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RETHINKING PRIMARY HEALTH CARE TRAINING



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“VIEWPOINT”

Rethinking PHC Training

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RETHINKING PHC TRAINING

The effectiveness of primary health care (PHC) interventions depends not only on what is done but on how well and how widely it is done. In most programs that aim to improve the quality and coverage of PHC services in developing countries, training is a major component. Those involved in PHC recognize the importance of training; however, they continue to struggle to maximize the contribution of training to overall PHC development. Some of the major training-related challenges facing PHC planners and managers are summarized here. Several of the issues we discuss have been addressed in the professional literature, but many have to date been unpublished topics of discussion among PHC managers, other public health professionals, and international technical assistance agencies. We bring them together in this paper as a series of questions, to stimulate further discussion and action in the public health community. Each question is relevant both to basic (or preservice) training and training that occurs after health workers have taken up their posts (inservice training). We focus on inservice training of health personnel in the public (government-supported) sector, and draw our examples from African countries.

QUESTION 1:

Is training alone the solution to problems in the delivery of primary health care?

When a health service delivery problem is identified, the immediate response is often to initiate or expand an inservice training program. While inservice training can improve health worker knowledge and skills,^{1,2} the ability to perform a task correctly does not in itself guarantee that services of adequate quality will be provided.^{3,4,5} In both Côte d'Ivoire and Niger State, Nigeria, health workers were capable of providing correct case management of children with fever and diarrhoea after participation in an inservice training program. However, shortages of oral rehydration salts in Nigeria and antimalarial drugs in Côte d'Ivoire precluded their delivery of correct treatment in health facilities.⁶ Monitoring of health service delivery in Mozambique found that over 50% of performance problems were attributable to inadequate logistic support. Effective technologies, availability of commodities, support for health personnel, community involvement, and adequate resources are necessary if health worker skills are to result in improved service quality.⁴

A first and continuing step in the improvement of a health care system is to diagnose the nature, extent, and etiology of service delivery problems. If inadequate skills or knowledge are identified as part of the problem, training will be required but should be sequenced appropriately relative to other strategies to improve the quality of services provided. For example, inservice training of personnel should ideally be done before community education designed to improve service utilization, and after the institution of a system that ensures the availability of needed supplies and drugs.

Training may or may not be an appropriate solution for a particular problem in the provision of PHC services, and training is rarely the only solution to such problems.⁷ Ministries and their technical assistance partners must reexamine their allocation of resources to ensure that new skills gained through training are supported in field sites by adequate commodities and other necessary PHC system elements.



QUESTION 2:

Is technology transfer the most important goal of inservice primary health care training?

During the 1980s, inservice training activities for PHC emphasized the transfer of skills in simple child survival technologies and basic management techniques to health personnel in developing countries. Training modules were developed that presented standard case management algorithms for diarrhoea and malaria, and target-setting, monitoring, and logistics management for individual PHC program areas. These modules have been used widely to introduce new technologies and lay the foundation for country specific problem-solving.

In the 1990s, additional skills in public health planning, management, and problem-solving will be needed.^{3,5,7,8,11} Program managers need to be equipped to develop culturally-specific and responsive approaches to meet continuing and new public health challenges such as malaria, tuberculosis, and sexually transmitted diseases including HIV disease. Since July 1991, malaria program managers from most francophone African countries have been developing these skills through a "Malaria Initiative" designed by African Ministries of Health, the World Health Organization, the Centers for Disease Control and Prevention, and the U.S. Agency for International Development. The program is being carefully monitored and evaluated for its potential contributions to other disease interventions.

As illustrated by the Malaria Initiative, in addition to the transfer of technologies and techniques, inservice training programs will be increasingly challenged to develop skills in policy formulation, the analysis and use of data, and broader management areas such as human resource development, budget and finance, commodities, physical infrastructure, and working effectively with families and communities. In the Central African Republic, for example, primary health care managers are conducting a review of their essential drugs program that includes an assessment of current policies, an audit of commodities across various PHC interventions, and an analysis of alternative cost-recovery mechanisms.

