

**JHPIEGO**  **TECHNICAL REPORT**



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for International Education  
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**EVALUATION OF PHASE I:  
STRENGTHENING  
VOLUNTARY STERILIZATION SERVICES  
IN THE PHILIPPINES**

*by*

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# PREFACE

"Strengthening Voluntary Sterilization Services through Standardization of Training" (TCA-90) is a JHPIEGO-sponsored project with the Fertility Care Center (FCC) in Metro Manila, Philippines. This project is part of a major collaborative planning effort by the Government of the Philippines (GOP) to strengthen and expand (VS) services throughout the country. This is a two phased project and this evaluation of the accomplishments of the first phase was planned to ensure that the second phase of the project proceeds successfully.

AVSC conducted the first phase of a training evaluation study in December, 1992. Given that the two organizations are collaborating to standardize VS training in the Philippines, it was deemed appropriate to also standardize the evaluation process. Thus, a similar strategy and data collection tool were used to conduct the evaluation. In both evaluations, two groups were interviewed using a structured questionnaire. The first group was service providers trained by FCC's master trainers; the second group was the master trainers themselves. The information presented in this report was collected using both qualitative and quantitative methodologies including: review of documentation, informal discussions, structured interviews and observation.

The evaluation results are organized to reflect the training evaluation framework that USAID and many USAID-supported training Cooperating Agencies (CAs) have agreed to use. The levels of evaluation include: needs assessment/training strategy; inputs; processes; outputs; outcomes/impact. The priority evaluation questions that were addressed in this evaluation using this framework are:

- ◆ Is the FCC's training selection process appropriate and has it been followed?
- ◆ Is the training process effective in producing providers skilled in minilaparotomy under local anesthesia (ML/LA)?
- ◆ Are the trainees using the skills acquired after training and if not, why not?
- ◆ Have trainees retained the skills they acquired during training?
- ◆ Are the services being provided by trainees having an impact on (or have the potential to impact) the national family planning (FP) program?

The major findings of this evaluation were as follows:

- ◆ Through observation and interviews it is apparent that the training provided at FCC is of good quality.

- ◆ Although in general the service providers trained thus far were providing minilap services before their training, minilap training at FCC has influenced these providers to perform procedures under local anesthesia/sedation rather than under spinal/general anesthesia
- ◆ In addition, all centers to which trainees return are now using improved infection prevention procedures.
- ◆ As training activities continue, and trainees not previously providing minilap procedures are trained, the magnitude of the outcome of this project should be increased.
- ◆ Prior to this evaluation, almost all trainees had been contacted by phone by FCC staff. This informal follow up was useful to FCC in assessing the short term outcome of their training.
- ◆ The service provision volume of the non-governmental organizations (NGOs) is too low for them to undertake their own training activities.
- ◆ In addition, due to changes in government policy towards reimbursements for VS services, many NGOs do not have the funding to underwrite neither service provision nor training activities.
- ◆ It is far too early for TCA-90 to have had a large (observable) impact on national service statistics. The project does represent, however, an investment toward the quality of VS procedures that will be performed in the future.
- ◆ At the pre-service level, the project is having impact in that residents are now being trained in local anesthesia procedures. This will result in reduced operating time and lower costs in these facilities.

## **LIST OF ABBREVIATIONS**

|                |   |                                                                                |
|----------------|---|--------------------------------------------------------------------------------|
| <b>AVSC</b>    | - | <b>Association for Voluntary Surgical Contraception</b>                        |
| <b>CA</b>      | - | <b>Cooperative Agreement (with USAID)</b>                                      |
| <b>CYP</b>     | - | <b>Couple Years of Protection</b>                                              |
| <b>DOH</b>     | - | <b>Department of Health</b>                                                    |
| <b>FCC</b>     | - | <b>Fertility Care Center</b>                                                   |
| <b>FP</b>      | - | <b>Family Planning</b>                                                         |
| <b>FPLM</b>    | - | <b>Family Planning Logistics Management Project</b>                            |
| <b>FPOP</b>    | - | <b>Family Planning of the Philippines</b>                                      |
| <b>GOP</b>     | - | <b>Government of the Philippines</b>                                           |
| <b>IMCH</b>    | - | <b>Institute of Maternal and Child Health</b>                                  |
| <b>JFH</b>     | - | <b>Jose Fabella Hospital</b>                                                   |
| <b>JHPIEGO</b> | - | <b>Johns Hopkins Program for International Training in Reproductive Health</b> |
| <b>JSI</b>     | - | <b>John Snow, Inc.</b>                                                         |
| <b>LA</b>      | - | <b>Local Anesthesia</b>                                                        |
| <b>LGU</b>     | - | <b>Local Government Units</b>                                                  |
| <b>MCHSDI</b>  | - | <b>Maternal and Child Health Service Delivery Inc.</b>                         |
| <b>minilap</b> | - | <b>Minilaparotomy</b>                                                          |
| <b>MJH</b>     | - | <b>Mary Johnston Hospital</b>                                                  |
| <b>ML/LA</b>   | - | <b>Minilaparotomy Under Local Anesthesia</b>                                   |
| <b>NGO</b>     | - | <b>Non-Governmental Organization</b>                                           |
| <b>Ob/Gyn</b>  | - | <b>Obstetrician/Gynecologist</b>                                               |
| <b>POGS</b>    | - | <b>Philippines Obstetrics and Gynecology Society</b>                           |
| <b>QA</b>      | - | <b>Quality Assurance</b>                                                       |
| <b>SP</b>      | - | <b>Service Provider</b>                                                        |
| <b>TCA</b>     | - | <b>Third Cooperative Agreement</b>                                             |
| <b>TOT</b>     | - | <b>Training of Trainers</b>                                                    |
| <b>UPPGH</b>   | - | <b>University of the Philippines Provincial General Hospital</b>               |
| <b>USAID</b>   | - | <b>United States Agency for International Development</b>                      |
| <b>VS</b>      | - | <b>Voluntary Sterilization</b>                                                 |

