courses: a Family Planning Technology Update course, a Training of Trainers course, and a separate MCH/FP certificate course for the Clinical Officers and Registered Nurse/Midwives who are responsible for management of the SDPs and supervision of the enrolled nurses who provide MCH/FP services.

An extensive evaluation of the MCH/FP certification course and of the performance of family planning service providers was conducted during 1989.[1] USAID/Kenya provided the stimulation for this evaluation, as well as technical and financial assistance. During this evaluation five field teams directly observed 128 MCH/FP service providers performing their jobs at 42 SDPs in 20 districts. In addition to the observations, the service providers and their supervisors (N=36) were interviewed, and 420 FP client records were randomly selected and examined. All 11 District Training Centers were visited, and 34 of the 36 MOH MCH/FP trainers were interviewed.

Major Findings from the Evaluation:

Current MCH/FP workers:
- 78% were ECNs or ECN/Ms;
- 48% worked in Health Centers, 40% in hospitals;
- most were fairly experienced (average of 4 years with MOH);
- 80% had never had a family planning update course.

Areas of adequate performance:
- history and physical examination;
- counselling on use of pills, IUD, condoms and Depo-Provera injections;
- adequate equipment disinfection/sterilization when supplies available.

Areas of inadequate performance:
- counseling on voluntary surgical contraception;
- inquired about side effects in only two-thirds of revisits;
- no contraceptive stock control records in 59% of service sites; -many sites were out of key commodities;
- short supply of disinfectant, sterile gloves and other equipment.

Problems with supervision:
- 90% of supervisors had no standard supervisory guidelines to follow;
- 60% of supervisors had never had formal preparation in supervision;
- one-third of supervisors were hindered by lack of transport;
- most of supervisors' time spent doing administration, not supervision;
- 75% of supervisors have never had a contraceptive update course;
- 43% of MCH/FP staff receive no supervision.

Problems with training course content and process:
- shortages of basic manuals;
- supplementary training materials generally not available to trainees;
- curriculum says what to teach but not how;
- trainers spend much time dealing with problems of ad hoc facilities (i.e., the use of hotels for classrooms);

[1]Kenya, Government of. Ministry of Health, Division of Family Health. Evaluation of the Maternal, Child Health and Family Planning In-Service Training Programme. Nairobi. June 1990.

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- much course time used travelling to and from clinical practice sites and waiting for enough clients who want specific methods, especially IUDs; lack of transportation is a problem.

Problems with trainer's performance and administration of training:
- 60% of trainers have been trained in training methods, but there is no TOT curriculum;
- high turnover of trainers (12 of 28 positions vacated during (1986-88);
- 75% use lectures as the major method of instruction;
- 54% of trainers have never had contraceptive update course;
- no records on placement of trainees after completing course;
- need to double output of trained people by 1994, but no detailed planfor expanding training.

Recommendations based on these findings called for:
- development of a training policy and plan;
- development of an information system to document current manpower utilization, project future requirements and facilitate optimum re-deployment of trained personnel;
- reorganization of the central training office;
- developing a stronger, standardized TOT curriculum;
- making sure that all trainers have taken both the TOT and the Contraceptive Update course;
- recruiting more nurses with Diplomas in Advanced Nursing (DAN) as trainers (the DAN curriculum includes an emphasis on training methodology);
- developing a plan to improve the physical facilities available to DTCs, and to provide better access to transportation;
- developing a cadre of trained clinical preceptors to guide trainees during their clinical learning experiences;
- procuring large, bulk supplies of basic training and reference books and manuals;
- using NGO training institutions to supplement MOH capacity until existing MCH/FP Training Programme is strengthened;
- offering the Contraceptive Update course to all former trainees;
- changing the basic 7-week course to emphasize counseling about tubal ligation and the need to ask revisit clients about side effects;
- increasing the number of supervisors and developing guidelines for them.

JHPIEGO's Involvement with this Training:

During a May 1990 visit to Kenya, JHPIEGO's Director (Noel McIntosh) and a program officer (Anthony Nathe) observed that sexually transmitted genital tract infections, such as gonorrhea and chlamydia, are prevalent in Kenya and that introduction of the Copper T 380A IUD had been "somewhat stormy," with both physicians and nurse-midwives expressing concerns about its safety (due to tarnishing in the package), efficacy (alleged high expulsion and failure rates) and acceptability (potential users refusing to accept a tarnished IUD). At the request of Dr. Oyoo, Director of the DFH, the JHPIEGO team conducted a two-hour seminar to demonstrate JHPIEGO's IUD Training Package to the DFH's "nurse IUD trainers", as well as USAID HPN Officers. The DFH trainers were particularly interested in the IUD training video, slide set and pelvic models. The report from this trip notes that JHPIEGO might be asked to assist the DFH to redesign the clinical component of their "IUD training program."[2]

Following Mr. Nathe's and Dr. McIntosh's next trip to Kenya (June/July 1990), they reported that "A major problem regarding nurse IUD training, which was identified during the last trip, concerns the need to update the basic family planning course for nurses. . . . The course content, curriculum and teaching methods used by the trainers . . . are in need of an overhaul." (The curriculum for the current MCH/FP course, a condensation of an earlier 9-week version, had been written in 1986.) At USAID's request the JHPIEGO

[2]McIntosh, Noel and Andrew Nathe. Trip Report, Kenya, May 8-23, 1990.

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team met with Dr. Oyoo to discuss how JHPIEGO might assist the nurse trainers to revise the FP training course. It is not apparent from the trip report that the JHPIEGO team reviewed the report of the field-based assessment that had been conducted in 1989. The options presented to Dr. Oyoo by the JHPIEGO team included conducting a TOT course and holding a workshop to assist the nurse trainers to develop a plan for revising the course curriculum. At the end of the discussion they all agreed that the current course is not achieving its objectives, is too long and needs to be revised.

On May 15, 1991, JHPIEGO began a nine-month technical assistance activity to help the DFH strengthen its in-service MCH/FP Training Programme by revising the curriculum and improving the skills of the trainers. The project was based to a large extent on findings from the joint USAID/MOH evaluation of the training program. The JHPIEGO paper which describes the project used information from the evaluation to identify specific problems that could be addressed by training: management of clinic supplies, adherence to standard counseling procedures, inadequate preparation of the nurses in independent case management, the need of some trainers for a more detailed curriculum to teach from, and the need to find adequate numbers of clients for IUD insertions as a problem which interfered with the efficiency and effectiveness of the entire training program. The evaluation report also noted that training is an additional task added to the workload of nurses who are basically service providers and that many of the clinical instructors "are disinclined to be involved and...view the trainees as a burden and obstruction to their regular tasks." The JHPIEGO paper states that "USAID feels that additional instructional tools and supports are indicated" and that the curriculum should be presented in a format which includes "sufficient detail (both in terms of subject and pedagogical content) to allow a service provider, recently designated as a trainer and/or clinical instructor, to rely exclusively on this manual to prepare for, present and evaluate a training session." (However, while the JHPIEGO project paper includes IUD insertion and aseptic technique as areas of weak performance, neither was noted as such in the summary of the evaluation report.)