QUESTION 3:

Do workshops constitute an inservice training program?

When Ministries of Health and donors consider inservice training, they often think of and plan for discrete, time-limited activities such as workshops or seminars. Effective training requires the assessment of needs leading to the development of learning objectives, and plans for monitoring and follow-up. Field follow-up that includes on-site refresher training is an essential component of inservice programs.^{8,9} It is still not uncommon for teams external to Ministries of Health to initiate workshops without spending sufficient time to conduct or review local needs assessments, or to assist the MOH in developing mechanisms, funding, and commitment for field application of new skills.

Effective training also requires the evaluation of health worker competence at different points in time.² Health workers participating in an inservice training program in Nigeria, for example, were evaluated using measures of both knowledge and skills at three points: before training, at the close of the training period, and several months later in field settings. Results demonstrated that while dramatic improvements in skills can result from training programs, all material covered in the curriculum is not mastered by participants.² Appropriate and feasible methods for conducting such skill-based evaluations need to be developed and applied.

Discussion of both field follow-up and efforts to address managerial, administrative, and resource constraints on health worker performance frequently revolve around the need for improved supervisory systems. While African program managers have recognized that effective supervision is critically important for improving and maintaining the quality of PHC services, few countries have been able to develop sustainable supervisory systems that meet the needs of front-line health workers. Examples of sustained, effective supervision need to be documented, because supervision could potentially enhance the positive effects of discrete workshops and address other performance constraints at the point of service delivery.¹⁰ Resources must be invested in operational research on appropriate models for combined training and supervision strategies to improve and maintain health worker performance,^{11,12} and mechanisms for financing these activities.

Workshops alone do not constitute a training program. A broader definition of the term “training” should incorporate needs assessment and planning, field follow-up, and evaluation. More effort should be directed to the development of strategies that complement training, such as supervision.

QUESTION 4:

Are standardized curricula the most cost-effective means of transferring new technologies to large numbers of health workers?

Challenged by the need to train the greatest number of people as quickly as possible to use various simple technologies of PHC, international agencies have invested in the development, testing, and dissemination of standardized curricula that include both content and suggested teaching methods. The perceived advantages of these materials are that they can be:

- targeted to different levels in the health delivery system;
- adapted to local situations by trained ‘facilitators’ who have limited expertise in adult education;
- incorporated quickly into training programs at minimal cost to Ministries of Health, because they obviate the need for each country to invest time and resources in developing their own curricula; and
- used to promote procedures consistent with international health standards.

There are also limitations of pre-packaged materials. Their pre-determined content, format, and instructions to trainers often fail to take into account the existing skill levels of trainees. For example, some target-setting manuals seriously overestimate the level of quantitative skills of district personnel,² and management training materials often do not take realistic account of the limited managerial autonomy available to district personnel.⁷ Training materials designed for use in both classroom and health facilities are often not adequately explained and demonstrated during training and are therefore infrequently used in the field.

While there is certainly standard information that will not vary across cultural or administrative systems, training materials need to be responsive to changing public health needs and priorities, which do vary widely by country and level of health system development. Although there are increasing efforts to support local adaptation of standardized materials¹³, success will require building national capacity, supporting the adaptation process, and ensuring that there is local “ownership” of the adapted materials.

One question that is rarely posed is whether any written materials are necessary for effective PHC training at peripheral levels. Most developing countries have a strong tradition of oral learning in formal and non formal settings. In Mozambique, a provincial inservice training center used progressively fewer external materials as the focus shifted to the most peripheral health facilities, and trainers and trainees alike posed the question “how can we explain this concept or technique to mothers, using resources available in our place of work?”.¹⁴ Future curricula may not include formal written teaching materials, but instead a reduced set of pictorial job aids and teaching support documents.

