

# **Establishing Integrated Family Planning/Reproductive Health Preservice and Inservice National Clinical Training Systems in Turkey**

**JHP-18**

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**CREDITS**

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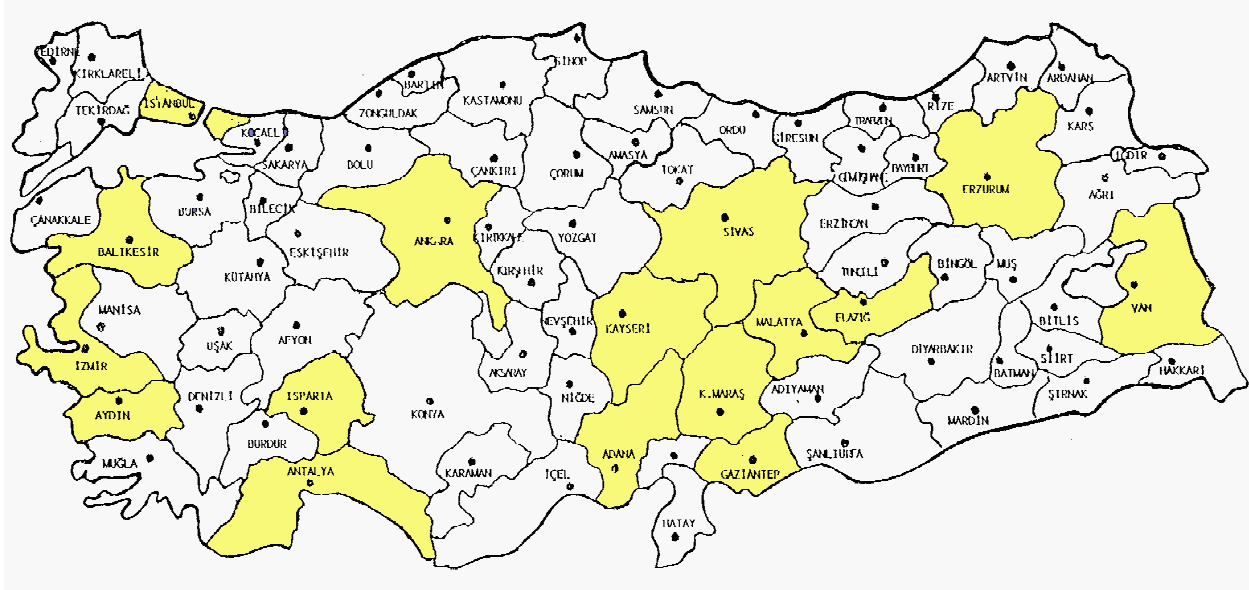
## ABBREVIATIONS AND ACRONYMS

ATS	Advanced training skills
CA	Cooperating agency
CAI	Cooperative Agreement Indicator
CPR	Contraceptive prevalence rate
CTS	Clinical training skills
CTT	Central Training Team
CTU	Contraceptive technology update
CYP	Couple years of protection
DCR	Discontinuation rate
FP	Family planning
GD/HT	General Directorate for Health Training
GD/MCH/FP	General Directorate for Maternal and Child Health/Family Planning
GTI	Genital tract infection
HPHF	Hacettepe University, Public Health Foundation
HSPH	Hacettepe University, School of Public Health
IP	Infection prevention
IR	Intermediate Result
IUD	Intrauterine device
KIDOG	Nongovernmental Organization Advocacy Network for Women (translation from Turkish)
M&E	Monitoring and Evaluation
MNH	Maternal and neonatal health
MOH	Ministry of Health
MSH	Management Sciences for Health
NFPSDGs	National family planning service delivery guidelines
NGO	Nongovernmental organization
NTT	National Training Team
OJT	On-the-job training
RETAG	Reproductive Health Technical Advisory Group
RH	Reproductive health
SDGs	Service delivery guidelines
SO	Strategic Objective

SSK	Social Insurance Organization for the Self-Employed
TALC	Technology-assisted learning center
TIS	Training information system
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization



# MAP OF TURKEY



Bridging Europe and Asia Minor, Turkey is a land of geographic, economic, and social contrasts. Slightly larger than Texas, Turkey is home to bustling cosmopolitan centers, pastoral farming villages, barren wastelands, peaceful Aegean coastlines, and steep mountain regions. More than half of Turkey's population lives in urban areas that juxtapose Western lifestyles with traditional mosques and markets. Most Turks, however, work in agriculture. Although Turkey is still a developing country, recent improvements have resulted in the proliferation of electricity nationwide and telephone connections for all its 34,500 villages.

All but 2% of the Turkish population is Muslim, although the country has been officially secular since 1924. Most Turkish Muslims belong to the Sunni branch of Islam, but a significant number are Alevi Muslims. The appeal of political Islam and the Kurdish insurgency continue to fuel public debate on several aspects of Turkish society, including the role of religion, the necessity for human rights protections, and the expectation of security.

Turks of Kurdish origin constitute a discrete ethnic and linguistic group. Estimates of their population run as high as 12 million. Although an increasing number have migrated to the cities, the traditional home of the Kurds is in poor, remote areas of the east and southeast, where incomes are less than half the national average and all other economic and social indicators lag.

Policies related to population have been formulated since the establishment of the Turkish Republic in 1923. The government implemented a somewhat pro-childbearing population policy aimed at increasing the population size until the mid-1960s, after which an anti-population growth policy was adopted. The shift in policy is manifested in the Population Planning Law of 1965. The high population growth rates prevailing in the 1950s produced medical problems, such as high maternal mortality from illegal abortions. In response, the State Planning Organization and the Ministry of Health allowed limited importation of contraceptives under the Population Planning Law. In 1983, the law was revised and a more liberal and comprehensive law was passed. The new law legalized abortion (up to the tenth week of pregnancy) and voluntary surgical contraception. It also permitted the training of auxiliary health personnel in IUD insertion.

## EXECUTIVE SUMMARY

Under the United States Agency for International Development's (USAID) Family Planning and Reproductive Health Assistance Program in Turkey, JHPIEGO has been working since 1991 to support the development of a national integrated clinical training system used for both family planning/reproductive health (FP/RH) preservice education and inservice training. JHPIEGO has done this with the help of the Ministry of Health (MOH) General Directorate for Maternal and Child Health/Family Planning (GD/MCH/FP), MOH General Directorate for Health Training (GD/HT), Hacettepe University, School of Public Health (HSPH), Hacettepe University, Public Health Foundation (HPHF), medical institutions, and vocational and university-based midwifery schools. JHPIEGO and its partners have used cost-effective means to strengthen both preservice education and inservice training systems by developing, printing, and disseminating initial and updated (2000) national FP service delivery guidelines (NFPSDGs), infection prevention (IP) guidelines, national preservice medical and midwifery training materials, and national FP/RH inservice training materials. In addition, two national and two provincial FP/RH training teams with clinical instructors and clinical training sites for both preservice education and inservice training have been developed and sustained.

Training for both preservice and inservice physicians and midwives has been linked at the clinical training site. Using one group of trainers for a variety of training needs has resulted in economies of scale and consistency in delivery. A National Training Team (NTT) was established for preservice education and a Central Training Team (CTT) was established for inservice training. Training has been decentralized from the national-level NTT and CTT to the provincial training teams in target provinces, so that more FP/RH training is conducted each year. Training costs for FP/RH inservice courses will continue to be reduced as the preservice medical and midwifery programs are able to absorb more FP and RH interventions. In support of this integrated system, JHPIEGO, in collaboration with the groups mentioned above, developed quality national preservice education materials for medical and midwifery schools, IP guidelines, and inservice training materials for physicians and midwives based on the NFPSDGs. JHPIEGO has also provided technical assistance and training to ensure that FP/RH trainers have standardized clinical FP/RH training skills and knowledge and skills in IP and FP counseling. Because Turkey has a high IUD acceptance rate, skills in IUD insertion and removal are an essential part of both preservice and inservice clinical FP/RH training for physicians and midwives.

JHPIEGO has provided technical assistance to the MOH to decentralize clinical and training expertise from central to provincial training centers. To this end, provincial training teams have been developed and subsequently supervised by NTT and CTT members. Each provincial training team member attended standardized clinical training courses. Course topics include IUD services, clinical training skills (CTS), and IP. Master and advanced trainers provide multiple followup visits where they oversee the new trainers' initial activities until they demonstrate proficient technical knowledge and competent training skills. After the initial followup visits, the NTT and CTT provide additional supervision visits to monitor the quality of care at the clinic and the quality of classroom and clinical training. JHPIEGO/Turkey staff have provided technical assistance to the GD/MCH/FP to develop a standard followup system, including standardized forms and checklists.

As the provincial training teams develop, they are responsible for training hospital and MCH (Maternal and Child Health) center staff throughout their respective province. Team members are coached as they provide followup for healthcare providers in their districts using standardized materials based on the NFPSDGs.

FP/RH preservice education for physicians and midwives has been strengthened in Turkey. JHPIEGO has provided technical assistance to 17 preservice medical institutions, 7 vocational midwifery schools, and 19 university-based midwifery schools that have strengthened their competency-based FP/RH classroom and clinical training. FP/RH training materials have been developed for medical internship and vocational and university-based midwifery preservice education based on the NFPSDGs. The training materials are based on general FP topics, including postpartum and postabortion FP, IP, and FP counseling. JHPIEGO supported courses in IP, FP counseling, contraceptive technology, and CTS for selected faculty from project-affiliated schools. These faculty members provide training for other faculty and clinical instructors from their respective schools.

The 1996 evaluation of the results of the preservice medical project indicated that the NTT and the 13 project-affiliated medical institutions (4 more joined in 1998) had improved FP/RH clinical training programs for interns and other faculty members independently (see **Appendix F**). Interns are monitored annually to determine whether they are using their skills.

The 1999 evaluation of the results of the preservice vocational and university-based project-affiliated midwifery schools (**Appendix G**) indicated that the 7 vocational schools and 19 university-based midwifery schools had improved their FP/RH clinical training programs, including IUD insertion skills. Midwives are monitored annually to determine whether they are using their skills.

From FY1999 to 2001, emphasis was placed on strengthening postpartum and postabortion FP services in both the public and private sectors. EngenderHealth and JHPIEGO worked together to improve the quality and availability of postabortion FP counseling services. To this end, information on postpartum and postabortion contraception was added to the revised (second edition) NFPSDGs, intern and midwifery training materials, and clinical training activities. Postpartum and postabortion FP services have been integrated into public hospitals and MCH centers in the target provinces.