The JHPIEGO project designed to redress these problems includes plans for a three-week curriculum design workshop to help DFH senior trainers develop a comprehensive, competency-based MCH/FP curriculum, and then to assist them in writing a comprehensive technical and clinical instructional-reference manual on reproductive health and family planning for use in the SDPs. This manual is to include guidelines for competency-based evaluation, incorporate adult learning methods, and be consistent with the new curriculum. An important element of the plan is JHPIEGO's use of a technical assistance approach aimed at maximizing the transfer of skills to designated DFH trainers and institutionalizing MCH/FP curriculum development expertise within the DFH training unit. It is understood that full implementation of the revised curriculum will require work beyond that outlined in the current JHPIEGO project, and it is expected that the designated DFH trainers should be able to carry out this work as a result of skills developed during their involvement with JHPIEGO consultants.

The first phase of the JHPIEGO project was a two-week field-based task analysis conducted in May 1991 by 7 persons (MOH/DFH staff and JHPIEGO consultants) who went in twos or threes to visit 17 SDPs in one region of Kenya for the purpose of assessing the actual tasks and responsibilities of family planning service providers. Although the decision to conduct this field-based needs assessment was made before JHPIEGO became involved in the project, JHPIEGO supported the idea and contributed consultants whose expertise helped to make exercise a success. The field-based assessment was fairly structured, using a data collection instrument developed by the MOH/DFH staff with input from the JHPIEGO specialists and the USAID/Kenya mission. In addition to observation of tasks and roles of FP service providers, the assessment team documented operational constraints to the provision of effective, high quality FP services.

The second activity was **a three-week curriculum design workshop held in July 1991.** The planned outcome of the workshop was to be a new course schedule and an outline (including learning objectives and instructional processes) for each subject to be covered both in the classroom and during the practicum. The workshop participants were 14 members of the "core curriculum group," including the 6 DFH senior trainers and representatives from the MOH Division of Nursing, the Kenya Nursing Council, and the pre-service school for ECNs, and two JHPIEGO consultants, who served as facilitators. The original plan called for the first

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week of the workshop to be used for updating the group in contraceptive technology. However, as the participants' knowledge was found to be more deficient than anticipated, it was ultimately necessary to devote two weeks to technical updates in a variety of subjects, including contraceptive technology, infection control, contraceptive logistics, and management. The core group decided the topics for the updates and asked local experts to give the presentations. The core group also made plans for regular, annual updates in contraceptive technology and other related fields.

The group also focused on defining the main elements of the job of an MCH/FP service provider. The end product was a comprehensive, detailed job description and agreement within the core group to use the job description as the focus for identifying the end-point competencies for the new curriculum. The job description agreed upon includes 21 tasks related to management of the care of individual clients; 10 tasks related to clinic management; 15 related to supervision of staff; 7 related to ordering and care of supplies; 8 for record keeping; 10 for information, education and communication; and 16 for infection control.

Since it was not possible for the core group to accomplish all of the original goals of the workshop, the participants agreed to continue working over the summer and to complete the curriculum during **a second three-week workshop in September.** The next step is to identify what the nurses already know and know how to do before they begin the MCH/FP in-service course; this will be determined in large part by examining the learning objectives and content of the pre-service curriculum for each category of service provider. **The gap between the demands of the job (as per the new job description) and the pre-service training of the service providers will define the necessary content for the in-service training course.**

Assessment of This Process and JHPIEGO's Contributions

JHPIEGO was invited into this project by USAID, and by the Director of DFH, apparently because of JHPIEGO's special interest and expertise in training related to IUDs. This is of interest because insertion and management of IUDs had not been identified as a particular weakness of the DFH family planning training program during the extensive evaluation conducted in 1989. It should also be noted that AID had been providing assistance to the DFH training unit for many years through INTRAH, and that this assistance had contributed to the development of an on-going, well-institutionalized MOH in-service training program; although the 1989 evaluation found weaknesses in the training, there were strengths as well.

However, JHPIEGO had identified certain problems regarding the use of Copper T 380A IUDs in Kenya, especially regarding concerns about tarnishing, an there seemed to be interest in having a fresh influence and approach. In addition, JHPIEGO's "humanistic" and "efficient" approach to IUD training, emphasizing the use of anatomic models and thereby reducing the number of actual IUD-insertions needed for each trainee, should reduce the logistical and transportation problems noted in the 1989 evaluation of the DFH training program. The curriculum being developed with assistance from two JHPIEGO consultants will specifically address the problems related to ordering and management of supplies that were also documented in the 1989 evaluation.

This project is unusual, and will probably be successful because of the high degree to which it is based on a systematic gathering and analysis of objective data:

- **The decision to revise the curriculum followed and was made possible by the field evaluation of the training program, which was conducted by the MOH and USAID in 1989.** This careful, systematic evaluation, necessitating much group processing of the findings, made it possible for the DFH training team to look at their own program more objectively and with a different perspective. It was this which provided the entre to meaningful change. (It should be noted, however, that the evaluation did not recommend a complete overhaul of the basic MCH/FP curriculum, and that revising the curriculum will do little to solve programmatic deficiencies regarding supervision.)

- **The curriculum will be designed to produce a worker who is able to perform a specific job; the job has been carefully defined based on systematic observations of persons performing the job in the field, and of the demands and constraints of the job in its actual work-sites.**

- **The curriculum will be based on a careful determination of the knowledge, skills and attitudes that the trainees will bring with them to the training course.**

USAID/Kenya deserves credit for initiating and sponsoring the original evaluation and planning the field-based training needs assessment that was the first phase of the curriculum development project. JHPIEGO deserves credit for supporting the idea of a field-based training needs assessment, for providing excellent consultants to support and guide the curriculum development process, and for permitting their consultants to take the additional time and expend the additional effort needed to assist the Kenyan curriculum group to go through every step, even though time-consuming, of a logical curriculum development process.

II. A CONTRASTING EXAMPLE: MOROCCO

Family planning leaders in Morocco have decided to "medicalize" family planning by increasingly training and using doctors, instead of nurse/midwives, to provide clinical family planning services. This decision seems to be based in large part on a political decision to expand the number of physicians being produced each year (and to provide employment for them), augmented by a desire to increase the use of IUDs and a vague understanding that there are "problems" with the current IUD program, which is managed mainly by nurse-midwives. It does not appear that this major change in direction is based on any intensive, systematic observation and analysis of the strengths and weaknesses of the current family planning service delivery system, or of the nature of the "problem" regarding IUDs. Although the Evaluation Team was not in a position to make such an assessment, the IUD "problem" does not seem to be related to excessive morbidity but rather to nurse-midwives' (and doctors') reluctance to insert IUDs in women whose cervices are red and appear inflamed, and the relative frequency of such cervical abnormalities.

In most countries, including the United States, most of the direct patient care in government-funded family planning clinics is managed by nurses and midwives. Family planning is consistent with the role of nurses and midwives, which features health education, counseling, a focus on prevention, and the management of common, non-acute health problems, especially among women. Studies have consistently found that nurses and midwives are interested in family planning, are more consistent than doctors in following family planning and STD protocols, and that they insert IUDs carefully and gently. This is not to say that there is not an important role for doctors in routine contraceptive care. However, few doctors maintain an interest in seeing large numbers of healthy women for a service which requires a great deal of counselling and patient education. Based on this background, the Evaluation Team was concerned about the decision to "medicalize" family planning in Morocco, especially since it does not seem to be based on a systematic observation and objective analysis of the strengths and problems of the present system.