Ministry of Health personnel in some African and Asian countries have developed their own curricula, and expressed a keen interest in further developing their skills in this area.^{15,16,17} Development of training content within country allows the context of training to be taken into account, so that health workers are taught at an appropriate level and pace to carry out tasks that are feasible. While the development of custom made materials at the national level may demand significant time and resources, the benefits that accrue to learners and to Ministries of Health through trainers’ intimate involvement in the design of curricula, teaching methods and materials, as well as their delivery, may have significant implications in the long term for the sustainability of PHC programs.^{18,19}

Given the difficulty of producing and updating materials, the advantages and disadvantages of different types of materials such as modular training aids, quick reference materials, and manuals or checklists of program norms, should be evaluated.²⁰ Further research is needed to determine how and to what extent written materials can assist both trainers and learners in the mastery of skills essential to PHC programs.

Standardized curricula are not necessarily the most cost-effective approach to PHC training in the long term. It may be that we need to develop more trainers with skills in curriculum design, delivery, and evaluation, and fewer prepackaged materials. Further research is needed on alternative models for curriculum development at various levels of the health system.

QUESTION 5:

Is the inclusion of participatory methods in a curriculum sufficient to ensure effective learning in training programs for primary health care?

The presence of training methods that encourage active participation by trainees in the learning process (e.g., role plays, demonstrations, problem-solving exercises in small groups) is often equated with state-of-the-art PHC training. However, the method used is less important than the quality of the teaching. Participatory methods are difficult to master, particularly when trainers themselves have been educated didactically. Brief training of trainers sessions are rarely adequate to learn how to use participatory teaching techniques well; effective teaching will require more intensive opportunities for practice, team-teaching, and modeling. The Teaching Primary Health Care Course offered by the Liverpool School of Hygiene and Tropical Medicine devotes three months to teaching these skills to PHC personnel from developing countries.

Teaching methods must be carefully selected to fit the kind of learning that is sought; the degree of experience, confidence, and comfort level of the trainer; the training time available; and the diversity of participants (e.g., language, seniority, gender) in a given training setting. Teaching methods found effective in transferring procedural skills may need to be adapted or refocused to address critical thinking and problem-solving skills.^{11,21} For example, if African program managers responsible for malaria and tuberculosis programs are to respond swiftly to changing patterns of resistance to medicines, the presentation and discussion formats often used to build skills in commodities distribution will need to be supplemented with paper and pencil sessions devoted to the practice of data summary and interpretation skills.

The inclusion of participatory methods in a curriculum does not in itself guarantee effective learning. Planners should analyze the skills and experience of available trainers and identify the methods needed to achieve the learning objectives.¹⁸ If participatory methods are called for, planners should either invest sufficient time and resources to ensure effective use of such methods, or find the next best alternative that can be implemented well by available trainers.

QUESTION 6:

If we transfer technical skills to people in more responsible positions, will they in turn transfer these skills to those with whom they work?

The assumption that “cascade” or “trickle-down” training will occur often determines the selection of participants for workshops and seminars. Persons who are in charge of health centers or specific programs are repeatedly invited to attend workshops with the assumption that they will train colleagues upon returning to their place of work. For workshop participants to transfer skills and knowledge to others, they must have the authority and resources to organize inservice training at the local level and to provide associated follow-up; they must be able to use needed teaching techniques effectively; they must recognize training as a valued part of their job descriptions; they must not feel threatened by passing on information and skills which they may regard as privileged commodities; and they must receive support and encouragement from their supervisors.⁴¹ Few of these conditions are taken into consideration in most “cascade”-type training programs, so it is not surprising that in practice, this transfer of skills rarely occurs.

Without additional effort and attention, it is unlikely that “cascade” approaches to PHC training will result in improved performance at the peripheral level. To achieve this goal, program managers will need either to support and reinforce second-generation training activities or to develop strategies for direct training of personnel at all levels.

QUESTION 7:

At the national level, should responsibility for inservice training rest with a centralized unit that cuts across vertical or disease-specific programs?