# **EVALUATION OF PHASE I:**

## **Strengthening Voluntary Sterilization Services in the Philippines**

### **INTRODUCTION**

"Strengthening Voluntary Sterilization Services through Standardization of Training" (sub-agreement TCA-90) is a JHPIEGO-sponsored project with the Fertility Care Center (FCC) in Metro Manila, Philippines. This project is part of a major collaborative planning effort by the Government of the Philippines (GOP), in collaboration with JHPIEGO and the Association for Voluntary Surgical Contraception (AVSC) to strengthen training in voluntary sterilization (VS) services in the Philippines. This effort, in turn, is part of a larger GOP plan to strengthen and expand VS services throughout the country. JHPIEGO's eighteen month project is being conducted in two phases, the second phase was due to start in January 1994. This evaluation of the accomplishments of the first phase was planned to ensure that the second phase of the project proceeds successfully.

AVSC conducted the first phase of a training evaluation study in December, 1992, to ascertain if their training strategies were viable and to identify any infrastructural issues that affected the ability of providers to apply their skills on the job. The results of that evaluation are summarized in a trip report by J.L. Griffin and E. Landry (AVSC, December, 1992). Given the collaborative nature of JHPIEGO and AVSC's training efforts, and the fact that the VS training itself is standardized between the two organizations, it was deemed appropriate that the evaluation activities also should be comparable. Thus, a similar strategy and data collection tool were used to conduct the outcome/impact component of this evaluation. It is anticipated that future evaluation activities will continue to reflect the collaborative nature of this project.

### **EVALUATION METHODOLOGY**

The evaluation results in this report are organized to reflect the training evaluation framework that USAID and many USAID-supported training Cooperating Agencies (CAs) have agreed to use (including AVSC and JHPIEGO). The levels of evaluation include the following: needs assessment/training strategy; inputs; processes; outputs; outcomes/impact. The priority evaluation questions that were addressed using this framework are:

- ◆ Is the FCC's training selection process appropriate and has it been followed?

- ◆ Is the training process effective in yielding providers skilled in minilaparotomy under local anesthesia (ML/LA)?
- ◆ Are the trainees using the skills acquired after training and if not, why not?
- ◆ Are the services being provided by trainees having an impact on (or have the potential to impact) the national family planning (FP) program?

The information presented in this report was collected using both qualitative and quantitative methodologies including: review of documentation, informal discussions, structured interviews and observation. Structured interviews—which were the main source of data on the outcome and impact of FCC’s training—also were conducted by AVSC during their December, 1992 evaluation. Two groups were interviewed using a structured questionnaire designed specifically for each target group. The first group was service providers trained by FCC’s master trainers; the second group was the master trainers themselves.

## RESULTS

### *Needs Assessment/Training Strategy*

In 1988, JHPIEGO completed a *Reproductive Health Training Sector Assessment for the Philippines* (in collaboration with in-country experts). This assessment was updated in 1992 and formed the basis upon which TCA-90 was developed. A VS training strategy was outlined by the GOP in 1990/91 to expand the country’s training capacity and the number of clinicians available to provide VS services. The strategy focused on giving opportunities to both the public and non-government organization (NGO) sectors through technical assistance from AVSC and JHPIEGO, respectively.

The TCA-90 project includes activities aimed at strengthening the capacity of non-government institutions (the most active FP NGOs in particular) to provide quality VS training and services. Six potential NGO training sites were identified as focal points for training assistance in the sub-agreement:

- ◆ Ago Medical Center in Bicol Region
- ◆ Sacred Heart Hospital in Cebu City
- ◆ Brokenshire Hospital in Davao City
- ◆ Brent Hospital in Zamboanga City
- ◆ IMCH in Santiago Isabela
- ◆ Bethany Hospital in Tacloban City

It also was recommended that the service providers participating in FCC courses be from the following institutions: Mary Johnston Hospital-Fertility Care Center (MJH-FCC); University of the Philippines Provincial General Hospital (UPPGH); Family

Planning of the Philippines (FPOP), the Institute of Maternal and Child Health (IMCH), and Integrated Maternal and Child Health Service Delivery Inc. (MCHSDI). This last recommendation was, in fact, incorporated into FCC's training strategy and representatives from all of these institutions have been involved in their training activities.

Since the project was first conceptualized, a number of events have taken place which have affected the appropriateness of the original training strategy (and the corresponding project activities):

- ◆ Decision-making in the health arena in the Philippines has been partially decentralized to the local government units (LGU)
- ◆ In August, 1992, the Secretary of Health (Dr. Flavio) decided that health institutions would no longer be reimbursed by the government (through USAID funding) for VS procedures. Instead, NGOs were encouraged to charge for VS services to cover their costs. Consequently, a guaranteed source of financial support for FP among the NGOs was taken away which negatively affected their capacity to routinely provide VS services.
- ◆ The six NGO institutions that were initially identified to function as regional training sites were selected based on prior VS performance. Given the current problems among NGOs supporting VS services, however, it is unclear whether it is still feasible for these facilities to serve this function.
- ◆ The DOH decided that training would no longer be separate for the public and NGO sectors. This means that FCC can provide training to public providers whenever appropriate (and vice versa).

Despite the socio-political events identified above, the FCC—in order to fulfill its commitments outlined in the sub-agreement—developed a number of strategies to identify potential NGO training candidates. The strategies have been successful to varying degrees, although, to date, the FCC always has been able to fill its **service provider** training courses with candidates. A brief description of the sources that FCC has used to identify training candidates is provided below. The focus on NGO sources reflects the initial training strategy of the project (and, correspondingly, of the GOP).