To help monitor human resources developed under the preservice project, the HPHF and JHPIEGO/Turkey staff have maintained databases of faculty who have been trained under the JHPIEGO program. The JHPIEGO/Turkey staff and the MOH GD/MCH/FP have maintained a database of the inservice trainers, midwifery faculty, and clinical instructors whose skills have been developed during the project.

In summary, this project has made substantial gains in meeting the USAID/Turkey results package from the Strategic Objective, *Increased Utilization of FP/RH Services*, through Intermediate Result 2, *Expansion of High Quality FP/RH Services in the Public and Private Sectors*, and two Sub-Results—2.1 *Increased Availability of Postpartum and Postabortion FP Services* and 2.3 *Improved Job Performance of Health Providers, Trainers, and Administrators*. It has been successful in assisting the MOH, medical institutions, and midwifery schools to establish a national, integrated training system capable of sustaining high-quality preservice education programs for interns and midwives. The inservice training system that has been established will support the MOH in their effort to expand FP/RH training to other provinces in coming years. The preservice education system will support all university-based midwifery school students by strengthening their FP/RH and maternal health skills as they progress toward their degree.



# Establishing Integrated Family Planning/Reproductive Health Preservice and Inservice National Clinical Training Systems in Turkey

## INTRODUCTION

As part of the United States Agency for International Development's (USAID) Family Planning and Reproductive Health Assistance Program in Turkey, JHPIEGO has provided technical assistance to strengthen the capacity of the country's family planning/reproductive health (FP/RH) clinical training systems. Starting in 1992, JHPIEGO worked primarily with Hacettepe University, School of Public Health (HSPH) to develop a program to strengthen FP and RH skills of medical interns (see **Appendix A** for more detailed background on this program). In recent years, JHPIEGO efforts have focused on improving the preservice education and inservice training systems. This report reviews more than a decade of experience in institutionalizing an integrated training system in Turkey.

The report is organized around the Monitoring and Evaluation (M&E) Framework for JHPIEGO country training programs. It summarizes progress over the past 10 years using the indicators and benchmarks that JHPIEGO/Turkey committed to achieve. It focuses on the establishment of an integrated FP/RH preservice clinical training network and the inservice training system in USAID's target provinces. Relevant achievements are discussed under the key M&E indicators as well as within their relevant components.

## BACKGROUND

The JHPIEGO/Turkey program was implemented in three phases:

- ◆ Assessment (1990–1992)
- ◆ Development of national preservice education and inservice training systems with a focus on preservice medical education (1992–1997)<sup>1</sup>
- ◆ Refocus on preservice midwifery education and the decentralization of inservice training to target provinces (1997–2002)

During the assessment phase, JHPIEGO determined which clinical skills physicians and midwives were lacking and what infrastructure support needed upgrading to ensure appropriate and adequate training. In phase two, JHPIEGO focused on developing standardized FP/RH guidelines, intern training materials, and national-level preservice education and inservice training teams. At this time, the preservice medical National Training Team (NTT) was developed. The NTT used the intern training material to train faculty and clinical instructors at medical institutions to become advanced trainers. By building the human and material infrastructure necessary for clinical training for both preservice education and inservice training at key clinical training sites, JHPIEGO successfully completed this phase. Physicians would provide some FP/RH services, but they would also be responsible for supervising the midwives' services. Seventeen medical institutions institutionalized the FP/RH curricular changes, ensuring that physicians graduate with basic FP/RH skills. Although

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<sup>1</sup> USAID funding for Turkey was reduced in 1995 when the USAID/Turkey mission was closed, making it a USAID non-presence country. The FP/RH program continued and thrived under a Health and Population Advisor assisted by Michigan Fellows under the supervision of the US Embassy Economic Officer. This program became a model for USAID non-presence countries as well as for joint planning and implementation efforts by all cooperating agencies.

JHPIEGO's assistance to the medical institutions ended in 1997, medical students and interns continue to be trained in IUD insertion and other FP/RH skills.

During phase three, the Turkish Ministry of Health (MOH), USAID/Washington, USAID/Turkey, and JHPIEGO decided the medical program was adequately institutionalized and could continue without further USAID funding. Because midwives provide the bulk of the FP/RH services in rural and high-risk urban areas, the focus then shifted to support for preservice midwifery education. Although phase two was effective, it became clear that FP/RH inservice training was too expensive to be sustained without donor funding. Therefore, the goal of the MOH General Directorate for Maternal and Child Health/Family Planning (GD/MCH/FP) was to limit the length and sharpen the focus of inservice training as it institutionalized quality preservice education for midwives. With support from the MOH, JHPIEGO's program strategy shifted from supporting preservice medical education and decentralized inservice training to promoting preservice midwifery education along with the decentralization of inservice training. JHPIEGO/Turkey conducted research in 1999 that measured the cost of inservice training and preservice midwifery education. The results clearly showed the cost savings of preservice education (Saat et al 1999).

In 1997, JHPIEGO initiated the development of vocational midwifery FP/RH training materials and began strengthening 8 vocational midwifery schools. Clinical training sites developed for preservice intern (medical) education and inservice training were used in this phase of the project. In 1999, the MOH upgraded midwifery education by moving it from vocational schools into university-based programs overseen by the Council on Higher Education. JHPIEGO provided technical assistance by developing university-based midwifery FP/RH training materials and began developing faculty and clinical instructors. Instructors undergoing training moved through the standard Turkish faculty and trainer development pathway adapted from the JHPIEGO model (see **Appendix B** for trainer definitions and **Appendix C** for JHPIEGO's Faculty and Trainer Development Pathway). JHPIEGO/Training in Reproductive Health provided financial and technical support to these institutions as they made the transition to the university-based education system.

During the third phase, JHPIEGO also worked closely with Management Sciences for Health (MSH), The Futures Group International (TFGI), and EngenderHealth to expand quality FP/RH services in the target provinces of Istanbul and Cukurova. Following a joint provincial needs assessment, the Central Training Team (CTT) provided inservice training for provincial training team members. The provincial training teams then trained FP/RH healthcare providers in hospitals and MCH centers in districts throughout their respective provinces. In the future, the MOH training teams will be able to use the gains made in FP/RH training in target provinces to prepare for further expansion in other high-risk areas. They will also be able to help roll out training in the remaining university-based midwifery schools as they are established.

## MONITORING AND EVALUATION FOR RESULTS

Since 1991, JHPIEGO has been able to track the majority of its activities through the use of the Automated Program Monitoring System<sup>®</sup> (a JHPIEGO M&E system in place until 2000). In 1994, a detailed M&E framework was developed to provide both tracking and measurement of progress in global and country program activities reported to USAID at the Cooperative Agreement Indicator (CAI) level. The framework breaks down complex CAIs, such as capacity-building activities, into various benchmarks so that progress in achieving the CAIs can be monitored incrementally. For complex indicators (e.g., establishment of training programs), benchmarks are also categorized into components such as those that constitute training programs.<sup>2</sup>

The key indicators for the Turkey program were:

- ◆ Country training sector assessed
- ◆ Joint national FP/RH training strategy developed and implemented
- ◆ National service delivery guidelines (SDGs) developed/updated, adopted, and disseminated
- ◆ Institutionalization of national SDG process (revision, updating, and dissemination) for continuing change in medical and training policies
- ◆ FP/RH preservice education and inservice training programs established
  - FP/RH education program established in one or more of the major preservice (medical, midwifery, nursing) systems
  - FP/RH inservice training system (government or nongovernmental organization [NGO]) established
- ◆ Peri-program components<sup>3</sup>

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<sup>2</sup> The M&E Framework has four levels of achievement for benchmarks:

Level 1: Necessary first steps in a new training activity that are undertaken or, in a mature program, training activities that are revised/upgraded

Level 2: Achievements expected after a period of time (usually two to three years)

Level 3: The outcome expected after a minimum of five years of coordinated program efforts

Level 4: The ultimate goal of functioning in an organized fashion within the individual component

Achievement of benchmarks in levels 1 and 2 takes a period of intensive interventions supported by technical assistance. These interventions ensure the building of a foundation for a sustainable training system. Achieving a level 3 benchmark indicates that interventions supported by technical assistance and policy/advocacy work have resulted in all elements of the training system functioning at a basic level, with appropriate human capacity to sustain these elements.

<sup>3</sup> Those training-related areas that are not tied directly to either preservice education or inservice training—but rather support both—and link training to the service delivery system

## USAID/Turkey Results Framework

When USAID/Washington instituted its results framework approach in both central and field programs, JHPIEGO's M&E Framework responded by linking workplan activities to relevant USAID results. JHPIEGO's primary linkage has been to the Global/Population, Health, and Nutrition Center's Strategic Objective (SO) 1: *Increased use by women and men of voluntary practices that contribute to reduced fertility.*

For USAID/Turkey, the JHPIEGO country program responded to the SO for the Turkey results package, *Increased Utilization of FP/RH Services*, through Intermediate Result (IR) 2, *Expansion of High Quality FP/RH Services in the Public and Private Sectors*. Of the three sub-results (SR) for this IR, JHPIEGO/Turkey's program responded specifically to SR 2.1, *Increased Availability of Postpartum and Postabortion FP Services*, and SR 2.3, *Improved Job Performance of Health Providers, Trainers, and Administrators* (see text box for the USAID/Turkey results framework).