Despite the attractive simplicity of prescribing an ideal government structure for the organization of PHC training programs, this may be unrealistic. National needs, resources, political realities, and existing organizational structures must guide the development of an effective administrative system to support inservice training. Potential disadvantages of a national training office include the lack of credibility of trainers in relation to other technical staff, competition with disease-specific programs for scarce training resources, and difficulties in obtaining needed cooperation from program staff in technical content areas. The decision to develop a national training office will also be affected by the degree of decentralization of health service management.

Combinations of entities, such as a national training office that works closely with smaller units located within separate technical departments or at different levels of the health system, might provide the synergy necessary for success in many countries. The inclusion of provincial and district medical officers in networks of national facilitators in the absence of central or departmental training units in the Central African Republic²² and Ghana²³ has increased the responsiveness of inservice curricula to the realities of work in the field.

There is no one administrative structure that will guarantee high-quality and high-coverage PHC training. Alternative management approaches should be evaluated for their capacity both to provide “catch-up” training to address skills not included in preservice training, and to promote the longer-term improvement of preservice curricula. This development process must be based on country-level priorities and capacity to change.⁴

QUESTION 8:**Is training for primary health care sustainable?**

The sustainability of projects, or even of health status, is currently of major concern to the public health community.^{24,25} Training has been identified as an important contributor to project sustainability on the basis that it can create interest in health projects among local personnel and enable them to acquire the skills they need to make these projects effective.²¹ Bossert²¹ suggests that the costs of on-going training can be maintained by the government, implying that the training process itself can be continued with decreased donor support. Training workshops are also a favorite of funding agencies, because funds can be disbursed quickly and there are measurable outputs in the form of the number of people trained.

There are dangers, however, that inservice training programs may actually work against sustainability. Even short seminars can disrupt health care delivery for prolonged periods while the trainee is absent. In Zambezia province, Mozambique, for each 1-2 week inservice seminar, district-based workers spent an average of 6 weeks (one eighth of the working year) away from work, and replacements were rarely available. If training is not linked with carefully planned career development and manpower management, this time may be wasted when trained personnel are abruptly transferred to other positions where their recently-acquired skills are not relevant. Some district managers have come to equate attendance at workshops with a loss of qualified staff from their district. Their response may be to boycott workshops or to send the staff they consider the most dispensable, who are often the least likely to benefit from the workshop.

The financial aspects of inservice training can also work against sustainability. First, the proliferation of workshops has increased competition among agencies. Donors may use training (either in-country or abroad) as an incentive to attract personnel to particular projects or interventions, especially if there is no strong government coordination or standardization of per diems. In 1987, four donor agencies were paying the same group of health workers in Togo different per diem rates for attendance at similar workshops. Second, per diems can create expectations among personnel that they will receive payment for training. In Mozambique, for example, one donor agency recently paid the equivalent of 18 months' salary as per diem to health workers attending a three-week provincial workshop. Attendance at workshops or conduct of supervisory visits usually are viewed as "extra" activities, outside the normal job performance of health workers. Subsequently, these activities cease when donor funds are no longer available. Third, special training centers or units are often built with donor assistance, but their maintenance falls to the overstretched recurrent budget of the MOH.

While expanding preservice capacity may promote the sustainability of PHC projects, further research is needed to identify how inservice training programs can be made more sustainable. In addition, sustainability issues should be carefully considered when planning inservice PHC training programs.

CONCLUSIONS

There is no doubt that training programs are and should continue to be a cornerstone of successful PHC programs. This brief examination of selected questions facing PHC managers is by no means exhaustive or prescriptive. Still, each question represents a challenge: to broaden inservice training beyond workshops into the less-well-defined areas of supervision and follow-up; to continue to develop curricula responsive to the changing needs of health workers and program managers; to balance training with direct efforts to improve the availability of commodities; to build the skills of program managers in curriculum design, implementation, and evaluation; and to explore alternative models for disseminating new skills and providing administrative leadership and support for sustainable PHC training efforts. This list of questions represents only one small step toward increasing the effectiveness of training within PHC programs. We must continue and expand our efforts to address each of these issues and to share alternative solutions.

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