### Sources of Trainees

One source that the FCC had turned to for NGO candidate trainees was the *Philippine Directory of NGOs for Health*, compiled for the First National Convention of NGOs for Health in July 1990. 243 NGO institutions, organizations, etc. are listed in this directory, which is organized by region. A reduced list of NGOs that participate in FP was developed from this directory in early 1993. This was done in consultation with John Snow (JSI)'s Family Planning Logistics Management (FPLM) Project staff and

includes all facilities that receive contraceptives from FPLM. Clinics that receive supplies from other sources (e.g., private practitioners) are not included in this list, although this information is available from the Philippines Medical Association.

Eight major NGOs involved in FP service delivery were targeted for training by the FCC. The estimated number of facilities per NGO that are likely to provide VS services now or in the future (i.e., hospitals and/or pericultural centers) is listed in **Table 1**. The proportion of these that currently have a physician qualified to provide VS services (and, therefore, are actually **eligible for training**) varies by NGO group. For some, this proportion is fairly low, and for other NGOs, they have not yet completed an assessment of the capability of their institutions to provide VS services. Therefore, a more accurate estimate of the number of physicians actually eligible for training was not available.

In light of the GOP policy change which eliminated reimbursements for VS procedures, many facilities currently do not have the financial resources to provide VS services (even if there is a trained provider). For this reason, requests for training have not been readily forthcoming from many NGO's. This problem was identified by many interviewees during this consultancy. It was noted repeatedly that interest among NGOs to send qualified physicians for training would increase substantially if support for VS services (for supplies, etc.) to facilities were guaranteed after training. Demand among the NGO client population seems to have decreased in recent years due to both socio-religious and economic reasons; with the provision of facility support for supplies, however, at least one source of constraints would be reduced.

To supplement the list of NGOs serviced through FPLM, another list of private hospitals (compiled by the Department of Health) was obtained by the FCC. Six hundred twenty four: primary (1°), 338 secondary (2°) and 133 tertiary (3°) facilities are included on this list (organized by region). Given that only 2° and 3° level hospitals are likely to provide VS services, the total number of private hospitals from which candidates could be selected is reduced to 471 (**Table 2**). Assuming that there is a minimum of two physicians that could be trained per facility, the pool of candidate physicians from private hospitals could be as high as 1,000. It is likely, however, that some physicians from NGO facilities also serve the private hospitals. In addition, this estimate assumes that all 2° and 3° facilities will begin or are providing VS services; this is unlikely, however, as some facilities do not provide contraceptives for religious reasons and others do not do so because of a lack of demand and/or financial constraints. The target number of private facility physicians to train, therefore, could be substantially less than 1,000.

**Table 1**

**Summary of NGO and LGU Training Plans**

| <b>Organization</b>  | <b>No. of Facilities</b> | <b>Date Contacted by FCC</b> | <b>Number of VS Facilities</b> | <b>Response to training invitation</b> | <b>No. of Candidates Proposed</b> | <b>No. Trained</b> | <b>No. Scheduled</b> |
|----------------------|--------------------------|------------------------------|--------------------------------|----------------------------------------|-----------------------------------|--------------------|----------------------|
| <b>NGO</b>           |                          |                              |                                |                                        |                                   |                    |                      |
| FPOP                 | 31                       | 8/92; 3/93                   | 7                              | Yes                                    | 11 teams                          | 1                  | 10                   |
| DND                  | 22                       | 8/92; 3/93                   | ?                              | Yes                                    | 1 team                            | 0                  | 1                    |
| IMCHSDI              | 84                       | 8/92; 3/93                   | Possibly 24                    | No                                     | 0 teams                           | 0                  | 0                    |
| IMCH                 | 169                      | 8/92; 3/93                   | < 10                           | Yes 5/93                               | 2 teams                           | 0                  | 2                    |
| CMPDA                | 6                        | 8/92; 3/93                   | ?                              | Yes 1/93                               | 3 teams                           | 3                  | 0                    |
| DOLE                 | 61                       | ?                            | ?                              | No                                     | 1 team                            | 0                  | 1                    |
| PCPD                 | 86                       | ?                            | 1 soon                         | No                                     | 0 teams                           | 0                  | 0                    |
| PRRM                 | 3                        | 9/92                         | 0                              | Yes 1/93                               | 1 team                            | 1                  | 0                    |
| <b>TOTAL</b>         | <b>462</b>               |                              |                                |                                        | <b>19 teams</b>                   | <b>5</b>           | <b>14</b>            |
| <b>Government</b>    |                          |                              |                                |                                        |                                   |                    |                      |
| Local City (Large)   | 66                       | Informally                   | ?                              | Yes                                    | 3 teams                           | 3                  | 0                    |
| Provincial Governors | 74                       | 7/93                         | ?                              | No                                     |                                   |                    |                      |

**Table 2**  
**Licensed Private Hospitals (1991)**

| <b>Region</b> | <b>1<sup>o</sup></b> | <b>2<sup>o</sup></b> | <b>3<sup>o</sup></b> | <b>Total</b> |
|---------------|----------------------|----------------------|----------------------|--------------|
| I             | 38                   | 22                   | 6                    | 66           |
| II            | 30                   | 11                   | 1                    | 42           |
| III           | 53                   | 51                   | 10                   | 114          |
| IV            | 51                   | 59                   | 19                   | 114          |
| V             | 62                   | 24                   | 8                    | 94           |
| VI            | 13                   | 7                    | 10                   | 30           |
| VII           | 20                   | 15                   | 14                   | 49           |
| VIII          | 11                   | 12                   | 2                    | 25           |
| IX            | 33                   | 14                   | 2                    | 49           |
| X             | 72                   | 25                   | 7                    | 104          |
| XI            | 130                  | 19                   | 9                    | 158          |
| XII           | 67                   | 20                   | 6                    | 93           |
| CAR           | 19                   | 12                   | 1                    | 32           |
| NCR           | 25                   | 47                   | 38                   | 110          |
| <b>TOTAL</b>  | <b>624</b>           | <b>338</b>           | <b>133</b>           | <b>1,080</b> |

In the initial project strategy developed by JHPIEGO and FCC, it was suggested that only hospitals accredited (as training facilities by the Philippines Obstetrics and Gynecology Society [POGS]) be targeted for VS training during Phase I of the project. The names and addresses of all 62 accredited training facilities were compiled by POGS and published in the 1992 Annual POGS Convention Report. Twenty-two percent (22) of these training facilities already had been contacted by the AVSC-supported Jose Fabella Hospital (JFH) for training at the time of this consultancy.