Conclusions and Recommendations

Family planning training is the means to fill the gap between the attitudes, knowledge, and practices of the persons being trained and the attitudes, knowledge and practices which are needed to provide safe and effective family planning services. Such training should be based on an understanding of the people to be trained, what they already believe and know, and their existing skills, competencies and deficiencies. Training must also be based on a clear understanding of the demands of the job(s) the trainees will be expected to perform, and any deficiencies in the performance of people already filling those jobs.

It takes time and resources to plan and conduct a systematic, objective training needs assessment. For this reason, training is often based on a vague or incomplete understanding of the pre-existing attitudes, knowledge

and skills of the people to be trained, the demands and constraints of the job the trainees are being prepared to do, and the strengths and shortcomings of the current family planning workers and the services they provide. Trainers, and family planning service leaders, often think they know what the problems are and what needs to be done, and they usually do, to a degree. As a result, "training needs assessments" are often based primarily on informed opinion. However, what we think we know can prevent our learning more; it may especially prevent us from learning something new or different. Short-cutting the "needs assessment" process can result in training which, though beneficial, results in unfortunate waste -- wasted time and energy when people are "trained" in things they already knew, wasted opportunity when training fails to fill gaps and solve problems that were not clearly defined, wasted human potential when trainees or trainers become bored with training that does not really "fit" existing needs.

Recommendation: The training strategy for each country should be based on systematic, objective information (data) about: (1) the pre-service training, numbers, roles and general performance of the various categories of health professionals and other workers who might play roles in the provision of contraception; and (2) strengths and weaknesses of existing family planning service delivery systems, including evidence of safety or lack of safety and evidence of effectiveness (such as contraceptive prevalence and method-specific continuation rates).

Appendix M

USAID Mission Comments on JHPIEGO

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The following are responses from USAID missions to an Office of Population request for information on JHPIEGO's performance. The Office cable was sent to help provide a broad field perspective for this evaluation. The missions were asked to comment on JHPIEGO's anticipated future role in each country, its contribution to work of the mission, its strengths and weaknesses in project planning, in project implementation strategies, and in project evaluations. Nineteen responses were received.

The following are excerpts from the cables. All evaluative comments were kept but information on specific country programs was omitted. Other minor editing was done when the cabled responses were illegible.

Responses are in alphabetical order, by country, grouped by region, as follows: Africa, Latin America, and Asia.

Africa

Burkina Faso

JHPIEGO has provided centrally-funded training activities in Burkina [which was] particularly useful since no similar training is conducted in-country. Family planning training also important because it offers a means to train nurses and physicians assigned outside USAID project area. Laparoscopy training has provided new skills to physicians.

With regard to project-funded activities through a mission buy-in, JHPIEGO trained lab technicians and service providers in two STD reference clinics. This training was well done and provided important skills to lab technicians, physicians and midwives. In addition, JHPIEGO conduced an "academic skills in reproductive health" update: seminar at the university medical school this session was highly appreciated by faculty who credit the class for improving their teaching.

Finally, it almost goes without saying, educational packages and equipment provided to MOH and the university are much appreciated and useful.

JHPIEGO does a thorough job in project planning.

[All] very satisfied with the competence of consultants who conducted courses in Burkina [but] critical of administrative and reporting procedures for JHPIEGO-assisted activities. These should be streamlined and should conform with those of other contracting agencies. Project reporting required was straightforward and uncomplicated, but one project put an extra workload on mission personnel who were responsible for distributing funds and collecting receipts. Reporting and administration of the regular subproject was complicated. The MOH was required to fill out numerous forms including participant lists, institutional enrollment forms, payment requests, annual reports and the final report. These forms are not similar to those used by other contract agencies and thus were confusing to the project administrators. Some of the forms did not seem to serve any purpose especially the institutional enrollment forms. In addition, the MOH was confused by the tuition rate method for reimbursement.

A regional office would facilitate project implementation. Although in theory JHPIEGO and INTRAH/PAC project have distinct mandates, in reality the projects often cover the same ground. For instance, it is not always practicable or advisable to provide separate FP training for physicians and nurses. Thus, for general FP training mission has relied on the PACII Project Mission funds JHPIEGO's ability to provide centrally funded participant training has been highly appreciated. JHPIEGO [should] continue to have access to central funds to support participant training costs for countries with relatively small budgets such as Burkina.

Cameroon

Ministry of Health personnel benefit tremendously from short-term training organized in the USA and in third countries; support provided through JHPIEGO using central funds.

JHPIEGO gives most country institutions the opportunity to identify program activities. Institutions are requested to establish priority activities and submit them to JHPIEGO for review and funding. This method assures maximum host country participation and commitment to the project. The roles of counterpart institutions and JHPIEGO are clearly noted in project documents. Training aids and training materials are appropriately identified and budgeted for during the project design phase. These materials are procured by JHPIEGO and sent directly to the concerned institutions.

Little planning is done to try to assure sustainability of project activities. Concerning short-term training, letters informing participants of their selection for training are sometimes received too late. Lack of planning to cover recurrent costs and supplies after the project ends.

JHPIEGO permits counterpart institution to employ local consultants as appropriate, rather than bring in foreign consultants. This strategy encourages development of individual and institutional skills for sustainability. Short-term training organized by category for doctors and nurse/midwives at experienced family planning clinics resulted in well trained personnel to carry out program activities. JHPIEGO training provides opportunities for women to receive training in family planning which has significantly increased the roles of women in designing, implementing, administering and evaluating projects.

Concerning short-term training, the final selection of candidates is too close to training starting dates. This results in limited time for mission to advise and process participants before departure dates. In some cases, letters informing candidates that they have been selected often arrive when the participants have returned from training. The letter also contains reimbursement forms and instructions. This results in the participants not being reimbursed for expenses, since reimbursement forms are to be filled out and returned within thirty days of the travel.

Annual comprehensive evaluations occur. They include evaluating personnel and their abilities to use equipment provided by JHPIEGO as well as those who received their training from personnel who have attended JHPIEGO training. Annual evaluations allow project officers to identify and solve problems early. Joint supervisions are conducted by MOH's family and mental health division and JHPIEGO. This assures standardization of reproductive health training. In addition, reproductive health training sites in the public and private sectors benefit from joint supervision.

For short-term training, it is suggested that candidates be selected at least two months in advance. Letters with instructions on training sites, institutional contacts and reimbursement forms should arrive at the mission before the participants depart for training. Sub-contracts between Ministry of Health and JHPIEGO should contain a clause to encourage the government to maintain trained personnel at clinical sites until the technology has been transferred.

Central African Republic

JHPIEGO should have two principal objectives: 1) provide initial training and follow-on of in-service training and 2) increase the local capacity to undertake training programs in general. We believe that increasing the local capacity to undertake training is particularly important and over time we would hope to see fewer external resources (consultants) and third country training sites being used. The CARG is looking for a greater transfer of resources across a broader range of activities than the JHPIEGO activity is designed to deliver. Overall, the next project should be programmed with so-called sunset provision in mind over a ten year time-frame.