### USAID/Turkey Office of Population and Health Results Framework

SO: Increased Utilization of FP/RH Services

IR 1: Strengthened Sustainability of FP/RH Program

SR 1.1 Improved Policy Environment for the Provision of FP/RH Services in the Public and Private Sectors

SR 1.2 Strengthened NGO Advocacy for FP Programs

IR 2: Expansion of High Quality FP/RH Services in the Public and Private Sectors

**SR 2.1 Increased Availability of Postpartum and Postabortion FP Services**

SR 2.2 Increased Accurate Knowledge of Clients About Modern Methods and FP Services

**SR 2.3 Improved Job Performance of Health Providers, Trainers, and Administrators**

Four cooperating agencies (CAs)—MSH, The Futures Group International, EngenderHealth, and JHPIEGO—provided assistance to Turkish counterparts to implement the FP/RH program. The SRs were monitored in Turkey with baseline and annual assessments of the following indicators:

#### SR 2.1

- ◆ Quality index (method availability; availability of trained personnel; perceived quality of FP counseling; adequate infection prevention (IP) measures; availability of information, education, and communication materials; physical access to FP/RH services)
- ◆ Number of facilities in target regions that provide FP/RH services
- ◆ Percentage of women in target area hospitals who receive postabortion FP services
- ◆ Percentage of women postpartum in target area hospitals who receive postpartum FP services

#### SR 2.3

- ◆ Percentage of healthcare providers or trainers who apply their clinical training to their subsequent work
- ◆ Percentage of healthcare providers who have access to up-to-date data



## JHPIEGO/TURKEY PROGRAM ACHIEVEMENTS

### Country Training Sector Assessed

In 1991, JHPIEGO and its partners at the MOH GD/MCH/FP and the HSPH conducted a comprehensive assessment of the FP/RH training sector in Turkey (JHPIEGO Asia/Europe/Near East Office, 1991). USAID facilitated JHPIEGO's collaboration with other partners in Turkey during this assessment for two reasons: to obtain a comprehensive picture of the FP/RH training and service delivery system in the country, and to ensure that the resulting recommendations would reflect the input of everyone involved.

The results of the assessment indicated the need to:

- ◆ Establish FP/RH services in existing health facilities
- ◆ Standardize FP/RH SDGs and preservice education materials
- ◆ Develop FP/RH clinical training sites and trainers
- ◆ Strengthen the preservice education system to supply the ongoing need for trained providers, because the cost of providing inservice training following graduation would be excessive for the MOH
- ◆ Strengthen the inservice training capacity to provide continuing education for existing healthcare providers
- ◆ Strengthen the capacity of the private sector to provide FP/RH services

Additional assessments were conducted at targeted medical institutions and midwifery schools. After developing project participation criteria, schools were formally assessed for general interest and enthusiasm, faculty preparation, FP/RH knowledge and skills of faculty and graduates, FP/RH curriculum, MCH/FP clinic affiliation, number of students, quality of education, and leadership potential.

### Joint National Family Planning/Reproductive Health Training Strategy Developed and Implemented

In phase two and following the completion of the Reproductive Health Training Assessment, USAID, JHPIEGO, the MOH GD/MCH/FP, and representatives from eight universities under the coordination of HSPH developed a country training strategy. This strategy was revised in 1997 and 1998 due to changes in USAID funding levels and training priorities. During 1998, USAID, MOH, medical institutions, and all CAs providing assistance to Turkey began working closely together to draft a joint development strategy and results package.

The training strategy followed the JHPIEGO framework for integrated FP/RH training (see **Appendix D** for framework). International resource materials were used to develop national FP service delivery guidelines (NFPSDG) to be used for preservice education and inservice training materials and training team development. The NTT was created to train other medical faculty and regional MOH trainers. FP/RH clinical training<sup>4</sup> was strengthened for both preservice and inservice clinical training sites. More effective modern contraceptive methods became available at MOH service sites to replace traditional method use such as withdrawal. At this time, the second phase of the project was developed to shorten and focus FP/RH inservice training and strengthen preservice education in medical institutions during the internship period.

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<sup>4</sup> Interactive and participatory methods and a competency-based approach were used in all trainings.

By 1997, faculty in 16 of 17 medical institutions were using standardized FP/RH training materials to train selected interns. At this time, the third phase began and the training strategy shifted to place special emphasis on strengthening the classroom and clinical FP/RH preservice midwifery education. The strategy was changed to help prepare midwifery students to better provide the majority (63%) of FP/RH services in Turkey, including IUD insertion and removal.

As USAID/Turkey led the joint strategy planning sessions with the MOH, Hacettepe University, Public Health Foundation (HPHF), CAs, and JHPIEGO worked closely with MSH, The Futures Group International, and EngenderHealth to improve regional FP/RH training in two target provinces—Istanbul and Cukurova. Regional inservice training teams were developed by the CTT and FP/RH healthcare providers in the provinces were trained in FP counseling, IP, and clinical services, including postpartum and postabortion FP services.

USAID, JHPIEGO, other CAs, and the Turkish MOH conducted annual joint national strategy development sessions to plan the activities for the upcoming year. This planning reached benchmark level 4 (see **Table 1**) in reviewing and revising the national strategy with MOH leaders, assuming approval.

**Table 1. Benchmarks of Progress for Joint National Family Planning/Reproductive Health Training Strategy Developed and Implemented**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Host country officials sensitized to the need for an integrated approach to improving FP/RH service delivery</i> <ul style="list-style-type: none"> <li>• <i>SDGs</i></li> <li>• <i>Preservice</i></li> <li>• <i>Inservice</i></li> </ul> </li> <li>• <i>Advisory group comprised of relevant stakeholders in the involved systems is formed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>An integrated strategy based on needs assessment findings is designed/developed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Integrated strategy endorsed by policymakers and major stakeholder bodies represented in the advisory group (as formed in level 1)</i></li> <li>• <i>Integrated strategy is introduced and disseminated</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Mechanism for review and revision of the integrated strategy is in place (ongoing stakeholder meetings, etc.)</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### **National Service Delivery Guidelines Developed/Updated, Adopted, and Disseminated**

Turkey’s NFPSDGs work reached benchmark level 4 (see **Table 2**). In 1995, JHPIEGO helped the MOH GD/MCH/FP and the HSPH develop NFPSDGs. The guidelines incorporated JHPIEGO and World Health Organization (WHO) standards as well as other international standards. All training curricula developed with support from JHPIEGO were adapted to reflect the changes made to the NFPSDGs. The first edition of the NFPSDGs was published in mid-1995 and disseminated by the MOH in 1995–1996. The guidelines were printed with financial assistance from USAID through JHPIEGO to ensure enough copies were produced for all service delivery points in Turkey. A national dissemination strategy was developed that included training by CTT members—benchmark level 4 (**Table 2**). Guideline updates were conducted for key administrators, educators, and healthcare providers.

**Table 2. Benchmarks of Progress for National Service Delivery Guidelines Developed/Updated, Adopted, and Disseminated**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Host country officials sensitized to the need to strengthen the policy environment through revising SDGs/policy norms</i></li> <li>• <i>FP/RH knowledge of host country officials updated</i></li> <li>• <i>Consensus reached on the need for policy/service guidelines revision</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>RH Technical Advisory Group (RETAG or equivalent) formed to lead service guidelines revision process</i></li> <li>• <i>Draft service guidelines document produced (by RETAG)</i></li> <li>• <i>Medical barriers are addressed in national FP/RH guidelines</i></li> <li>• <i>Service guidelines externally reviewed by e.g., key educators, providers, and program managers</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>National service guidelines officially endorsed by national policymakers</i></li> <li>• <i>National service guidelines document published and distributed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Dissemination strategy developed</i></li> <li>• <i>System exists to institutionalize and standardize guidelines development, including regular revision, and updating</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

The NFPSDGs were revised in 2000 with the assistance of some of the original technical committee members, NTT and CTT members, and JHPIEGO consultants. In that same year, the second edition of the NFPSDGs was printed and disseminated.

### **Institutionalization of National Service Delivery Guidelines Process (Revision, Updating, and Dissemination)**

Institutionalization of the NFPSDGs process—regular updating, continued dissemination of new information, and assessment of service provider performance in accordance with the NFPSDGs—reached level 4 in the target provinces (**Table 3**). Although dissemination was just beginning to reach district levels, training materials were consistent with the NFPSDGs and trainers had been oriented to the materials. MOH GD/MCH/FP supervisors and provincial supervisors in the target regions systematically assessed healthcare providers’ performance using a standard checklist based on regularly updated guidelines.

**Table 3. Benchmarks of Progress for Institutionalization of National Service Delivery Guidelines Process (Revision, Updating, and Dissemination)**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Availability of guidelines is systematically promoted</i></li> <li>• <i>Implementation plan for dissemination strategy developed and approved</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Core group of resource personnel are conducting technical updates based on new information in guidelines</i></li> <li>• <i>Training and educational materials are harmonized and consistent with guidelines</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Mechanisms in place to ensure providers deliver services according to the guidelines</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Ongoing quality assurance and supervision documents that healthcare providers are still performing to the standards established in the guidelines</i></li> </ul>

## **FAMILY PLANNING/REPRODUCTIVE HEALTH PRESERVICE EDUCATION AND FAMILY PLANNING/REPRODUCTIVE HEALTH INSERVICE TRAINING PROGRAMS MODIFIED AND STRENGTHENED**

The key components of the M&E Framework for establishing preservice education and inservice training programs are:

- ◆ FP/RH Curricular Component/Course Schedule
- ◆ Staff/Faculty: Classroom Instruction
- ◆ Staff/Faculty: Clinical Practice
- ◆ Training Materials
- ◆ Clinical Training Sites
- ◆ Quality Monitoring System
- ◆ Training Information System (TIS)
- ◆ Preservice/Inservice Program Advocacy

For both preservice and inservice interventions, JHPIEGO's programming assistance focused on the first five synergistic components. The last three components—quality monitoring system, TIS, and preservice/inservice program advocacy—require more than just targeted technical assistance and provision of materials to achieve progress. Therefore, interventions related to these areas usually follow achievement of benchmarks in the first five components (usually after achieving benchmark level 2 or greater in one or more components).

### **Family Planning/Reproductive Health Curricular Component/Course Schedule**

By 1995, the MOH, selected NTT and CTT members, and JHPIEGO technical advisors had developed, printed, and disseminated national FP/RH inservice and refresher training materials for physicians and midwives. The course materials developed for inservice training consisted of one week of classroom training with one additional week of clinical training for physicians and two additional weeks of clinical training for midwives. The inservice course was designed for health professionals who had had no previous FP/RH training or had no FP/RH training within the last five years.

Training course materials were also developed for what was termed “refresher training.” This training was provided for healthcare providers who had not had FP/RH training within the last five years. This one-week workshop included more than just a classroom contraceptive update. Trainers added an IP update and a requirements for demonstrated competency in IUD insertion and removal with anatomic models and/or clients using a standard checklist.

The Family Planning Reference Book for participants and the Family Planning Clinical Handbook (PocketGuide) were provided. These inservice training materials were based on the NFPSDGs. These activities resulted in achievement of benchmark level 4 (**Table 4**).