A letter was sent out in late 1992 by FCC to 150 of the 471 2<sup>o</sup> and 3<sup>o</sup> level hospitals that are accredited. FCC indicated that approximately 20% of the facilities contacted responded to their invitation and most of these had been targeted for future courses. To date, a provider team has been trained by the FCC in standardized minilap

using local anesthesia (ML/LA) procedures in 7/150 (4.6%) of the private 2<sup>o</sup> and 3<sup>o</sup> level facilities contacted. The service providers trained to date, however, came mostly from just the **training** hospitals. This was the strategy promoted in the project agreement because these providers are in a position to impart minilap skills to their medical residents (thus increasing the potential multiplier effect of the FCC's training). **A follow-up of the remaining 80% of the hospitals is required to determine whether minilap training is needed by these facilities, and if not, why not.**

Currently, minilap training is being provided to medical residents in some training institutions. Thus, the institutions where these physicians become employed may not perceive a need to take advantage of the FCC's training. (This was explained to the evaluation team by the physicians interviewed in one of the private medical hospitals.) The number of private facilities that should be targeted for training, therefore, may be below 150.

In addition, although the FCC provides standardized training in ML/LA, it was explained that some private physicians are not interested in using local anesthesia (LA) because their patients are "used to" having the procedure with general anesthesia (or using spinal anesthesia). The costs associated with minilap services could be reduced significantly, however, if the procedure was done using LA. If cost factors are, in fact, a major constraint among the private sector client population, switching to LA could result in substantial cost savings to the client. This is an important strategy for these private facilities to consider in an effort to increase demand for this procedure among their patients.

The amount of time saved by doing the procedure with LA was discussed with one trainee during the follow-up site visit at a private hospital. She estimated that the cost of doing a minilap using spinal anesthesia was three times that using LA. Furthermore, on the average, minilap under LA took 3-4 hours whereas, with general anesthesia, the patient had to remain in the hospital for 24 hours. The latter involves fees to the anesthesiologist, more medication and higher hospital stay costs. (The evaluation team mentioned that it would be useful to conduct an operations research study to document the actual cost savings realized with ML/LA. This information could then be shared with other private and NGO institutions in a conference [or as part of a cost-recovery workshop] as a means of promoting ML/LA training.)

As noted earlier, in June, 1993, the strategy to separate training of public versus non-public VS providers was reversed by the Secretary of Health. Another potential source of candidate trainees for the FCC, therefore, is government (including LGU) physicians. There are approximately 60 large cities throughout the Philippines, each with a minimum of one physician—and some with many more (e.g., Manila). There are smaller cities also, many of which have physicians that might be eligible for VS training in the future. FCC already developed a list of potential training candidates from each of the large cities and a letter of invitation was sent out to them in June, 1993. Two physicians from LGU facilities were involved in the training course that

was ongoing during this consultancy which suggests that this strategy for identifying additional VS training candidates is viable.

A negative side of the national policy of "devolution" (i.e. decentralized planning) for the FCC is that, whereas previously they had obtained direction from the national FP program, under the new system support for their FP activities must be obtained from any LGU where they intend to work. And, according to some sources, the city mayor for Manila does not seem to be very supportive of FP. The FCC, therefore, cannot conduct promotion activities in the area immediately surrounding the clinic (e.g., Tondo—a high need area). Efforts to increase its client load, therefore, need to shift to other, more receptive cities.

In addition to Jose Fabella Hospital (JFH), AVSC training takes place at six regional government training institutions throughout the country. Now that public and private VS training no longer need to be separate, it is possible that these AVSC-supported regional institutions can meet the training needs for VS services in those areas. **FCC, therefore, should concentrate its efforts on other areas of the country where no regional training capacity currently exists.** This was recommended by the USAID Mission/Philippines and is being looked into jointly by JHPIEGO and AVSC's country representatives.

### ***Inputs***

#### **Staff**

Currently, there are three physician master trainers and four nurse master trainers working full-time at FCC. Three other physician trainers are strengthening their skills so that there will be six full-time physician master trainers available to conduct courses at FCC. It was anticipated in the project agreement that six master trainers would be available for training sooner than they actually were. This did not happen because the TOT workshops, which the additional master trainer candidates were to assist with, were not conducted as scheduled (see **Outputs** below).

#### **Educational Materials**

It was anticipated that the following items would be among the training materials used in the service provider training courses: Minilap Reference Manual (developed jointly between AVSC and JHPIEGO); Minilap Course Handbook for participants; and Minilap Course Handbook for trainers. The reference manual (a document that came out of a joint (AVSC\JHPIEGO) FCC/JFH standardization workshop) was still under review by the DOH at the time of the consultancy. Thus, the FCC planned to use the draft guidelines developed in January, 1993 for their courses until the official version was published and available. The course handbooks were developed between September, 1992 and January, 1993 and were available in time for FCC's first course; they have been used as FCC training materials ever since.

## Educational Equipment

Minilap kits are given to all participants who are assessed as competent at the completion of the course. Unfortunately, the kits were not available in time for the first four courses at the FCC because they had been mistakenly shipped by JHPIEGO to the FCC directly (instead of to a tax exempt address). The kits had arrived by the time of the consultancy and were distributed to the former participants.