JHPIEGO has made a modest (Dols 40,000 per year) yet important, contribution to the small USAID program. It permits us to provide assistance in an area related to, but not directly impacted by, our on-going programs in child survival and HIV/AIDS prevention. The program has contributed to an improvement in maternal and child care through training, provision of equipment and supervisory visits.

Among the strengths of JHPIEGO's planning process is a highly relevant set of training programs and close collaboration with MOH officials in planning specific training. The weaknesses of the program include the MOH's limited planning capacity and the lack of personnel and operational funds to supervise health personnel who have been trained. Another weakness is the absence of a family planning course within the overall C.A.R. training program for health personnel. The MOH would like to see JHPIEGO planning missions lengthened (they currently run no more than 4 days to one week) with an even greater role for the

MOH in the elaboration of the training program. The MOH would also like to have material support to improve supervision of personnel.

In terms of implementation, the JHPIEGO program has established good communications with the ALO and MOH. Transfer of funds for training activities has also gone smoothly. At the same time according to the MOH, follow-up supervision of trained personnel has been inadequate. There have been frequent interruptions in the supply of condoms and difficulties in recruiting outside consultants. MOH officials suggest that JHPIEGO take on responsibility for logistics, provision of equipment and finance an adequate and continuous supply of condoms.

MOH officials felt that a once a year visit from JHPIEGO was inadequate to make useful evaluation of the program and they suggest evaluations on a more frequent basis, for example six months after a training session and they would also like to see more frequent visits by JHPIEGO personnel to the C.A.R.

MOH officials [identify as JHPIEGO's] strengths excellence of training modules, facility of communication, collaboration with most government ministries [and] as its weaknesses, free-standing TA whose ultimate success in impacting on the well-being of the population depends on government or other donor activities which are often not present. MOH remarks reflect as well a misconception of what JHPIEGO is designed to do and what the program capabilities are. JHPIEGO activities [are welcome] in the C.A.R. With an increased emphasis and funding for health activities, we can better integrate JHPIEGO training programs into other activities. At the same time, we strongly suggest that JHPIEGO make the investment in time to 1) integrate their training efforts with activities of other donors in population and maternal and child health activities and 2) provide for more frequent visits to the C.A.R. for evaluation and supervision purposes.

Ghana

JHPIEGO activities have complemented mission's bilateral project in providing academic skills training in reproductive health to the faculty members of the OB/GYN divisions of the two university teaching hospitals integrated family planning into the curriculum of all nursing institutions and provided family planning clinical training to all levels of health personnel in both the public and private sectors. These programs have positioned personnel trained in family planning skills at most of the regional and district hospitals as well as most of the clinics and health centers. In addition, JHPIEGO has established three centers in three regional capitals to train both tutors and service providers from all the ten regions to ensure that quality family planning service is easily accessible to all Ghanaian couples. Laparoscopic equipment has been supplied to 11 hospitals and a maintenance and repair center has been established with a team of trained technicians to service the equipment.

JHPIEGO uses Ghanaians to implement training programs in most of its training activities after ensuring that funds and training materials have been received in country. Consultants work with participants and not for them. JHPIEGO has been involved in different training activities covering various levels of health personnel. In all these activities funds, consultants, equipment, and teaching materials had been required for effective implementation of the activity. JHPIEGO has ensured that goods and services have been received and on time. In addition, as a result of JHPIEGO training the nurse has acquired an extended role in the community as a family planning advisor because of the inclusion of FP in her normal routine. JHPIEGO has also responded to requests submitted by groups such as the private medical practitioners, an act which has reaped dividends.

There are no refresher training courses designed for JHPIEGO activities for trainees to upgrade the newly acquired skills. Training coordinators are expected to supervise the work of trainees but there are no means of transportation provided JHPIEGO should provide durable instruments, equipment, and models for training.

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To date evaluations have been done by either questionnaires or by occasional site visits. JHPIEGO has not implemented mechanisms to measure people level impact of project inputs.

Rwanda

JHPIEGO conducts the project planning process in a collaborative manner, working closely with GOR officials to conduct needs assessment and design of training programs. JHPIEGO consultants and trainers are of the highest calibre and are respected by GOR professionals for their skills and cultural sensitivities.

JHPIEGO's efforts to maintain communication with host country and USAID officials is highly commended. USAID received copies of correspondence to host country officials and participants. Information on training opportunities is provided in a timely manner. FAX and telephone communications are used for urgent messages and consultant trips are planned and concurrences requested in a timely manner. USAID receives copies of trip reports and progress reports in a timely manner of all the population cooperative agencies working in Rwanda. JHPIEGO's administration and management function the best.

Unlike other cooperative agencies, JHPIEGO does not have regional offices nearby. Since JHPIEGO technical expertise is of the highest quality, it would be advantageous to have closer access to reproductive health experts. The new project might include resident advisors.

The evaluation planned for October 1990 was well designed and would have provided important information on the quality of the JHPIEGO training courses as well as evaluative data on the quality of FP services provided by GOR health workers.

Senegal

We have found that JHPIEGO relies heavily on its country backstop officer. Therefore, the planning process strengths and weaknesses depend on that one individual. JHPIEGO did not appear to have a systematized planning process or "cookbook." In some cases, the backstop officer would "develop/write up the program" with little input from the host country counterpart. And in those cases, the host country counterpart did not "own" the program.

Laparoscopy is not the method of choice for Africa given the difficulties with hygiene, electricity and logistics systems for spare parts. Therefore, an emphasis on minilap under local anesthesia should be stressed.

Focusing on in-country or regional training is definitely more appropriate than short-term training in the U.S. However, parachuting consultants in from the outside is an impossible management situation unless the activities directly complement bilateral activities and there is a bilateral contractor or an in-country administrator to manage the implementation and follow-up. Use of short-term consultants with sometimes uncoordinated administration in-country contributes to a weakness of JHPIEGO program.

JHPIEGO has concentrated training efforts in the past at the university level. This had led in some cases to an elitist, academic, physician control orientation. The reality in Senegal is that the university/hospital training approach must be balanced by in-country regional training.

JHPIEGO has tended to focus project evaluations on number of trainees, sessions completed etc. Two elements have been lacking. One is the operational and systematic follow-up of trainees: are they practicing their skills; was the training appropriate to the service delivery point conditions i.e. laparoscopy vs. mini-lap; are trainees posted in sites where they can use these skills? The second type of evaluation needed, but not practiced, is related to whether the training methodology, host country training institutions, etc. [have] been the most culturally appropriate and sustainable.

JHPIEGO has done a very good job, however, in assuring that the quality of training and skill level of their "graduates" is in accordance with specific objectives of any course as measured and pre- and post-training knowledge.

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Latin America

Barbados

The mission has benefited under the current cooperative agreement with JHPIEGO in the training of several doctors and nurses who attended courses in reproductive health, organized by JHPIEGO and conducted at the Baltimore training center. Of even greater benefit has been the collaboration between JHPIEGO, the advanced training and research in fertility management unit of the Department of Obstetrics and Gynecology of the University of the West Indies (UWI), the University of the West Indies distance teaching experiment (UWIDITE) and Ministries of Health in the Caribbean Region. Through this collaboration they have developed and transmitted reproductive health programs to eight sites in Antigua, Barbados, Dominica, Grenada, St. Lucia, Trinidad and Tobago, and Jamaica (two sites). This collaboration between JHPIEGO and ATRFN pre-dates the current cooperative agreement.