By 1998, the MOH, CTT, and JHPIEGO staff in Turkey developed, printed, and disseminated national vocational midwifery preservice education materials based on the NFPSDGs and the Medical Internship Training Materials. The materials included a 2-week Family Planning Course Manual for trainers and participants and a Family Planning Reference Book for participants. The Family Planning Clinical Handbook was also used for the course. Although the materials were distributed to all vocational midwifery schools, routine use was verified only at the 8 project-affiliated vocational midwifery schools. These activities resulted in achievement of benchmark level 3 (**Table 4**).

**Table 4. Benchmarks of Progress for Family Planning/Reproductive Health Curricular Component/Course Schedule**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li><i>Adequacy of FP/RH curricular component/course schedule has been assessed (preservice and inservice)</i></li> </ul>	<ul style="list-style-type: none"> <li><i>FP/RH curricular component/course schedule has been revised (preservice and inservice)</i></li> </ul>	<ul style="list-style-type: none"> <li><i>Revised FP/RH curricular component/course schedule has been implemented in one or more institutions on at least a pilot basis (preservice and inservice)</i></li> <li><i>Revised FP/RH curricular component/course schedule has been officially approved for use in all institutions (preservice and inservice)</i></li> </ul>	<ul style="list-style-type: none"> <li><i>Revised FP/RH curricular component/course schedule is the official standard for training in all institutions (inservice)</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

By 2000, the MOH, NTT, CTT, and JHPIEGO/Turkey staff had developed, printed, and disseminated national university-based midwifery preservice education materials based on the NFPSDGs, the Medical Internship Training Materials, and the Vocational Midwifery Training Materials. The materials included a 2-week *Family Planning Course Manual* for trainers and a *Family Planning Reference Book* for participants. The *Family Planning Clinical Handbook* was also used for the course. Although the materials were distributed to all university-based midwifery schools, routine use was verified only at the 8 project-affiliated vocational and 19 university-based midwifery schools. These activities resulted in achievement of benchmark level 3 (see **Table 4** above).

**Staff/Faculty: Classroom Instruction/Clinical Practice**

In 1994 and 1995, JHPIEGO conducted a variety of training activities (IP, contraceptive technology updates [CTUs], IUD standardization, counseling, clinical training skills [CTS], and advanced training skills [ATS] courses) for medical faculty, MOH training team members, and clinical instructors. These trainers evolved into two training teams: the medical faculty members constituted the NTT, and the MOH GD/MCH/FP and General Directorate for Health Training (GD/HT) members constituted the CTT. The NTT began training other faculty members from the 16 project medical institutions in IUD standardization, CTUs, and CTS. Selected faculty members also completed ATS courses.

By the end of 1999, these trainings resulted in 9 master trainers, 8 candidate master trainers, 9 advanced trainers, 97 clinical trainers, and 36 candidate clinical trainers, according to JHPIEGO’s Faculty and Trainer Development Pathway, which was adapted and used conscientiously by Turkish trainers (see **Appendix C** for JHPIEGO’s pathway).

The initial strategy for conducting these CTS courses was to bring a small number of general practitioner and midwifery staff from each MCH/FP center to a central clinical training center, usually in Ankara. CTT members and JHPIEGO staff or consultants were the lead trainers in each course. In 1998, the NTT, CTT, and JHPIEGO staff and consultants began conducting courses to develop faculty members from vocational schools, as they became university-based midwifery school instructors. Because the same clinical training sites were being used for preservice education and inservice training, many of the clinical instructors had already been trained. During the courses, participants practiced pelvic examinations and IUD insertion and removal with anatomic models, conducted role plays, and worked on case studies so that they became

comfortable with the variety of training methodologies (see text box “Clinical Training Skills Course Focus” at right).

Other faculty members and clinical instructors were trained as needed. During followup visits to assess skills transfer, JHPIEGO staff and consultants verified improvement in quality by the third followup visit (Öncüer and Tüzer, 1997). Vocational midwifery trainers are now capable of assisting the CTT in conducting FP/RH standardization training and CTS courses. This resulted in achievement of benchmark level 3 for both preservice and inservice (**Table 5**). Faculty members and clinical instructors from the schools trained additional faculty without USAID support. Independent training, without external support, provided by the school for other faculty members and interns became the HPHF criterion for institutionalization.

**Clinical Training Skills Course Focus**

Some of the clinics, particularly where interns and midwifery students do their clinical practice, had insufficient FP method caseload. Therefore, clinical instructors needed to use a variety of teaching methodologies (especially role plays for clinical situations) with students to achieve competency.

The focus in the CTS courses was on practicing role plays, working through case studies, participating in demonstrations, training on anatomic models for pelvic examination, and IUD insertion, along with coaching exercises and followup procedures until the trainers and clinical instructors felt comfortable with a variety of training methodologies.

**Table 5. Benchmarks of Progress for Staff/Faculty: Classroom Instruction/Clinical Practice (Preservice and Inservice)**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>A core group of faculty/tutors in one or more institutions has been updated in their FP/RH knowledge</i></li> <li>• <i>A core group of clinical trainers/preceptors involved in clinical practice has had their FP/RH skills standardized</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A core group of faculty/tutors has been trained to transfer FP/RH knowledge effectively in one or more institutions</i></li> <li>• <i>A core group of clinical trainers/preceptors involved in clinical practice has been trained to transfer FP/RH skills effectively in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Trained faculty/tutors are successfully providing FP/RH instruction in one or more institutions</i></li> <li>• <i>Trained clinical trainers/preceptors are successfully supervising FP/RH clinical practice in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Trained faculty/tutors are officially designated/responsible to teach the classroom portion of the FP/RH curricular component/course schedule in all institutions</i></li> <li>• <i>Trained practitioners are officially designated/responsible as clinical trainers/preceptors for the clinical practice portion of the FP/RH curricular component/course schedule in all institutions</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

Also in 1998, joint MOH, USAID, university, and CA efforts resulted in the identification of two target provinces (Istanbul and Cukurova) where more intensive efforts would be made to develop provincial training teams. These provinces were chosen based on criteria including population, future migration estimates, health needs, available FP/RH services, and requests by the provinces themselves.

JHPIEGO monitored the number of physicians and midwives trained as trainers each year until 1998 (see **Table 6**), after which time the HSPH, in collaboration with the MOH, assumed this responsibility.

**Table 6. Ministry of Health Trainers Trained for Calendar Years 1993–1998**

Trainer Type	Training by Calendar Year				
	1993–1994	1995	1996	1997	1998
Master Trainers	8	1			
Advanced Trainers + Candidate Master Trainers	6	5	1	5	
Clinical Trainers	33	24	12	18	10
Candidate Clinical Trainers	9	2	9	14	2
TOTAL	56	32	22	37	12
Total trainers in 1999: 159					

By 2000, 16 of the 17 (94%) medical institutions had institutionalized FP/RH training for faculty members and medical students in their final internship year. From 1997, when the HPHF Project closed, the medical institutions collected data on the number of faculty and interns trained each year independently. This resulted in achievement of benchmark level 4 for the target provinces and level 3 for the entire country (see **Table 7**).

**Table 7. Benchmarks of Progress for Staff/Faculty: Classroom Instruction/Clinical Practice (Country-Level Achievement)**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li><i>A core group of faculty/tutors in one or more institutions has been updated in their FP/RH knowledge</i></li> <li><i>A core group of clinical trainers/preceptors involved in clinical practice has had their FP/RH skills standardized</i></li> </ul>	<ul style="list-style-type: none"> <li><i>A core group of faculty/tutors has been trained to transfer FP/RH knowledge effectively in one or more institutions</i></li> <li><i>A core group of clinical trainers/preceptors involved in clinical practice has been trained to transfer FP/RH skills effectively in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li><i>Trained faculty/tutors are successfully providing FP/RH instruction in one or more institutions</i></li> <li><i>Trained clinical trainers/preceptors are successfully supervising FP/RH clinical practice in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li>Trained faculty/tutors are officially designated/responsible to teach the classroom portion of the FP/RH curricular component/course schedule in all institutions</li> <li>Trained practitioners are officially designated/responsible as clinical trainers/preceptors for the clinical practice portion of the FP/RH curricular component/course schedule in all institutions</li> </ul>
Benchmarks that have been achieved are shown in <i>italics</i> .			

## Training Materials

To support the development of the trainer resources needed to implement the inservice medical and midwifery training, JHPIEGO developed inservice and refresher training materials. By 1996, the MOH, the CTT, and JHPIEGO/Turkey staff had developed, printed, and disseminated national inservice and refresher training materials based on the NFPSDGs. The materials included a 2-week *Family Planning Course Manual* for trainers and physician participants and a 3-week *Family Planning Course Manual* for trainers and midwife participants as well as a *Family Planning Reference Book* for participants. The *Family Planning Clinical Handbook* was also used as a resource for the course.

Training centers received a training package of anatomic models and equipment. During ongoing supervision visits, MOH trainers and JHPIEGO consultants ensured that materials were in place and were being used appropriately. Benchmark level 3 was achieved (**Table 8**).

**Table 8. Benchmarks of Progress for Training Materials**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li><i>The adequacy of the training materials/ supplies has been assessed in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li><i>Adequate training materials have been developed for use in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li><i>Adequate training materials/supplies are available in sufficient quantities to support ongoing FP/RH training in one or more institutions</i></li> </ul>	<ul style="list-style-type: none"> <li>A system exists for ensuring the provision of a sufficient number of (new/revised) training materials/supplies to all institutions</li> </ul>
Benchmarks that have been achieved are shown in <i>italics</i> .			

For the preservice medical and midwifery programs, either the intern training materials or the vocational midwifery or university-based midwifery training materials were provided to the appropriate school. In addition, each school received a training package consisting of anatomic models (ZOE<sup>®</sup> pelvic, breast, condom, and handheld), IUD kits, CuT380a IUDs for practice use, audiovisual equipment, and training videos.<sup>5</sup> During ongoing supervision visits, MOH trainers and JHPIEGO consultants ensured that materials were in place and were being used appropriately. Benchmark level 3 was achieved (see **Table 8**).

### Clinical Training Sites

As part of the development of the MOH clinical training centers, the MOH and JHPIEGO conducted individual assessments of each center designated to be a training center for inservice and refresher training in the target provinces as well as for preservice education. During the clinical training site assessments of the target provinces, trainers examined variables such as number of clinical trainers, physical site conditions, FP method caseload, equipment and supplies needed for FP method provision, and clinic space for counseling and examinations. Based on the clinical training site assessment, JHPIEGO supplied anatomic models, resource materials, and essential equipment to the preservice and inservice training centers used in the integrated training network, resulting in achievement of benchmark level 3 (**Table 9**).