## Other Educational Supplies

There were four rooms and one conference center in which the classroom portion of the training course could be carried out. There were three Zoë pelvic models which were being used for practice, one of which was kept in the conference room so that participants could practice while they were waiting for clients. The evaluation team was told that the other two models had not been used very much, which suggests that FCC is not doing VS training to its maximum capacity. At the time of the consultancy, however, other training courses are being conducted as part of JHPIEGO's TCA-52 sub-agreement (Family Planning Services Practicum) with FCC (i.e., reversible methods). The same classrooms and master trainers were used to teach both courses, which cut down on their availability for VS training.

## Client Training

In terms of FCC's client population, many patients come from the surrounding area (e.g., Tondo), although a significant proportion also come from outside Manila (e.g., referrals from satisfied clients and those who know that there is no fee for services at FCC). FCC staff estimated that, in the past, 30% of all clients were walk-ins and the other 70% were referrals (50% from satisfied clients, 20% from other agencies). Referral information is routinely obtained from the client registration card which one of the nurse master trainers (Mrs. Valles) used to analyze on a periodic basis. Efforts to increase its client load were made by FCC after Dr. Margolis conducted an evaluation visit, and were intensified when Dr. Garcia came on board as a master trainer. FCC anticipated a 50% -100% increase in its case load in the next few years as a result of its outreach activities.

According to FCC staff, approximately 100 clients per month come through the FCC, 80% of whom are interested in VS. These FP clients are carefully screened (the husband is encouraged to come to the counseling sessions) and, on the average, 50% are assessed as appropriate VS clients. These estimates were confirmed by FCC's monthly statistics for 1992 and 1993 (see **Table 3**). The client load at FCC for all methods used to be much larger as reflected by the trend in services over the past two decades (**Figure 1**). Reasons for the drastic reduction in VS client load include:

- ◆ An increase in the number of other clinics in and around Manila that provide VS services (by people trained at the FCC in the past)
- ◆ The opening of Mary Stopes clinic in Manila (where the clinic pays money to motivate clients)
- ◆ Clients used to come by bus from outside Manila and many of the procedures were done by itinerant teams trained by FCC. Over the years, many of these providers have left practice or gone abroad, and, consequently, the network for referring clients is no longer available. Furthermore, there is no other funding for client transport.

The client load referred to in the sub-agreement is 20 clients per day for 62 days. This is an unrealistic client load that FCC has not experienced since the 1970's when cases were performed by laparoscopy (which is a much faster procedure and requires far fewer personnel). Even with a 100% increase in client population, it is unlikely that the FCC would have more than 120 clients/month, or five to six VS clients per day. At the time of the consultancy, FCC was sending its trainees to UPPGH to receive additional clinical experience whenever there were not enough VS cases scheduled during the training period. As of July, 1993, this had only been required for one of the four training courses.

The University of the Philippines Provincial General Hospital (UPPGH) has an average client load of approximately 1,000 VS clients per year. The number of procedures completed during a few months in 1993 in this facility also is indicated in **Table 3**. As noted, UPPGH's numbers are higher than those for FCC. During a facility assessment visit made to UPPGH by the evaluation team (during which the adequacy of the site for clinical training was assessed), the staff there explained that client demand for VS services had been low in 1993 due to problems with supplies. Despite the fact that the clinic is part of the University Department of Ob/Gyn, they are not provided with funding (or supplies) and, clients, therefore, must bring their own supplies. When the FCC used the UPPGH for training earlier in 1993, supplies for the procedure were provided by the FCC. Based on interviews conducted by the evaluation team, it was apparent that both FCC and UPPGH were in favor of making a formal arrangement whereby UPPGH could be used as a satellite clinical training site. This arrangement would have the additional advantage of providing more post-partum clients for training as FCC's clients undergo mostly interval procedures).

**Table 3**

**FCC's Monthly VS Statistics - 1992/1993**

| Yr | J  | F  | M  | A  | M  | J             | J  | A  | S  | O  | N  | D  | TOTAL |
|----|----|----|----|----|----|---------------|----|----|----|----|----|----|-------|
| 92 | 66 | 57 | 63 | 32 | 54 | 26            | 37 | 45 | 64 | 65 | 38 | 24 | 571   |
| 93 | 48 | 59 | 37 | 37 | 65 | not available |    |    |    |    |    |    |       |

**UPPGH Monthly VS Statistics - 1993**

| YR | J             | F | M | A  | M  | J  | J             | A | S | O | N | D | TOTAL |
|----|---------------|---|---|----|----|----|---------------|---|---|---|---|---|-------|
| 93 | not available |   |   | 66 | 75 | 83 | not available |   |   |   |   |   |       |

Considering UPPGH's client load, the maximum number of VS clients that would be available for training by FCC per month (assuming 100% increase in demand at FCC) is about 200 (or 10 per day). This estimate does not take into consideration the fact that UPPGH is a pre-service training institution where 20 residents per year are trained in minilap as part of their Ob/Gyn rotation. In order to accommodate both in-service and pre-service training demands at UPPGH, a number of the VS clients (e.g., 200 per year) would have to be "reserved" for the residents. Client demand for VS services at UPPGH could increase if support for supplies were provided, although with only one operating room (with three beds), it is unlikely that more than approximately 10 procedures could be scheduled on any one day. The estimate of 10 providers is based on the following calculations: nine cases/two hours (assuming 40 min. including prep time/case); max six working hours/day = 18 clients/day. With only a half day available during training course periods (i.e., mornings for surgery and the afternoons for classroom), the maximum time available for training at UPPGH would be 3½ hrs/day (18 clients × .58 day = 10.4 clients).