JHPIEGO has demonstrated strengths in the planning, implementation and evaluation processes in working with regional institutions. Training provided is responsive to the changing technical and informational needs of the region.

Bolivia

Planning process seems lengthy and implementation plans do not have enough detail in time line of activities, the who, what, when and where. Except for [the Reproductive Health Services project and some individual out-of-country training and educational materials], no in-country project implementation strategy/experience has been attempted. Country-specific strategy statements might assist in focusing their program specifically for Bolivia a 4-year strategy, which clearly states a few major objectives and includes activities to accomplish these objectives might be helpful.

We are just beginning to launch a new reproductive health program in Bolivia. Therefore, it is essential that well trained personnel (in JHPIEGO's case, clinical personnel) be in place via in-service training and other training programs, including continuing education.

Guatemala

Evaluation of the courses has been a weak point. This has only fairly recently been part of JHPIEGO's activities and the cooperating agency (APROFAM) had a difficult time implementing this component of the training. [Now] it appears this has been resolved and should remain a strong part of any new proposed training activity. More frequent TDY's or use of local professionals could help stimulate local involvement in the JHPIEGO effort.

Peru

Because of JHPIEGO's past, successful experience in Peru, their familiarity with the MOH and their overall mandate of training physicians and allied health workers in clinical family planning, they would be ideal to assist the mission in providing the TA to train MOH personnel [in provision of long-lasting methods]. JHPIEGO could also assist the private voluntary family planning organizations improve their capacity to deliver long lasting methods [interval voluntary surgical contraception services] through training and technical assistance.

JHPIEGO has performed extremely well over the past six years. They were responsible for the design and implementation of the landmark rationale for high risk surgical contraception. The development of this concept and its acceptance by the GOP and MOH is key to USAID/Peru's population sector strategy which includes as one of its priorities an increase in the availability of long lasting contraceptive methods to meet

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the demand for these services. Were it not for this high risk rationale it would be extremely difficult to carry on surgical contraception in Peru.

Selection of participants for training [for the public sector] was based on a needs assessment for each region. Those most requiring training and in a position to use training were given highest priority with a final goal of training all health workers involved in offering family planning services. It is difficult to determine how many of those trained remain in the public sector. However, based on field observations, mission believes that most of those trained continue to offer family planning services. The training materials were adequate and the local and visiting staff conscientious in their supervision during the life of the project.

In the last four years JHPIEGO has been very effective in tracking/monitoring project activities. JHPIEGO staff are competent and responsive to mission and country needs.

Some delays were experienced in achieving programmed activities and results but the delays were related to the MOH's inability to fulfill its administrative/management responsibilities under the project not to any weaknesses observed in JHPIEGO's performance.

JHPIEGO's continued work in Peru is essential to assist the mission in carrying out its population sector strategy, specifically in the training of all levels of personnel in long lasting family planning methods.

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Asia

Fiji/Papua New Guinea

JHPIEGO in our experience has been one of the most helpful and constructive cooperative agencies of those working in the South Pacific. It has responded with initiative, flexibility and ingenuity in the past to programming needs of the region and has produced excellent well targeted projects that have been well accepted and highly praised by the health departments of the region. Initially focusing its programs on Fiji in the mid 1960s, it identified the need for regional training and with full mission support and concurrence, followed up with an excellently conceived project that identified promising local clinicians, both physicians and nurses, provided them complementary education to strengthen their skills and developed them into strong field resources for family planning training in Fiji and neighboring countries. Unfortunately, this promising effort had to be discontinued after the coup in Fiji despite its strong regional component.

Subsequently JHPIEGO was invited to focus its attention on Papua New Guinea (PNG), the largest country in the region and one with minimal family planning activities at that time (contraceptive prevalence in PNG was estimated at 3-5 percent). JHPIEGO implemented a number of carefully planned and well targeted activities that developed experience and credibility in PNG.

JHPIEGO's planning process has been systematic, collaborative and thorough, building on their previous regional and in-country experiences, closely examining the available data, and involving host country counterparts in both design and implementation. Additionally, it networks closely with other A.I.D. supported projects and international donors and collaborates/coordinates with them where possible and appropriate.

Implementation of recent JHPIEGO projects has been smooth and without major problems. JHPIEGO reliance on buy-ins has, however, limited utilization of JHPIEGO to the extent we would have desired, given its experience, capability and track record.

JHPIEGO's evaluations, despite being in-house in the South Pacific, have been straightforward and candid. In one case, the evaluation revealed the ongoing activity as premature and unlikely to have much effect, despite having initially appeared to both JHPIEGO and RDD/SP as being well targeted. JHPIEGO, in close collaboration with government, intensively reviewed the activity and modified it based on the finding. The subsequent activity was carefully crafted and seems likely to have a major impact. JHPIEGO, quite appropriately and professionally, uses evaluations as a management tool to improve the effectiveness of implementation.

Indonesia

Although JHPIEGO's role in the Indonesian program has been relatively limited over the past four years, the subject cooperative agreement has provided some valued and timely technical and training inputs. JHPIEGO's contributions have been important in meeting specific needs of the National Family Planning Program and the Mission Bilateral Project, and have been coordinated with AVSC, which has had a broader role during the agreement period. We also have perceived a welcome new JHPIEGO emphasis, led by [the project director] ... on service quality, prevention of complications and infection, in addition to the usual clinical training emphasis. This has complemented our mission stress on quality assurance.

Examples of JHPIEGO contributions in the past four years include 1) infertility center needs assessment [which] identified a number of issues related to VSC on service quality and patient follow-up; prevention of infection and other complications; appropriate use of anesthesia etc.; and 2) training of staff and technical assistance to repair and maintenance (RAM) centers.

Given that JHPIEGO's contributions in Indonesia have primarily been short-term technical assistance, our experience with their project planning, implementation and evaluation capabilities are limited. We have

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generally found the JHPIEGO staff responsive and the planning implementation skills we have seen seem solid.

On the other hand the number of JHPIEGO staff is small and their availability is limited, and not always at the time desired. Therefore, their capability to maintain inputs and follow through has been less than ideal. For example, although JHPIEGO staff agreed to coordinate development of a Norplant strategy here, they still have been unable to set dates for the follow-up work needed. We would recommend expansion of their staff if demand warrants it.

Overall, [we] look forward to continued availability of JHPIEGO resources.

Thailand

According to the Thailand Demographic and Health Survey (TDHS) of 1987, the leading contraceptive method currently used by married women is female sterilization. This is believed to be still true in 1991. JHPIEGO programs in reproductive health training, counseling, and support for the repair and maintenance center for laparascopic equipment will no doubt contribute to sustaining this nighly cost effective method [and] in sustaining the long standing Thai-US collaboration in family planning and in fostering the professional relationships between Thai and U.S. institutions in Human Resources Development.

The outstanding strength of the JHPIEGO project is that JHPIEGO staff members work closely with recipient institutes in designing and planning activities. JHPIEGO experts also monitor the project during implementation and provide very valuable to the JHPIEGO evaluation process have been conducted by very capable persons.