During ongoing supervision visits, MOH trainers and JHPIEGO consultants ensured that the quality of care and the quality of training met national standards and that training materials were in place and being used correctly. These ongoing visits also contributed to benchmark level 3 (**Table 9**).

<sup>5</sup> Until 1998, microscopes and genital tract infection (GTI) kits were also provided to teach screening for GTIs before inserting an IUD.



**Table 9. Benchmarks of Progress for Clinical Training Sites**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Service delivery sites affiliated with one or more institutions have been assessed for adequacy as clinical training sites</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Services at sites affiliated with one or more training institutions have been strengthened (and/or the sites have been upgraded) to meet clinical training requirements</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Service sites affiliated with one or more institutions are functioning effectively (including being adequately equipped/supplied) as clinical training sites</i></li> </ul>	<ul style="list-style-type: none"> <li>• A sufficient number of sites are functioning effectively as clinical training sites to meet clinic practice training needs in all institutions</li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### Quality Monitoring System

The quality monitoring system for a training program is the program’s internal quality control mechanism. It ensures that participants have the required skills at the end of the learning intervention and that the quality of care and training at the training centers meet national standards. For the inservice intervention, the MOH national and provincial supervisors monitored the quality of care during practicum visits for development of inservice trainers and during followup visits to the medical institutions and midwifery schools. In the target provinces, training team members were trained to conduct standard supervision followup visits to the centers where trained healthcare providers had been assigned. The results of the followup visits were reported to the MOH and used for monitoring purposes (see **Appendix E**). This followup system resulted in the achievement of level 4 (**Table 10**).

Turkish medical training institutions require that participating interns demonstrate knowledge and skills competency on anatomic models prior to graduation and prior to providing pelvic examinations and IUD services. The midwifery schools require that all midwifery students demonstrate knowledge and skills competency with anatomic models prior to graduation. For the midwives participating in the advanced IUD training (competence in service delivery with clients), demonstration of competency on pelvic examinations and IUD services with clients is required to provide these FP/RH services upon graduation. Because FP/RH questions are included on the graduation examination and some clinical FP/RH training is required for graduation, these requirements have resulted in the achievement of level 2 for preservice education (see **Table 10**).

**Table 10. Benchmarks of Progress for Quality Monitoring System**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Students/participants are tested in FP/RH topics as part of the classroom portion of the FP/RH curricular component/course (preservice and inservice)</i></li> <li>• <i>Skills assessments (with anatomic models and/or clients) are part of the clinical practice portion of the FP/RH curricular component/course (preservice and inservice)</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A passing score on a knowledge-based FP/RH test is required to pass the classroom portion of the FP/RH curricular component/course (preservice and inservice)</i></li> <li>• <i>Skills competency is required to pass the clinical practice portion of the FP/RH curricular component/course (preservice and inservice)</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Demonstrated competency in FP/RH clinical skills is required to be able to provide these FP/RH services upon completion of training (inservice)</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A system exists for following up graduate participants to support skills retention and appropriate application of (newly acquired skills on the job) (inservice)</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### **Training Information System**

One of the findings of the 1991 Reproductive Health Training Assessment was the need for preservice education and the coordination of information regarding qualifications achieved to assist the MOH in their deployment efforts.

JHPIEGO subcontracted the HPHF in Ankara to track trainers' names, the training events they completed, and their level of achievement for all preservice activities. This information was provided to the MOH starting in 1998 for certification and deployment purposes, and provided to JHPIEGO for monitoring purposes. As a result of these efforts, the Turkey program has achieved benchmark level 4 for preservice efforts in training information systems (**Table 11**). The HPHF continues to keep these data for all project-affiliated schools. This information was used to report the number of qualified trainers to JHPIEGO and to conduct post-training followup to determine if students were using their skills after graduation. The information is still regularly provided to the MOH.

JHPIEGO/Turkey staff and the MOH GD/MCH/FP have kept records of inservice and refresher trainers and course participants (midwifery, faculty, and clinical instructors) and reported them regularly to the MOH, thus achieving benchmark level 3 (**Table 11**). These systems are not sustainable and recommendations were made for the MOH to take over monitoring responsibilities.

**Table 11. Benchmarks of Progress for Training Information System**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>Criteria are developed/revISED to select appropriate participants for specific FP/RH clinical training (preservice and inservice)</li> </ul>	<ul style="list-style-type: none"> <li>A TIS has been established at the national/regional/institutional level to document the number of FP/RH professionals trained, by method and cadre (preservice and inservice)</li> </ul>	<ul style="list-style-type: none"> <li>The TIS links training statistics with service delivery information to enable service delivery gaps to be identified (preservice and inservice)</li> </ul>	<ul style="list-style-type: none"> <li>A mechanism exists for monitoring whether adequate numbers of providers are available/being trained for FP/RH service provision, by method and by cadre to meet ongoing/changing service delivery needs (preservice)</li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### Preservice/Inservice Program Advocacy

The GD/MCH/FP General Director and Deputy General Director led the effort to strengthen FP/RH inservice training. The USAID/Turkey Health and Population Advisor led the effort to jointly design, plan, and measure the results of the inservice program annually. JHPIEGO/Turkey staff's efforts to coordinate the development of NFPSDGs and inservice and refresher training materials were critical to the project. For inservice training advocacy, benchmark level 3 has been achieved (see **Table 12**).

The HPHF project staff led the preservice medical advocacy effort to strengthen FP/RH training in medical institutions. The GD/HT Division led the preservice midwifery effort to strengthen FP/RH training in schools of midwifery. The GD/MCH/FP General Director and Deputy General Director advocated for the value of strengthening preservice education throughout the program. Although not specific to training, FP/RH advocacy was strengthened with the help of Nongovernmental Organization Advocacy Network for Women (translation from Turkish) (KIDOG), an NGO that coordinates women's group efforts. This important NGO led many efforts in FP/RH by speaking for Turkish women. Most notably, KIDOG successfully advocated for MOH procurement and distribution of contraceptives when external assistance was no longer available.

The USAID/Turkey Health and Population Advisor led the effort to jointly design, plan, and measure the results of the program annually. JHPIEGO/Turkey staff's efforts to coordinate the development of NFPSDGs and preservice and inservice training materials resulted in the following achievements:

- ◆ Opportunities for key stakeholders in the MOH, universities, and private sector to work together to develop consensus on acceptable FP/RH standards and training materials
- ◆ Sense of purpose among the key stakeholders that resulted in a cooperative approach to program implementation

For preservice education advocacy, benchmark level 3 was achieved (see **Table 12**).

**Table 12. Benchmarks of Progress for Inservice and Preservice Program Advocacy**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>National level players sensitized to and achieved consensus on need for strengthening/developing (inservice) or strengthening/revising (preservice) training system</i></li> <li>• <i>Advisory group formed to guide strengthening/developing (inservice) or strengthening/revising (preservice) training system</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Program for strengthening/developing (inservice) or strengthening/revising (preservice) training system designed</i></li> <li>• <i>Appropriate personnel implement program for strengthening/developing (inservice) or strengthening/revising (preservice) training system after orientation of all stakeholders</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Program for strengthening/developing (inservice) or strengthening/revising (preservice) training system is regularly assessed and revised during implementation</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Process for assessing and revising program for strengthening/developing (inservice) or strengthening/revising (preservice) training system has been institutionalized</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

## PERI-PROGRAM COMPONENTS

Peri-program components include areas that are crosscutting and affect both preservice education and inservice training programs:

- ◆ New Initiatives
- ◆ Participant Selection Criteria
- ◆ Provider Supervision
- ◆ Qualification of Trainers/Trainer Development
- ◆ Licensure/Certification of Providers<sup>6</sup>

### New Initiatives

In 1998, JHPIEGO/Turkey began working with EngenderHealth to improve postpartum and postabortion FP services in the target provinces. JHPIEGO/Turkey provided technical assistance to integrate postpartum/postabortion FP information into the NFPSDGs and into inservice, refresher, intern, and midwifery training materials. In 1998, postpartum/postabortion FP training began for preservice interns and midwifery students. Postpartum/postabortion FP services in hospitals and MCH/FP centers in the target regions were monitored during followup visits and through periodic quality surveys, and the results showed improvement from the baseline survey done in 1998. The success of the initiative in Istanbul resulted in a strategy to expand to new target regions and to include the information in the updated NFPSDGs, which were sent to all hospitals and MCH/FP centers throughout the country. These postpartum/postabortion FP initiatives have resulted in the partial achievement of benchmark level 4 (**Table 13**).

<sup>6</sup> Peri-program components also include the area of Provider Deployment/Job Assignment, which is not covered in this report.

**Table 13. Benchmarks of Progress for New Initiatives**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Key stakeholders are sensitized to the need for the new initiative</i></li> <li>• <i>Host country resources are educated about the new initiative</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A strategy is designed for incorporation of the new initiative into existing programs</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>The new initiative is implemented on a pilot basis and assessed</i></li> <li>• <i>A strategy for expansion of the new initiative is developed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>The new initiative is expanded into ongoing services</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### Participant Selection Criteria<sup>7</sup>

Since 1996, the MOH has used criteria for appropriately selecting providers to become trainers. They include competent clinical skills (as assessed with a skills checklist), IUD certification, a demonstrated commitment to training, and the intention to work in the same institution for a number of years following training. HPHF and GD/HT have accepted and used selection criteria for trainers as part of the integrated training network. The system has resulted in a benchmark level 4 achievement (**Table 14**).

**Table 14. Benchmarks of Progress for Participant Selection Criteria**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Selection criteria for participation in training system are identified and reviewed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Selection criteria revised so as to be supportive of quality training</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Revised criteria adopted for use in training system and are disseminated</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Revised criteria implemented throughout the training system</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### Provider Supervision

The JHPIEGO/Turkey staff and MOH have developed a followup and supervision system within the target provinces, and for inservice and preservice clinical training sites. After the practicum visits, trainers continue followup and supervision visits to monitor the quality of care at the clinic and the quality of CTS. JHPIEGO staff members have provided technical assistance to the GD/MCH/FP to develop a standardized followup system, including standardized forms and skills checklists. The NTT, CTT, and provincial training teams continue to provide followup and supervision visits using standardized materials based on the NFPSDGs. To train the second- and third-generation team members, a course handbook and 4-day workshop schedule were developed and used.