### Statistical Graph of New Acceptors VS (Female)

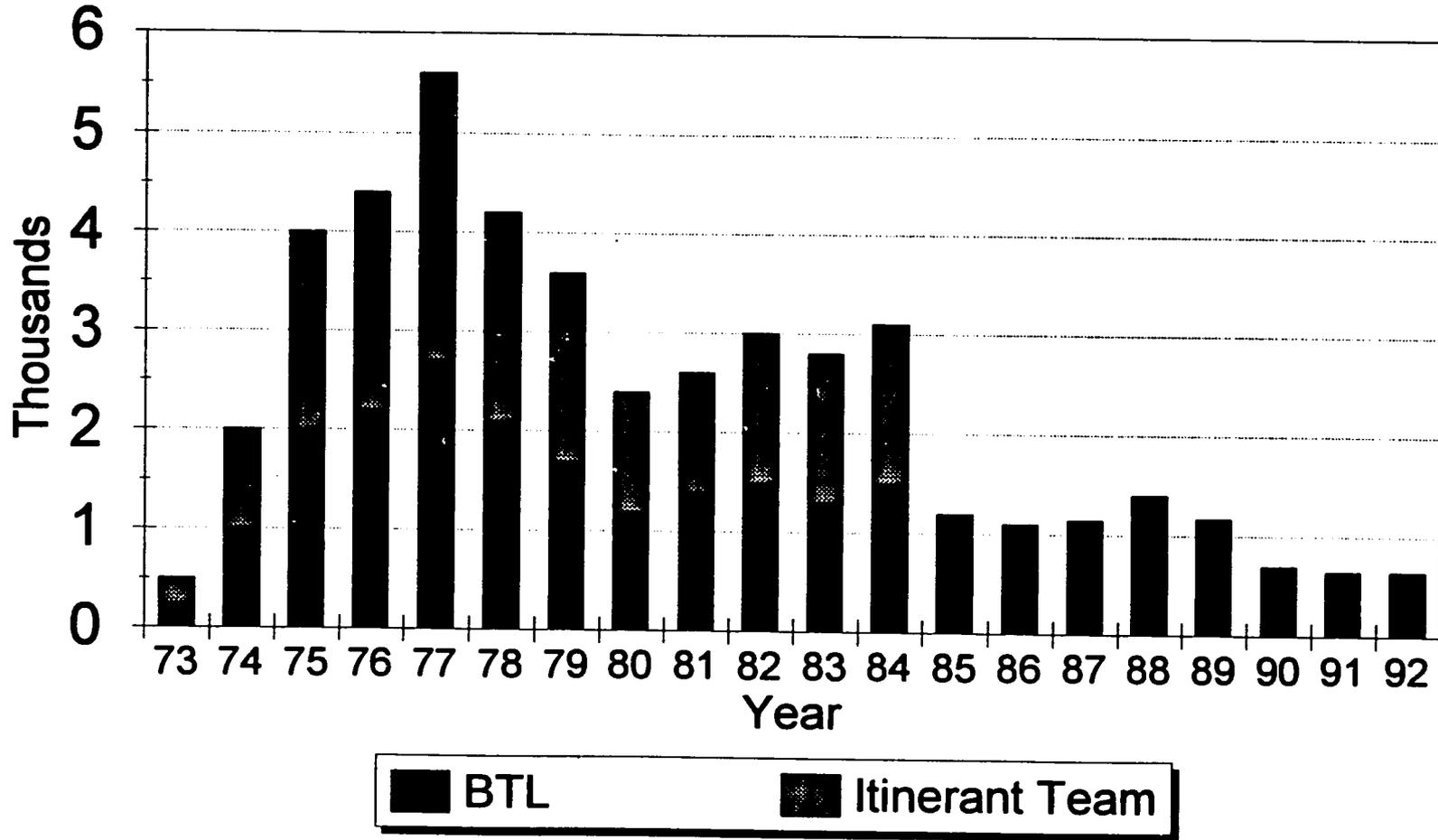


FIGURE 1

Fertility Care Center  
Mary Johnston Hospital

## ***Training Process***

### **Knowledge/Competency**

Levels of participant knowledge and competency are routinely assessed during FCC's courses using instruments incorporated from JHPIEGO's prototypic training materials. Scores for the mid-course (knowledge-based) questionnaire for the four provider courses that had been conducted by the time this consultancy was carried out are listed in **Table 4**. FCC staff explained that a review session is scheduled immediately after the exam is taken so that the material can be discussed with the participants. The reference manual is available for review during the session so that the participants know where to look up the correct responses. A few questions in particular were routinely answered incorrectly which led the master trainers to review the wording of the questions. These were subsequently altered to render the questions less ambiguous. As noted in **Table 4**, the mid-course scores were fairly low for some participants, which suggests that the trainers had not been as effective as they could be in transferring important knowledge. **Although these deficits in knowledge are made up during the post-exam review session (as promoted by JHPIEGO), strategies to improve initial mid-course questionnaire scores still need to be identified.**

**Table 4**

#### **Score on Mid-Course Questionnaire**

|              | <b>JANUARY</b> | <b>FEBRUARY</b> | <b>MARCH</b> | <b>MAY</b> |
|--------------|----------------|-----------------|--------------|------------|
| <b>Range</b> | Not completed  | 10-14           | 8-15         | 10-13      |
| <b>Mean</b>  | Not completed  | 12.5            | 12.3         | 11.5       |

Each participant is given the opportunity to gain competency in minilap skills through practice on the Zoë model and subsequent practice on clients. A minilap checklist is used for assessing competency at the end of the course. All of the participants were assessed as competent before returning to their home facility. **The training process used at FCC, therefore, is effective in producing providers skilled in ML/LA.** The range in number of procedures that participants needed to complete in order to achieve competency/proficiency during the four training courses is provided in **Table 5**.

**Table 5**

**Course Practice Procedures**

|              | <b>JANUARY</b> | <b>FEBRUARY</b> | <b>MARCH</b> | <b>MAY</b> |
|--------------|----------------|-----------------|--------------|------------|
| <b>Range</b> | 4-7            | 5-6             | 3-5          | 8-14       |
| <b>Mean</b>  | 5.5            | 5.75            | 4.6          | 10.6       |

Although JHPIEGO's programming policy is for participants to complete whatever number of procedures is needed to achieve competency, the GOP Guidelines state that 10 procedures should be completed for providers to be **government-certified** as competent. As the table indicates, fewer procedures were needed among course participants to become "competent." For providers who complete the course but do not achieve competency, FCC provides a certificate of attendance for participants as documentation for their parent organizations. In addition, for providers who do not achieve competency during the two-week course, FCC gives them an opportunity to continue practicing their skills at FCC (or UPPGH) until competency is achieved. This was only needed for one team so far (May's course, thus explaining the substantially increased mean number of practice procedures).