Tunisia

The Tunisian National Office of the Family Population (ONFP) is very interested in continuing and expanding its collaboration with JHPIEGO. Particular areas of interest are to develop new international training activities such as the training of trainers supervisors; the preparation of a practical training guide and a reference manual for training centers; and reinforce[ment of] family planning training for mid-wives and physicians.

Since the main JHPIEGO person sent to Tunis has considerable experience here, this has enabled easier contacts based on familiarity with the Tunisian family planning program, plus this person has experience with the fields of the required practical training.

JHPIEGO not particularly great at managing [illegible...cites some delays in equipment and supply shipments]. It would be advisable to send at least a month before the start of the seminar, the list of participants, their passports numbers (visas), any appropriate documentation and more importantly the practical training evaluation forms.

Overall, the ONFP and the mission have been pleased with JHPIEGO's performance.

Turkey

A number of constraints were faced in the implementation phases of JHPIEGO's projects; a major cause of these constraints was due to the rapid turnover of MOH's top level managers. We suggest JHPIEGO consider closer follow-up of ongoing projects to overcome such problems.

Embassy recommends JHPIEGO conduct an overall evaluation of its past and current activities in Turkey. This agency has been working in the country for several years and has initiated six subprojects in

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collaboration with MOH since 1988. We believe that an in-depth evaluation will contribute significantly to the future dimensions of activities.

Appendix N

Recommendations in Report

Appendix N

Reccomendations in Report[1]

PROGRAM MANDATE AND STRATEGIES

Recommendation to JHPIEGO:

1. Strategy-clarification. **JHPIEGO should engage in a "strategy-clarification" exercise to develop a set of strategies for working toward program objectives in the most cost-effective ways.** JHPIEGO should analyze its experience to extract lessons learned, but it should also look beyond its own experience to examine afresh evolving needs and possible new solutions. For each major program area, JHPIEGO should produce a short working paper in which the strategy, as well as pending issues, are set forth. Strategies developed should center on principles and processes that emphasize the importance of working from individual country needs; approaches should not be superimposed on countries. The deputy director for program management (to be appointed) should lead this exercise.

Recommendations to the Office of Population:

2. CA mandates. **The Office of Population should not try to define mandates so narrowly as would be necessary to prevent all overlap.** Nor should it prescribe roles so narrow that JHPIEGO and other CAs would be prevented from working with organizations with which they have long-term relationships and a natural entrée. Finally, **A.I.D. should not assume that having only one training project, or one training CA, would be a good situation, even** though this would minimize issues of overlapping mandates.

3. CA sharing of training expertise. **The Office of Population should find effective ways to facilitate sharing of expertise among its training CAs.** The following are appropriate topics: counseling; improving clinic management; clients' perspective regarding quality of service; IUD insertion, management and removal; infection prevention; management of genital tract infections in family planning service settings; curriculum development; development of effective simple training aids; natural family planning; management of family planning service delivery systems; family planning commodities management; supervision; and competency-based training and evaluation.

TRAINING MATERIALS AND METHODS

1. Revision of manuals. **JHPIEGO should continue to subject its current training manuals to the process of assessment, revision, field-testing, and revision.** Some changes are recommended below; others have been suggested in the text.

- Training and reference manuals should describe acceptable alternatives to ideal practices whenever possible in order to make it as easy as possible for developing country institutions to use them.

- Documents that seek to establish standards should attempt to motivate compliance with those standards by explaining clearly why each recommendation is necessary.

- JHPIEGO (and other CAs) should include names of authors and/or contributors on the inside cover of a manual. To minimize inter-organizational resentment when adapting materials developed by another organization, names of the original authors should be retained as part of the credit given the organization whose material is adapted.

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[1]Recommendations in boldface are the principal recommendations in this report.

2. Counseling, quality control and clinic management. **JHPIEGO should expand its attention beyond the technical aspects of the physical care of individual clients and give more emphasis to training in counseling, quality control and clinic management.** Where possible, it should incorporate materials already developed by others (with proper attribution) or collaborate with Cas specialized in these areas.

3. IUD training. **JHPIEGO should continue to play its key role in reviving the IUD and promoting its widespread availability and acceptability.** It should clarify lessons it has learned in the process of standardizing IUD training and services and use these for advancement of other contraceptive methods such as Norplant. Results from the Thai study (which documented IUD insertion competency after only a few insertions in actual clients by trainees who had used anatomic models for acquisition of initial skills) should be published, the study repeated elsewhere and, if results are similarly positive, incorporated into new standards for IUD training.

4. GTI management and infection prevention. **JHPIEGO should continue its work in infection prevention and the management of genital tract infections in family planning service settings.** Further work is needed on the issue in the Infection Prevention manual of soaking in bleach. If the standard is found to be absolutely necessary, the manual should be revised to communicate the need so effectively that it will be followed.

5. General training skills. **JHPIEGO should develop greater clarity and competence regarding the general training skills needed to design and implement a training program.** It should finish, circulate, and field test the draft manual which has long been under development.

6. Distribution of teaching aids. **JHPIEGO should assess the need and demand for the training products it has already developed** (manuals, slide sets, videos, and anatomic models) and **make a plan to produce and distribute large enough quantifies of these materials to meet the need** for them in a far more comprehensive way. Plans for low-cost publication of the Infection Prevention manual should be pursued.

7. Audio-visual materials. **JHPIEGO should produce more slide sets and videos to use in training.** (Slides would be a good adjunct to training materials related to differential diagnosis of cervical abnormalities.) JHPIEGO should get technical input from Johns Hopkins' Population Communication Services Project in this area.

8. Evaluation of the cervix. JHPIEGO should study the issue of cervical ectopy and decide how to advise clinicians in developing countries to proceed when they encounter a client with red, inflamed-appearing tissue surrounding the cervical os but no other signs and symptoms of vaginitis and/or cervicitis. JHPIEGO should seek help from outside experts to decide this. It should then revise its IUD and GTI training materials to incorporate this advice.

9. Screening for cervical cancer. The use of pap smears as a mass screening method for pre-cancerous conditions of the cervix is beyond the capacity of most developing countries. JHPIEGO should evaluate, by clinical research or pilot project(s), the value of gross inspection in the early diagnosis of cancer of the cervix. Subsequently, if proven advantageous, gross screening of the cervix for suspected cancerous lesions can be added to the GTI manual.

10. Emergency treatment of septic and incomplete abortion. JHPIEGO should prepare a training module for the emergency treatment of septic and incomplete abortion. Wherever possible, this clinical training should be planned and carried out in conjunction with activities (including those sponsored by other organizations) to provide post-abortion contraceptive counseling and services.

11. National family planning service guidelines. **A set of agreed-upon and appropriate standards of family planning clinical practice must exist to serve as the basis for all clinical work,** both in the classroom and in the family planning clinic. If guidelines don't exist, they should be developed.

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12. OPTEL (PC teleconferencing). JHPIEGO should try to find an appropriate cost-effective use for its OPTEL installation in Cairo. JHPIEGO should continue to share the teleconferencing facilities of the University of the West Indies and use evaluations from this system to assess its value. **OPTEL should *not* be extended to other countries until the usefulness and cost-effectiveness of this currently expensive communications method is evaluated more completely.** OPTEL should be installed in additional countries only when it can be demonstrated to have an important role in a larger, clearly articulated strategy in the proposed country. Ideally, this should be not only a JHPIEGO strategy but a country strategy.