Representatives from medical institutions, midwifery schools, and MOH and JHPIEGO staff/consultants have conducted joint followup visits and used coaching techniques to assess the quality of care. Problem-solving techniques are used to assist participants, their supervisors, and clinical instructors to make necessary changes to implement what they have learned. The results of the followup visits indicate that significant improvement in the quality of care has occurred between

<sup>7</sup> See previous section on **Training Information System** as well.

the first and the third followup visit. As a result, project staff adhere to a programmatic policy of planning three post-training followup visits to each service site (Öncüer and Tüzer 1997). Benchmark level 4 has been achieved in target provinces (**Table 15**). In target areas, provincial trainers make post-training followup visits and provincial supervisors conduct supervision visits. Both groups are routinely trained to conduct visits with standardized forms and checklists.

**Table 15. Benchmarks of Progress for Provider Supervision**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>Training officials and service delivery program managers have met to review and discuss how training meets service delivery needs</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A strategy for orienting and/or training “supervisors” so that they can effectively monitor post-training skills application has been developed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Orientation and/or training in clinical FP/RH skills has been initiated for existing “supervisors” who monitor post-training skills application</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A system exists to ensure compatibility and continuity between initial followup of trained providers (by the training organization) and routine/regular supervision of providers</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### Qualification of Trainers/Trainer Development

In all JHPIEGO/Turkey projects, there has been adherence to a standard faculty and trainer development pathway (see **Appendices A** and **B**). Members of national, central, and provincial training teams, faculty members, and clinical instructors followed that pathway to become clinical, advanced, and master trainers. In summary, the standard pathway conforms to JHPIEGO standards, including selecting experienced clinicians, attending clinical skills standardization, and CTS courses, and successfully teaching clinical skills standardization and CTS courses in a practicum to become clinical trainers. Clinical trainers who completed ATS courses and have successfully taught clinical skills standardization and CTS courses in a practicum became advanced trainers. When advanced trainers gained national and international experience and conducted ATS courses in a practicum under master trainers, they became master trainers.

A key achievement in this component is the MOH’s establishment of functioning training centers with the capacity to train in various RH areas. Because both the MOH and the universities accept the standard faculty and trainer development pathway, level 4 has been achieved (see **Table 16**).

**Table 16. Benchmarks of Progress for Qualification of Trainers/Trainer Development**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>A core group of clinical trainers have become advanced trainer candidates after completing the ATS course</i></li> <li>• <i>A core group of proficient advanced trainers become master trainer candidates after at least one experience in adapting or designing a training course or event within one year of the ATS course</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A core group of advanced trainer candidates have qualified to become advanced trainers after cotraining at least one training event within a year after the ATS course under the supervision of a qualified advanced or master trainer or technical expert</i></li> <li>• <i>A core group of proficient master trainer candidates participate in at least one Training Needs Assessment and one level 3 training evaluation within two years of the ATS course</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A core group of skilled* advanced trainers is still functioning in this role (conducting CTS courses, adapting training materials, and conducting needs assessments) one year after qualification (**"skilled" includes maintenance of routine service provision skills)</i></li> <li>• <i>A core group of master trainer candidates becomes qualified as master trainers by submitting for review and approval applications/portfolios with supporting documentation to the JHPIEGO Trainer Review Group</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A system exists for ensuring that all new clinical trainers are competent in both FP/RH clinical skills and CTS</i></li> <li>• <i>A system exists for ensuring that all new FP/RH instructors are competent in FP/RH classroom presentation skills</i></li> <li>• <i>A system exists for ensuring that all existing clinical trainers receive FP/RH clinical skills and CTS updates</i></li> <li>• <i>A system exists for ensuring that all existing FP/RH instructors receive teaching skills and FP/RH content updates</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

### Licensure/Certification of Providers

JHPIEGO provided technical assistance to the MOH to update Regulations #503 and #506, which include approval for physicians and nurse-midwives to provide IUD services. In 1983, the MOH authorized physicians and nurse-midwives to insert IUDs with legal and regulatory support legislated by the Turkish National Parliament. Physicians, midwives, and medical and midwifery students are certified as competent with clients according to the NFPSDGs and national skills checklists. Certification for physicians and midwives is reported to the MOH. A benchmark of level 3 has been achieved (**Table 17**).

**Table 17. Benchmarks of Progress for Licensure/Certification of Providers**

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <li>• <i>The licensure or certification process (for a particular professional cadre) has been assessed</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Consensus has been reached (by relevant officials) that the licensure/certification process should be based on an assessment of skills competency</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Competency assessment is built into the licensure/certification process</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>A mechanism exists for recertifying/relicensing based on a demonstration of adequate knowledge and application of skills (practice) according to service standards</i></li> </ul>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

## RESULTS AND DISCUSSION

The results of the joint CA baseline survey and the annual quality surveys indicate that JHPIEGO, MSH, The Futures Group International, and EngenderHealth have worked together in Turkey to increase the utilization of FP/RH services in the target provinces. The Turkey results package consisted of joint CA indicators.

### **Strategic Objective: Increased Utilization of Family Planning/Reproductive Health Services in the Target Provinces**

The contraceptive prevalence rate (CPR), modern method discontinuation rate (DCR), and couple years of protection (CYP) will be measured in the 2003 Demographic Health Survey as indicators for project success. This information will be compared to the CPR and DCR data from the 1993 and 1998 Demographic Health Surveys, shown in **Table 18**. We expect to see a further increase in CPR and a decrease in the method-specific DCRs.

**Table 18. CPR and DCR Data From the 1993 and 1998 Demographic Health Surveys**

Indicator	1993	1998
CPR	34.5%	37.7%
DCR		
IUD	10	9.4
oral contraceptive	55.7	56.4
condom	49.4	43.3

CYP in 2003 will be compared to the 1998 MOH service statistics and Social Insurance Organization for the Self-Employed (SSK) data for each method. For example, the 1998 CYP for IUD from MOH and SSK sites in 1998 was 1,373,040 and from private sector sites it was 280,000.

### ***IR 1: Strengthened Sustainability of FP/RH Program***

A sustainable FP/RH preservice education system has been established for physicians and midwives. A sustainable MOH inservice/refresher training system has been developed in target provinces. More time is required to determine if the MOH can expand this sustainable system to all provinces. Contraceptive self-reliance will be measured by different indicators as well as the percentage of contraceptive users supplied by the private sector.

#### ***SR 1.1 Improved Policy Environment for the Provision of FP/RH Services in the Public and Private Sectors***

NFPSDGs, with policies and clinical procedures, have been developed and revised and are being used by both the public and private sectors. Training materials for interns and midwives are consistent with the NFPSDGs and are used by public and private schools. Followup visit guidelines and clinical procedure checklists have been standardized and are used by public and private sector trainers/providers. A quality index of selected quality indicators was measured in 1998 for Istanbul and for Cukurova in 2000 (Topcuoglu and Tüzer 1998).



## **IR 2: Expansion of High Quality FP/RH Services in the Public and Private Sectors**

### *SR 2.1 Increased Availability of Postpartum and Postabortion FP Services*

The percentage of hospitals in target provinces providing FP services to postpartum and postabortion women who choose a modern contraceptive method will be measured annually for a 5-year period based on client exit interviews and compared with 1998 baseline data. An increase of 20% is expected in MOH hospitals and 30% in private hospitals.

### *SR 2.2 Increased Accurate Knowledge of Clients About Modern Methods and FP Services*

The percentage of antenatal clients with knowledge about the availability of FP/RH services will be measured biannually through client exit interviews and compared to the 1998 baseline data. The percentage of non-users who know where they can obtain FP/RH services and the percentage of method users with accurate knowledge about their chosen method will also be measured biannually. Utilization data for the national FP/RH hotline will also be collected regularly.

### *SR 2.3 Improved Job Performance of Health Providers, Trainers, and Administrators*

The percentage of healthcare providers who apply their clinical training to their subsequent work and the percentage of healthcare providers who have access to up-to-date data will be collected annually through telephone/mail surveys and faculty checklists and then compared to the 1998 baseline data.

## **Sustainability of the Training Systems**

Another way to examine the effect of the technical assistance provided in the project period is to examine the strength of the preservice education and inservice training systems. In preparation for the March 2002 closeout, JHPIEGO focused its efforts in the last two program years on improving FP/RH preservice training for midwives, resulting in assistance to 19 midwifery schools. The expansion of the preservice midwifery initiative strengthened the development of a sustainable core group of university-based FP/RH midwifery trainers, covering nearly half of the schools in the country.

Qualified midwifery trainers, with technical assistance from the NTT, trained faculty in schools that were added in the following project years. Selected midwifery faculty from each school trained in a 3-week IUD clinical skills standardization course and an IUD CTS course. Once a qualified trainer, these midwifery faculty then provided competency-based, participatory FP/RH training for additional classroom and clinical midwifery instructors and midwifery students. All schools received and used updated NFPSDGs, standardized university-based midwifery training materials, and anatomic models for their competency-based training. Affiliated clinical sites were also assessed and equipped so that students were able to work with clients. The level of achievement under the indicator, *Preservice RH Education Program Established*, is displayed in **Table 18**. The preservice education system in Turkey has been strengthened, is well established, and is functioning to meet national training needs for preparing physicians and midwives, as shown by its level 3 benchmark achievement in almost all of the program components<sup>8</sup>. This indicates there is a strong training system foundation upon which continued system strengthening can be based.

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<sup>8</sup> The level 2 benchmark for quality monitoring systems is because, at the time of this report, Turkey did not require demonstration of competency at graduation.

Achieving a level 3 benchmark indicates that interventions supported by technical assistance and policy/advocacy work have resulted in all elements of the training system functioning at a basic level, with appropriate human capacity to sustain these elements. Level 4 achievement focuses on institutionalization of a process for ensuring regular and continual updating of the system supporting the component. For example, for the preservice program advocacy component, achievement of a level 3 benchmark means the program for strengthening/ revising preservice training system is regularly assessed and revised during implementation (which is being done in Turkey), but the program hasn't yet achieved level 4, wherein a process for strengthening/ revising the preservice education system has been institutionalized.