Participant Satisfaction

Satisfaction with the VS training course is documented by FCC using an end-of-course evaluation form (Table 6). The paper copies of this tool are stored in files containing other course documentation. As noted, the average scores were generally high for all the questions asked. Participant satisfaction with each session is also assessed verbally throughout the course; these results are not documented in writing but the results are incorporated into planning for the remaining course sessions.

**Table 6**

**Course Evaluation Scores**

The course was evaluated using the following questions. Participants were asked to rate their opinion of the following course components using the following scale:

**5-Strongly Agree    4-Agree    3-No Opinion    2-Disagree    1-Strongly Disagree**

| <b>COURSE COMPONENT</b>                                                                                                                                             | <b>MEAN RATING</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| 1. The Pre-Course Questionnaire helped me to study more effectively.                                                                                                | 4.1                |
| 2. Ten days were adequate for learning how to provide minilaparotomy services to clients.                                                                           | 3.8                |
| 3. The role play sessions on counseling skills were helpful.                                                                                                        | 4.0                |
| 4. There was sufficient time scheduled for practicing counseling through role play and with clients and/or volunteers.                                              | 3.6                |
| 5. The teaching slide set helped me to get a better understanding of minilaparotomy procedures prior to practicing with the pelvic model.                           | 4.1                |
| 6. The practice sessions with the pelvic model helped me to learn the steps of the minilaparotomy procedure more effectively prior to practice with actual clients. | 4.2                |
| 7. There was sufficient time scheduled for performing minilaparotomy under local anesthesia with clients.                                                           | 4.7                |
| 8. I am now confident in performing minilaparotomy under local anesthesia.                                                                                          | 4.0                |
| 9. The infection prevention review and practice session was helpful.                                                                                                | 4.5                |

***Outputs***

**Courses/Trainees**

**i) Service Providers**

According to the sub-agreement (TCA-90) developed between JHPIEGO and FCC, training of service providers was supposed to begin in December 1992. The first service provider (SP) training course was conducted one month late with two teams of providers. The first course was postponed in order to provide time for the FCC master trainers to become proficient in their training and minilap skills. Each SP training course is supposed to include three teams, but as the January course was the first (pilot) course, only two teams participated. One of the two physician providers in this course had no previous minilap (and minimal recent

surgical) experience, whereas the other was routinely providing minilap services (but not using the standardized technique). By including these two teams, the usefulness of the course to physicians at both ends of the spectrum of experience could be assessed. They found that both types of providers could acquire competency using the training course materials.

In the next scheduled course (February) four teams attended and in the subsequent two SP courses (carried out in March and May 1993) three provider teams attended (as targeted). **Thus, FCC conducted the expected target number of SP training courses and trained the number of provider teams agreed upon in the sub-agreement.** This was accomplished within a five month time-span (versus four as planned).

Four items on the participants' course registration form were reviewed for nine trainees to assess the appropriateness of FCC's selection criteria (Table 7). The selection criteria promoted by FCC for participants in the SP course followed the DOH guidelines: a specialist Ob/Gyn, surgeon or general practitioner with surgical experience (evidenced by submitting certified copies of five hospital records of major operations done within the prior three months).

As seen in Table 7, The majority but not all of the trainees whose registration form was reviewed had had previous gynecological surgery. FCC staff explained that they ask those applicants who do not meet the DOH's criteria to expose themselves to/assist with a few surgical cases before attending the course. The evaluation team felt that surgical experience was important as a selection criterion because those with little experience require more practice to become both competent and confident in minilap. With low caseloads as a potential training problem for FCC and any VS training site, the team concluded that FCC's selection criteria of prior surgical experience was appropriate.

**Table 7**

**Select Criteria for Choosing Trainees**

These 9 trainees are not exactly the same as those interviewed during the consultancy visit.

|                                                     | <b>Yes</b> | <b>No/Not Noted</b> |
|-----------------------------------------------------|------------|---------------------|
| <b>Was a teacher in a pre-service institution</b>   | 2          | 7                   |
| <b>Had previous gyn. surgery (in last 3 months)</b> | 6          | 3                   |
| <b>Had previous minilap experience</b>              | 4          | 5                   |
| <b>Had previous course in training skills</b>       | 2          | 7                   |

## ii) Trainers

Two Clinical Training Skills Workshops were scheduled to be conducted in the first phase of the project. The first workshop—planned for November 1992—did not take place because JHPIEGO's expert trainers from the US were not available and the course materials were not yet ready. A workshop to train trainers was scheduled for July, 1993, and was re-scheduled for August due to time conflicts with the student trainers. The SP course that was supposed to be linked with the trainer's workshop in July was carried out anyway (and was ongoing during the evaluators' consultancy) because: it had been scheduled (and participants had been invited); and it provided the other three master trainer "candidates" with additional practice so that they could function effectively as trainers during the next phase of the project. The output of the training skills workshop and accompanying SP course was to be four competent trainers and five competent service provider (SP) teams. Four SP teams were trained during the July course but no clinical trainers were trained.

To be eligible to attend a FCC trainer's workshop, a service provider must successfully complete a two-week standardization course. The selection of candidate trainers also is based on whether they are in a position to train other providers at their institution. This was explicitly stated in the project sub-agreement as follows: "that trainers be individuals from large NGOs with large family planning service systems or highly motivated individual practitioners who have a site which could feasibly be used to train significant numbers of providers from the private sector."