PRE-SERVICE EDUCATION: INSTITUTIONALIZING FAMILY PLANNING EDUCATION IN MEDICAL, NURSING, AND MIDWIFERY SCHOOLS

1. Need for clear strategy. **JHPIEGO should articulate a "Strategy for Institutionalizing Reproductive Health and Family Planning in Medical, Nursing, and Midwifery Schools."** This should be a "working paper" based on lessons learned and related analysis; many statements may need to be viewed as hypotheses and subjected to objective validation. The working paper should be revised as JHPIEGO's understanding grows of what works best. As with all JHPIEGO's standardization work, this should embody adaptation of a general approach to local circumstances; a strategy does not mean "cookie-cutter" imposition of a single model.

2. Family planning basic knowledge for all health professionals. **Ultimately, in all countries *basic family planning and reproductive health care knowledge and values* should be part of the pre-service curricula for *all* medical, nursing, and midwifery students. Inclusion of *clinical* training should be determined on a country-by-country basis in accord with provider roles in the country's family planning services.**

3. Setting priorities: Choice of schools. **JHPIEGO should try to influence all schools of a category (e.g., medical, midwifery) in a country.** In countries without a uniform curriculum (which is the majority), JHPIEGO should work with leading schools able to influence others. Alternatively, or in addition, JHPIEGO should work with the organizations which accredit the schools (as it is doing with the Philippine midwifery schools) or with the organization which controls the national licensing or certification examination, where such exists. **JHPIEGO should give priority to schools whose graduates are most likely to fill positions that require the ability to provide family planning services.** This will vary from country to country, but is more likely to include midwives and less likely to include nurses.

4. "Academic skills". **JHPIEGO should provide "academic skills" training only under certain conditions. It should evaluate its experience to determine whether, and when and how, "academic skills" training is cost-effective.** A basic criterion should usually be that faculty members to whom "academic skills" are taught should each have a high proportion of students going on directly to work in family planning.

5. External advice on core knowledge and competencies. **JHPIEGO should bring nursing/midwifery/physician educators, clinicians and service administrators together to identify "core knowledge" and "core competencies" that graduates of pre-service programs should have.** Pre-service curricula should be based on a clear understanding of the roles, functions and tasks for which the students are being trained and the level of competence expected of new graduates. Tutors in pre-service educational programs need to understand the demands of the jobs their graduates will fill. Prototypic curricula for nurses, midwives, and physicians will all be different.

6. Pre-service education of doctors. **JHPIEGO should prepare a prototypic curriculum for medical students in their pre-clinical years.** This should be done in conjunction with external advisors. Like all prototype materials, this would need to be adapted or used in each country through a process that instills a sense of ownership among the local counterparts. Prototypic family planning modules for medical students should include: rationale and indications for family planning; contraceptive methods; advice giving; gender sensitization; and introduction to clinical skills (IUD and Norplant insertion and removal, male and female sterilization).

7. Clinical preceptors. JHPIEGO should continue to explore training and use of clinical preceptors to mentor and supervise students (i.e., courses that do not center on classroom teaching but emphasize "coach"-type methods, management of a clinical practicum, and assessment of clinical skills).

8. Nursing and midwifery education. JHPIEGO should consider midwifery education separately from nursing. Relatively few nurses fill jobs which require clinical family planning service delivery skills. In contrast, most midwives are directly involved in providing basic reproductive health care to women. Thus, in most countries it is desirable for midwives to become competent family planning service providers during their pre-service training. For pre-service training intended to provide family planning service competency, it may be worthwhile to try to improve the faculty members' training skills. However, it is probably not cost-effective for JHPIEGO to invest time and resources trying to improve the teaching methods of nursing school teachers.

9. Pre-service education of nurses. Efforts to improve the family planning content of pre-service nursing education and training should be directed to:

- Providing accurate information about the effectiveness and mode of action of all traditional and modern methods of family planning used in the country;

- Providing accurate information about the laws and rules which regulate family planing service delivery in the country;

- Developing positive attitudes about family planning and its contribution to the health of women and children and the well-being of families and society;

- Developing competency in communication and counseling skills;

- Giving students some experience in counseling and/or client education regarding family planning, and

- Exposing students to positive models of nurses playing roles in the delivery of family planning services.

10. Pre-service education and training of midwives. **JHPIEGO's mandate concerning pre-service education should explicitly include midwives.** JHPIEGO should develop prototypic curricula in accord with principles recommended above.

11. Pharmacists. **JHPIEGO's mandate for pre-service education should be expanded to include pharmacists.** During their pre-service training, pharmacists should be given information about family planning as well as learning experiences to help them develop pro-family planning values and IEC skills.

12. General. Support to include or strengthen family planning in the pre-service education of health workers who will not be providing family planning services should be limited to curriculum development and provision of carefully-selected teaching aids (e.g., videos, slide sets). A limited amount of training in effective teaching methods might be provided as an adjunct to curriculum development.

IN-SERVICE TRAINING OF DOCTORS, NURSES, AND MIDWIVES

1. Needs assessment. **In-service training should be based on objective data regarding the pre-service training, numbers, roles and general performance of the various categories of health professionals and other workers who might participate in the provision of contraception. It should also focus on strengths and weaknesses of current family planning service systems,** including evidence of safety or lack of safety and evidence of effectiveness (i.e., contraceptive prevalence and method-specific continuation rates).

2. Training of Trainers. **JHPIEGO should develop a consensus regarding who should be recruited and developed as trainers.** This should explore whether it is better to:

- start with a proficient clinician and try to add training skills, or

- start with training proficiency (a good teacher) and provide technical inputs regarding the technical subject, or

- train a proficient trainer to teach the didactic aspects and use proficient clinicians as clinical preceptors (i.e., to supervise, teach, and mentor trainees during their clinical learning experience).

JHPIEGO should consider a strategy to develop as trainers selected supervisors of family planning and primary health care service providers (perhaps in combination with clinical preceptors).

3. "Master trainers." **JHPIEGO should reach consensus (at least preliminary) on what needs to be included in the training of trainers of clinicians and of master trainers.**

- JHPIEGO should develop a definition of "master trainer." This should address the following questions: Does a master trainer need to be able to train clinicians, train other trainers (i.e., TOT), conduct training needs assessments, and develop curricula to address newly identified training needs? Does a person who is able to train clinicians and other trainers but does not have curriculum development skills qualify as a "master trainer"?

- JHPIEGO might consider a middle position with regard to the question of whether all master trainers should have curriculum development skills: namely, that a select few but not all of the trainers in each institution should be given these skills. This would permit institutionalizing a training capability without overburdening the training program for master trainers.

4. Streamlining to improve efficiency of training. JHPIEGO should refine its thinking about and develop clearer strategies for "removing inefficiencies" in-service training. This should be linked to improved needs assessment and country strategies.

5. Training in Baltimore. In general, people should be trained as close to their own work environments as possible. An exception might be when training them at a distant site can expose them to family planning service delivery or training models that are not available in their own countries.