**Table 18. Achievement of Benchmarks of Progress for Family Planning/Reproductive Health Preservice Medical and Midwifery Education Program Modified and Strengthened**

Component	Medical Schools	Midwifery Schools		Benchmarks of Progress			
		Vocation	University	Level 1	Level 2	Level 3	Level 4
FP/RH Curricular Component/Course Schedule	X 1997	X 1999	X 2001			X	
Staff/Faculty: Classroom Instruction	X 1997	X 1999	X 2001			X	
Staff/Faculty: Clinical Practice	X 1997	X 1999	X 2001			X	
Training Materials	X 1995	X 1999	X 2001			X	
Clinical Training Sites	X 1997	1997 strengthened sites were used				X	
Quality Monitoring System	X 1997	X 1999	X 1999		X		
TIS	X 1997	X	X				X
Preservice Program Advocacy	X 1995	X	X			X	
Shaded area signifies achievement of benchmark(s) at that level.							

The FP/RH inservice training model for Istanbul and Cukurova provinces promoted the development of a core group of 12 GD/MCH/FP trainers to provide competency-based inservice or refresher training for general practitioners and midwives at six MCH/FP and health centers with emphasis on improving postabortion FP, IP, and FP counseling. The MOH CTT members conducted followup visits that assessed the performance of the newly trained trainers and supported them in their first training sessions in Cukurova. After the practica for the new trainers were completed, a smaller group was trained for local followup visits with help from the Istanbul provincial training team. Trainers used the updated NFPSDGs and standardized FP/RH inservice and refresher training materials developed for Istanbul. In addition, the Istanbul training team received MOH funding to continue monthly inservice workshops and followup visits and has been doing this since December 2001. **Table 19** shows that the inservice program for medical and midwifery training is strong and functioning well to meet national training needs, with all component benchmarks achieved at level 3 or 4.

**Table 19. Achievement of Benchmarks for Family Planning/Reproductive Health Inservice Medical and Midwifery Education Program Modified and Strengthened**

Component	Medical	Midwifery	Benchmarks of Progress			
			Level 1	Level 2	Level 3	Level 4
FP/RH Curricular Component/Course Schedule	XX	XX				XX
Staff/Faculty: Classroom Instruction	XX	XX			XX (national)	XX Target*
Staff/Faculty: Clinical Practice	XX	XX			XX (national)	XX Target*
Training Materials	XX	XX			XX	
Clinical Training Sites	XX	XX			XX	
Quality Monitoring System	XX	XX				XX
TIS	XX	XX			XX	
Inservice Program Advocacy	XX	XX			XX	

Shaded area signifies achievement of benchmark(s) at that level.  
\* = Level achieved by target provinces of Istanbul and Cukurova for midwifery training

### Elements that Strengthened the Program

The Turkey FP/RH program is a strong model for USAID, CAs, and Turkish counterparts. Its strengths have been:

- ◆ **Joint development of a USAID/Turkey results package and performance benchmarks by the MOH, NGO partners, HPHF, and all USAID/CAs assisting Turkey:** USAID/Washington and the Health and Population Advisor at the US Embassy in Turkey led the MOH, NGO partners, HPHF, private sector representatives, and members of USAID/CAs to develop the USAID/Turkey results package jointly, including performance indicators. This combined planning led to model coordination among representatives of MSH, The Futures Group International, EngenderHealth, and JHPIEGO to implement and evaluate the program together. The importance of country representatives for each CA leading the initiative with assistance from home offices cannot be underestimated.

- ◆ **Adherence to the JHPIEGO Framework for Strengthening Reproductive Health Systems in National Programs:** JHPIEGO staff and consultants initially updated Turkish counterparts about the JHPIEGO framework. The JHPIEGO/Turkey program adapted the framework as a guide for their program and strictly adhered to the structure.

NFPSDGs were developed from international standards. Both preservice education and inservice training material and clinical training teams were developed and linked at the same service delivery sites. Routine data were collected on performance of participants and evaluation activities were regularly conducted.

- ◆ **Adherence to the Faculty and Trainer Development Pathway:** Turkish counterparts working on preservice and inservice projects adapted the JHPIEGO Faculty and Trainer Development Pathway and strictly adhered to the standard course and performance requirements throughout the program. The adherence to the system of required practica and followup performance monitoring resulted in quality training teams and systems.
- ◆ **Transfer of the project focus to preservice midwifery schools after a critical mass of medical institutions had been strengthened:** The Government of Turkey has been transferring preservice midwifery education and training from a vocational level to a university level, because midwives provide the majority percent of FP/RH services and they need training that is not offered at vocational midwifery schools. HPHF project staff worked collaboratively and effectively with MOH GD/HT to train faculty and later helped university-based schools of midwifery develop training materials. This collaboration was very successful and was a tribute to the leadership of both groups. Upon graduation, midwifery students are expected to provide all reversible methods of contraception, including IUD insertion and removal.<sup>9</sup> To keep pace with the Turkish government's upgrade of midwifery education, JHPIEGO helped institutionalize the newly developed university-based curriculum so that graduates could perform these new skills competently in the field.
- ◆ **Establishment of a followup system of reinforcement and supervision for service delivery and clinical training sites:** The JHPIEGO/Turkey, MOH, and HPHF staff developed a followup and supervision system within the target provinces for preservice and inservice clinical training sites. After the practicum visits, trainers continued to conduct followup and supervision visits to monitor the quality of care at the clinic, the quality of skills training, and the quality of CTS. NTT, CTT, and provincial training team members have a sustainable followup system and continue to provide followup and supervision visits using standardized materials based on the NFPSDGs.
- ◆ **Joint use of clinical training sites for preservice education and inservice and refresher training:** As in the JHPIEGO framework, linkages between preservice education and inservice training were made using joint clinical training sites. From the beginning of the project, Turkish counterparts pioneered an integrated clinical training system with joint clinical training centers. By developing a common core group of clinical instructors and by upgrading integrated clinical facilities, JHPIEGO/Turkey staff/consultants and the MOH have improved both training systems at a much lower cost than would have been the case if both systems were upgraded independently.

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<sup>9</sup> The IUD is the most commonly used form of modern contraception in Turkey.

- ◆ **Improved relations between faculty members and clinical healthcare providers /clinical instructors:** The joint planning process that included MOH and university faculty members helped link the two groups and foster a better working relationship. At the health center level, faculty members and experienced healthcare providers/clinical instructors were trained simultaneously and developed a working relationship providing preservice education and inservice and refresher training together.
- ◆ **Improved relations between the Council on Higher Education and the MOH led to certification of providers:** Improvement in the quality of FP/RH education at medical institutions was significant. Because the MOH CTT had been trained in the same methods used for the NTT, trust developed between the council and the MOH. MOH trainers understood and recognized the depth of improvement and the quality of the standardized FP/RH training. The HSPH developed a system of routinely reporting to the MOH the names of interns assessed as competent in IUD insertion and removal. Certification was provided by the MOH for these individuals so they could officially provide FP/RH services without additional inservice training.
- ◆ **Ongoing attention to evaluation:** Throughout the program, HPHF, USAID/CAs, and JHPIEGO staff have conducted assessment and evaluation activities. Data were consistently collected before, during, and after inservice, refresher, and preservice clinical training and followup activities. Data were analyzed and synthesized into timely reports. Evaluations of followup activities, preservice medical, and preservice midwifery were conducted. Client assessment of the quality of care was also included (see **Appendices D, E, and F**).

After the MEASURE project conducted evaluation training for key members of CA incountry staff, joint quality pre-and mid-intervention assessments were conducted by CA staff to measure and evaluate the results of program interventions. A cost analysis was conducted comparing preservice midwifery education to inservice midwifery training showing a cost savings of US\$96.00 per midwife trained (Saat et al 1999).

- ◆ **Use of standardized training materials developed from NFPSDGs for all training activities:** During the program, NFPSDGs were developed, accepted, revised, and disseminated. All training materials developed were based on the original or updated guidelines. Standards were distributed and disseminated and followup visits were based on the updated guidelines. All CAs used the guidelines and training materials and the standardization of FP/RH services was successfully accomplished.
- ◆ **Field-testing process for training materials:** The NFPSDGs and all training materials for medical and midwifery students were field tested and revised before being used nationally.
- ◆ **Efficient use of intern and vocational midwifery training materials to develop university-based midwifery FP/RH training materials:** Whenever possible, existing training materials were used to develop other materials. Turkish counterparts and CAs worked collaboratively, shared materials, and efficiently used existing materials when available.
- ◆ **Financial monitoring system developed for project management:** The JHPIEGO/Turkey Office staff developed a financial monitoring system for monitoring activity funds, which allowed the staff to manage funds and make recommendations to JHPIEGO headquarters staff about the use of additional funds. This financial management tool was shared with other JHPIEGO/Baltimore program staff.

During the evaluation of preservice midwifery education, JHPIEGO/Turkey staff included a cost study comparing preservice midwifery education and inservice training. The results indicated that training a midwife before her graduation costs 15.3% of the cost of providing inservice training (Saat et al 1999).

- ◆ **MOH training budget and contraceptive procurement:** The MOH allocated separate funds for FP/RH training and supported trainers who could plan, train, and evaluate training activities. During the program, through the advocacy of women's groups, the Government of Turkey also began providing support for the purchase of contraceptives. Many developing countries do not have the ability to support these efforts, but the sustainability of the FP/RH program was greatly enhanced through the independent support for some inservice training and contraceptive procurement.

## RECOMMENDATIONS FROM KEY FINDINGS

Since 1994, the MOH, HPHF, and JHPIEGO greatly contributed to the way both FP/RH preservice education and FP/RH inservice training were conducted in Turkey. The training focus moved from funding for preservice education for medical students to strengthening preservice midwifery. MOH funding for group-based inservice and refresher training provided training for new information and skills, while strengthening preservice education for standard knowledge and skills.

- ◆ **The need for the MOH to fund supervision activities, because of the importance of intensive post-training followup:** Throughout the program, JHPIEGO/Turkey staff and consultants conducted three post-training followup visits per year to each school and clinical training center to continually assess and monitor the quality of training and service provision. Coaching and reinforcement were found to be essential to complete and reinforce the training (Öncüer and Tüzer 1997). The number of practica and post-training followup visits that could be funded limited the expansion of the program to additional midwifery schools. The staff and consultants upheld the quality of classroom and clinical training throughout the program.

Supervision followup visits were also effective for maintaining quality services. MOH national and provincial supervisors were trained and used coaching skills to reinforce quality services and recommend any changes necessary to adhere to national standards of care.