In terms of identifying potential trainers who meet these criteria, however, the pool of candidates is fairly small because only 12 providers had been trained by the time of this consultancy by FCC in the standardized technique, and no refresher training course (for providers who are doing minilaps but not using the standardized technique) had yet been conducted. One such refresher course was scheduled for November 1993. As of July, 1993, two candidates for FCC's refresher course already had been identified by Jose Fabella Hospital staff. Some of the recently trained providers expressed interest in taking the trainer's workshop, but it was difficult for them to arrange to get (an additional) three weeks off of work. AVSC/JFH support a **one-week** training of trainers (TOT) workshop, an alternative which should be looked into by JHPIEGO as a means for training providers who are qualified candidates but who cannot arrange to get three weeks of time off. Jose Fabella Hospital's TOT is not linked to a two week SP course (as is FCC's) and the student trainer receives his/her training practice during the one week workshop. The FCC is actively trying to identify trainer candidates for future TOT events through telephone

interviews (during which the provider's ongoing involvement with minilap services is assessed). The trainers for the training course in August had been identified and were among those trained in one of the SP courses in Phase I.

iii) Cost Strategies

A cost recovery strategy workshop for 12 participants was supposed to be conducted in October 1992; this was intended as a forum for developing plans to implement cost recovery interventions among NGOs. The workshop was not held as planned because JHPIEGO was in the process of identifying and hiring an in-country representative. Given, however, that financial constraints among NGOs is a major reason why client demand is low and, correspondingly, why demand for training among NGO service providers has been slow, there is a clear need for this type of a workshop. A cost-recovery workshop just for VS services was scheduled by JSI for July, 1992 to which many of the NGOs involved in FCC training were invited to attend. The need for other workshops on this subject to be scheduled as part of TCA-90's activities depends on the outcome of the August event.

iv) Quality Monitoring System

A quality assurance (QA) workshop was scheduled to take place in December, 1992, for 16 participants. The purpose of the workshop was to delineate appropriate QA monitoring strategies for the public and private sectors. The need for such strategies was identified in August, 1992, during the joint FCC/JFH standardization workshop. The QA workshop did not take place as planned for the same reason as noted above (for the cost-recovery workshop) and because the first training course was late in being implemented. The QA strategy that was identified during the consultancy for FCC to use in the future:

- ◆ Is an indicator-based system
- ◆ Involves continual assessment of different components of the service provision system
- ◆ Includes review of QA reports at a monthly staff meeting.

Because QA is an area of concern to USAID/Philippines, the above strategy was discussed and agreed upon between FCC staff and the evaluation team during this consultancy. Follow-up will be needed to ensure that this strategy is being followed at FCC.

### ***Outcome/Impact***

Follow-up of service providers after training was scheduled for February, 1993. By that time, however, only two SP courses had been completed. Given FCC's training schedule and the fact that procedures were being done by graduate trainees only on an infrequent and unpredictable basis at their home facilities, follow-up of trainees at the time of this consultancy had only been conducted via telephone (within a month or so of training). In addition, FCC staff noted that they were waiting for the VS guidelines to be printed and distributed by the DOH before initiating follow-up visits *as stipulated* in the project sub-agreement with JHPIEGO. On-site follow-up visits were conducted as part of this evaluation consultancy, all of which were jointly conducted by one of the three FCC master trainers. Nine out of twelve teams trained were visited during this consultancy.

As noted in the introduction, the questionnaire used to interview trainees during the follow-up visit was similar to that used by AVSC during its December, 1992 evaluation. Based on suggestions by the AVSC evaluation team, observation of minilap procedures by a clinical evaluator was included as part of JHPIEGO's evaluation strategy. Due to a lack of clients at the provider institutions, however, only two trainees' minilap skills could be observed during this consultancy. Both were judged to be competent in all aspects of minilap services. **This confirms that FCC's training is effective and that trainees, if they perform procedures and are able to use their skills post-training, maintain competency in the procedure.**

In summary, the provider interviews revealed that:

- ◆ FCC's strategy of sending invitation letters to facilities was successful in producing candidate trainees.
- ◆ All trainees understood the objectives of the course and the major objective—the ability to competently perform ML/LA—was met in all cases.
- ◆ Prior surgical (especially minilap) experience was an advantage in acquiring ML/LA skills considering caseload available during the course period.
- ◆ Competence in skills does not necessarily come with confidence to apply these skills post-training. A lack of confidence was associated with a lack of prior minilap experience and, in particular, with little prior surgical experience.
- ◆ Use of the model helped trainees gain both competence and confidence.

- ◆ Competence in local anesthesia skills is not enough to change minilap practices in some facilities. Trainees need additional support from the FCC to incorporate LA (versus general or spinal anesthesia) as part of routine VS services (especially in private facilities).
- ◆ All trainees wanted more follow-up and felt that such follow-up would increase the extent to which they used their skills post-training.
- ◆ The major impediment to increased VS services in trainee facilities was the cost to the client of the procedure.

In short, only some of the trainees were using their skills post-training. Those that were not had problems in their facilities in terms of a lack of demand for the method (as a reflection of the inability to pay for the procedure rather than disapproval of the method). The impact of FCC's training at the time of the consultancy, therefore, had been minimal in terms of FP program indicators such as couple years protection (CYP). For FCC to increase its potential to have impact, it must adopt a selection strategy that also considers the demand for VS services in candidate institutions. Support for VS supplies, etc. in trainee facilities (post-training) would aid considerably in this regard.

The master trainer interviews revealed that:

- ◆ Training in training skills prior to conducting clinical courses was useful in building their confidence and improving their training styles.
- ◆ FCC should focus its selection strategy to identify candidates who can acquire ML/LA skills in the time allotted and who are likely to use those skills post-training.
- ◆ Due to current problems nationwide with the inability of potential VS clients to pay for services, training should be conducted should only where the caseload is sufficient. Regional training would be appropriate only where an adequate training caseload could be guaranteed.
- ◆ Follow-up site visits soon after training (i.e. within six months) are necessary to improve both the outcome and the impact of training.