6. Regional/international training centers. **JHPIEGO should carry out a systematic assessment of the strengths, weaknesses, effectiveness and impact of its efforts with the regional (international) training centers it helps to support** and base future activities on this analysis. Activities JHPIEGO seeks to undertake with these centers should be coordinated with country strategies and concurred in by the local USAID mission. A designation such as "JHPIEGO-Affiliated Training Center" should be used in place of "JHPIEGO Training Center."

7. In-service training of physicians. In developing new in-service activities, JHPIEGO should look for government or major private sector initiatives to increase use of a particular contraceptive method, understand through needs assessment which providers can have the greatest impact with regard to the method, and plan training as part of a strategy aimed at a countrywide impact.

9. Trainee selection and follow-up. **For any courses it presents or supports, JHPIEGO should have good criteria for trainee selection,** i.e., criteria that relate training directly to service delivery or country strategies, **and seek to accept only trainees who meet these criteria.** (These criteria might be included in each training package.) JHPIEGO should try to develop some practical strategies for it and host-country training institutions to use to address "trainee follow-up" issues.

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10. Institutionalization of in-service training. **JHPIEGO should develop a strategy for institutionalization of in-service training (including host-country management of in-service training).** It should analyze its experience to date with activities aimed at institutionalizing in-service capabilities. It should consider developing a clear "two-track" strategy -- "direct" training plus parallel systematic efforts at institutionalization.

MANAGEMENT STRUCTURE, PROCESSES, AND ISSUES

1. Staffing and management development. **The project director should not be obliged to change his modus operandi or to reduce the amount of time he spends in the field. However, there must be a deputy director with authority to make decisions in his absence.** If the two new deputy director positions are appropriately filled, this strengthening at the top level may prove a good formula for success. Follow-through of these plans must be monitored.

2. Relationship to Johns Hopkins University

a) **Scientific Advisory Committee (SAC).** JHPIEGO should develop a strategy to add to the SAC a group (or sub-groups) of technical experts knowledgeable in aspects of family planning education, training, and service delivery who can augment JHPIEGO's own staff in needed areas. This would require adding persons from outside Johns Hopkins University. Serious consideration should be given to including representation from the Center for Communication Programs on the SAC.

b) **Restructuring of the Board of Trustees** should take place in concert with plans to bring additional technical expertise onto the SAC. International family planning experts should be chosen with great care. They should be in agreement with JHPIEGO's new directions and ideally should come from a major BIG country.

3. Use of Host Country Personnel.

a) Project/Country directors. JHPIEGO should examine each of its country programs in which there are two or more Project Directors, and in close consultation with the respective USAID mission, discuss the possibility of placing or hiring an in-country representative. The decision should be based on the need to facilitate coordination between JHPIEGO projects, the need to identify and remove medical or legal barriers to contraceptive use, and to focus the JHPIEGO country program and ensure that it complements the USAID country strategy.

b) JHPIEGO should articulate a development-oriented philosophy as a guiding principle for its work and then develop an approach as to how to implement this in its activities. This would be an appropriate follow-on to the organization development work JHPIEGO has undertaken during 1991.

c) JHPIEGO should look beyond the upper academic levels to identify younger, rising professionals who could broaden JHPIEGO's base of activities and help expand country commitment to improving reproductive health care.

d) JHPIEGO should consider some strategy for bringing together developing country experts who can infuse the organization with greater developing country input and perspective. Something along the lines of the earlier International Advisory Council (IAC) might be the answer.

4. Country or Regional Representatives/Advisors. **JHPIEGO should consider, in consultation with local USAID missions, whether its impact could be increased by placing representatives in specific countries.** A.I.D. should not force a country advisor or regional representative structure on JHPIEGO. If persons are to be hired for these positions, it is essential they have the appropriate combination of skills.

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IMPACT AND EVALUATION

1. **A.I.D. and JHPIEGO need to develop new indicators for project effectiveness and impact (beyond simple figures such as "numbers of courses" or "numbers of people trained").** Expected program outputs should be phrased not only in terms of quantities; achievements must have qualitative measures as well.

2. **JHPIEGO's Monitoring and Evaluation staff should have a major role in helping set priorities and articulate strategies for JHPIEGO's program and its various components.** Design and evaluation should go hand in hand. An immediate task for the office should be to finalize its preliminary framework for evaluation and begin pulling together data and descriptions in a way that facilitates program decision-making.

RECOMMENDATIONS FROM APPENDICES

1. JHPIEGO and the IUD: JHPIEGO should continue to play its key role in reviving the IUD and promoting its widespread availability and acceptability. It should clarify lessons it has learned in the process of standardizing IUD training and services and use these for advancement of other contraceptive methods such as Norplant.

2. A paper which reports results from the Thai study (which documented IUD insertion competency after only a few insertions in actual clients by trainees who had used anatomic models for acquisition of initial skills) should be submitted to The Lancet or another highly respected and widely distributed medical journal. In the meantime, JHPIEGO and its Thai colleagues should present results of that study to WHO and ask WHO to collaborate in a study which attempts to replicate the Thai findings elsewhere. If findings prove similar, JHPIEGO should ask WHO to revise its IUD insertion training standards and methods.

3. JHPIEGO should encourage its physician director to continue his interest in applying the model described above and align his administrative and other responsibilities to permit his "hands on" involvement with programs in the field so they may continue to evolve and improve.

4. Family planning guidelines or standards. A set of agreed-upon and appropriate standards of family planning clinical practice ("practice guidelines" or "national family planning service guidelines") must exist to serve as the basis for all clinical work, both in the classroom and in the family planning clinic. Implemented properly, national standards can link training to service delivery and increase contraceptive prevalence. If guidelines don't exist, they should be developed.

5. Concerning pre-service nursing education in general:

a) In countries where all nursing schools follow a standard curriculum, it is important and cost-effective to direct efforts at strengthening the reproductive health/family planning content of the pre-service nursing curriculum through curriculum revision augmented by the development of complete and detailed lesson plans. In most countries, the appropriate objectives of such efforts should be:

- To develop positive attitudes about family planning and its contribution to the health of women and children and the well-being of families and society;
- To provide accurate information about the effectiveness and mode of action of all traditional and modern methods of family planning used in the country;
- To provide accurate information about the laws and rules which regulate family planning service delivery in the country;

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o To expose students to positive models of nurses playing roles in family planning service delivery.

b) Competence in the provision of family planning services should rarely be an objective of the pre-service education of nurses.

6. Regarding JHPIEGO pre-service efforts in the Philippines:

a) JHPIEGO and the ADPCN should postpone or abandon plans to develop family planning *clinical skills electives* in nursing colleges. Graduates who want to have a career in family planning can take the DOH in-service comprehensive family planning course.

b) JHPIEGO should *not* direct additional resources toward improving teaching skills of faculty members of the Philippine nursing colleges, except through the development of additional detailed lesson plans.

7. Country training strategies. The training strategy for each country should be based on systematic, objective information (data) about: (1) the pre-service training, numbers, roles and general performance of the various categories of health professionals and other workers who might play roles in the provision of contraception; and (2) strengths and weaknesses of existing family planning service delivery systems, including evidence of safety or lack of safety and evidence of effectiveness (such as contraceptive prevalence and method-specific continuation rates).