- ◆ **Importance of ensuring national standards and national training materials, because university-based schools are autonomous:** University-based schools of medicine, midwifery, and nursing are autonomous. There is potential for joint development of maternal and neonatal health (MNH) training materials for midwives in the future. A protocol between the MOH and the Council on Higher Education to institutionalize this project has been drafted and approved by both parties.
- ◆ **Importance of a decentralized training capacity to ensure countrywide training capacity:** A national training team is important to initiate training, but, as quickly as possible, training should be decentralized to provincial and district levels. The program in Turkey began with the development of two national training teams (NTT and CTT) and then began focusing on target provinces. The provincial trainers trained healthcare providers from district-level MCH/FP centers, but thus far the decentralization has been limited to the provincial level.
- ◆ **Human resources monitoring provided by HPHF needs to be taken up by the MOH:** The HPHF continues to keep these data for all project-affiliated schools. This information is used to

conduct post-training followup to determine if the students are using their skills after graduation, and to report the number of qualified trainers to JHPIEGO. The information is regularly provided to the MOH.

JHPIEGO/Turkey staff have also kept records of inservice and refresher trainers and course participants and reported them regularly to the MOH. These systems are not sustainable and recommendations were made for the MOH to take over monitoring responsibilities.

- ◆ ***Integrated training system investments need to be maintained:*** JHPIEGO established an integrated clinical training system with sites that are used for both preservice education and inservice training. These sites have adequate clinical training materials, including anatomic models, reference materials, and clinical equipment. This structure makes it easier to decentralize training expertise to regional and district training teams. These sites are also monitored to assist clinical preceptors/healthcare providers establish and maintain high quality services, thus providing a model for students to follow when they graduate. The MOH must not lose sight of the investment made in this system and its potential for achieving a broad reach for training and learning in Turkey.

With USAID funding, the MOH, HPHF, and JHPIEGO established the basic framework for a national integrated clinical training system. Recommendations for future training programming include:

- ◆ ***ModCal® IUD translated and used in preservice medical and midwifery education:*** JHPIEGO and LearnWare have developed a computer-assisted learning module for IUD services that can be translated into any language and local photographs can replace the internationally-oriented pictures. This training methodology is interactive and can be used by novice computer users who are taught to use a mouse on a desktop or laptop computer. Pre- and midcourse knowledge assessments are contained within the program and complement clinical IUD training.

Students throughout the country could receive standardized information through computer-based courses, thereby eliminating many faculty lectures. Computer-based courses would free faculty to spend more time on clinical demonstrations and supervision to ensure the competency of graduating students. In addition, the computer-based examinations assist tutors in calculating student results and ensure that no student proceeds to the clinical areas without the requisite knowledge.

Due to the demand for and acceptability of IUDs by women in Turkey, JHPIEGO recommends that Turkish counterparts seek external funding (e.g., World Bank) to translate the text and modify the photographs to the Turkish setting. In the future, as additional university-based midwifery schools begin using computers, these programs will provide an excellent method of training and will free the faculty to spend additional time conducting clinical training for performance improvement.

- ◆ ***ModCal CTS translated and used in the development of faculty trainers and MOH training team members:*** JHPIEGO and LearnWare have also developed a computer-assisted learning module for CTS based on the international standard CTS manual. Medical institution faculty have found that the competency-based training skills taught in this manual are helpful for faculty members from all medical disciplines, but they have had insufficient time and funding to provide CTS training for all faculty in their schools. This module would allow faculty members a self-study way to learn and trainers would need less time before conducting their practicum.

- ◆ **Establish technology-assisted learning centers (TALCs) at MOH and key medical institutions:** Pilot TALCs could be set up at preservice midwifery schools first and, if successful, the MOH and selected medical institutions should establish TALCs where FP/RH training programs are part of the curriculum. ModCal modules could be made available through TALCs. In addition, TALCs also provide Internet access, making new international training materials and medical information on all subjects available as resource materials in the future.
- ◆ **Develop a structured on-the-job training (OJT) system for midwifery students who cannot become certified for IUD services with clients during basic training because of the limited IUD caseload:** Although the IUD caseload is high as compared to many other countries, there is still insufficient client load to train all midwifery students in IUD insertion and removal. An individualized learning approach such as structured OJT will be needed for the remaining midwifery graduates who have not been certified for IUD services with clients. Midwifery students who were not selected to receive IUD training with clients are highly motivated and anxious to receive this training. The structured OJT IUD materials written in English and developed in Zimbabwe could be adapted and translated for Turkey.
- ◆ **Strengthen MNH at the same schools and clinical training centers:** Although the training system has been developed using an FP/RH focus, performance improvement for other MNH interventions can be incorporated effectively by adding selected MNH technical components. International MNH guidelines and preservice midwifery education materials can be adapted and existing training teams developed for MNH technical components. Clinical training sites can be strengthened for key MNH interventions for midwifery students, as well as OJT for midwifery students who are not able to complete their MNH clinical certification.

### **Sustainability Challenges for the Ministry Of Health**

The Turkish MOH has institutionalized FP/RH training and the procurement of contraceptives through its commitment to ongoing internal funding. It has also shown commitment to strengthening FP/RH preservice education. Challenges remain for the sustainability of the program, however, and the following recommendations should be considered:

- ◆ **Continue the commitment to following the faculty and trainer development pathway:** There is a strong commitment to the faculty and trainer development pathway, but financial support will be needed to enable Turkey to continue to maintain the NTT, CTT, provincial training teams, and faculty and clinical instructor trainer development process. A strategic plan will be needed to guide the maintenance process. United Nations Population Fund (UNFPA) will take over some of these responsibilities.



- ◆ **Use CTT and Istanbul MOH trainers to develop training teams in other provinces:** NTT, CTT, and GD/HT team members should be maintained as trainers in order to expand the development of provincial training teams. Only two provinces have had the opportunity to intensively develop training teams and a FP/RH training system. National- and central-level training team members will be needed to add training teams in other provinces. An expansion plan should be considered to continue to develop the provincial inservice training system for FP/RH and other MNH technical capacities.
- ◆ **Seek external funding for the expansion of the FP/RH program to other provinces and to all schools of midwifery:** At the close of the JHPIEGO program, there were 20 university-based midwifery schools that had not received training. Additional university-based midwifery schools were anxiously seeking assistance from JHPIEGO/Turkey for strengthening their FP/RH program. The newly developed university-based midwifery materials were also in demand. Again, UNFPA will be addressing these needs under its 5-year country program.
- ◆ **Continue to update NFPSDGs as needed without external support:** The NFPSDGs were last updated in 2000. To maintain the quality of care and the quality of the training system, the MOH should continue to keep the national guidelines updated. The technical capacity exists in Turkey, but funding will be needed either internally or from external sources other than USAID.
- ◆ **Maintain followup supervision system:** The MOH supervision system is key to the sustainability of quality services. Both national and provincial trainers/supervisors have been trained in pilot provinces as part of the system. This training must continue and funding for supervision visits is essential. A supervision system is a major challenge for all countries and one of the most difficult sustainability indicators to achieve.
- ◆ **Recommend use of participatory, interactive, competency-based training in other preservice subjects (e.g., CTS-Hacettepe University):** The staff of the project medical institutions and midwifery schools have expressed the desire to transfer participatory, interactive, competency-based training to other preservice subjects. Medical faculty want to provide CTS training to other faculty members teaching other subjects. Midwifery faculty have expressed interest in strengthening MNH training in a similar manner. The use of the ModCal CTS module would assist in this effort both in terms of efficiency and economy.
- ◆ **Add computer-assisted learning technology to the training methodologies:** Computer-assisted learning technology will increase the standardization of knowledge and free trainers to focus on anatomic models training and clinical skills competency. With the level of computer availability, skills, and technical support in Turkey, computer-assisted learning is feasible.
- ◆ **Expand IP training through a continuing education system:** IP needs to be strengthened throughout the country. While the most up-to-date IP resource materials have been translated into Turkish, printed, and distributed to preservice education and inservice training institutions, the document still needs to be disseminated. In Turkey, continuing education requirements are beginning to be enforced to retain medical and midwifery licenses. IUD and IP courses would be important subjects to include in the strengthening of a continuing education system. When ModCal IP is completed, this learning technology would be an effective method for use in continuing education courses.

- ◆ **Expand training model to MNH services in high risk Eastern provinces:** Although the population is smaller in the Eastern provinces of Turkey, there is substantial unmet need for improved FP/RH and MNH services in this high risk area. The improved FP/RH training system should be expanded to the Eastern provinces, and MNH interventions should be added to the technical subjects.

To ensure the long-term continuation of the program, it is essential that the followup supervision system be maintained—both the training of provincial trainers/supervisors and the funding of supervision visits. It is also recommended that the program be expanded to all midwifery schools and to other provinces with the development of additional provincial training teams. In addition, continual updates of the NFPSDGs are key to the sustainability of the program as well as to the use of competency-based training in other preservice subjects. These key recommendations will ensure that the FP/RH preservice education and inservice clinical training systems in Turkey will continue for future generations of trainers, healthcare providers, and their clients.

## SUMMARY

JHPIEGO made substantial gains in meeting the USAID's objectives for Turkey, including Increased Utilization of FP/RH Services and Expansion of High Quality FP/RH Services in the Public and Private Sectors. The project has been successful in assisting the MOH in establishing national FP/RH preservice education and inservice clinical training systems.

Since 1994, the MOH, HPHF, and JHPIEGO have made dramatic progress in the way both FP/RH preservice education and FP/RH inservice training were conducted in Turkey. The training focus moved from funding for preservice education for medical students to strengthening preservice midwifery. MOH funding for group-based inservice and refresher training provided training for new information and skills, while strengthening preservice education for standard knowledge and skills. The MOH, HPHF, and JHPIEGO established the basic framework for a national integrated clinical training system. The Turkish MOH institutionalized FP/RH training and the procurement of contraceptives through its commitment to ongoing internal funding. It had also shown commitment to strengthening FP/RH preservice education.

Training in both preservice and inservice medical and midwifery cadres has now been linked at the clinical training site where economies of scale result from using one group of trainers for a variety of training needs. Training has begun to be decentralized from the national to the provincial level, allowing more FP/RH training to be conducted each year. Training costs for FP/RH inservice courses have been reduced as the preservice medical and midwifery program is able to absorb more FP/RH education.

JHPIEGO and its partners have strengthened training in a cost-effective way by assisting the MOH, medical institutions, and midwifery schools in establishing sustainable high-quality preservice education, by preparing the MOH for future expansion of FP/RH training to other provinces, and by strengthening FP/RH and maternal health skills via a preservice education system.

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# APPENDIX A

## Background Summary of the JHPIEGO/Turkey Program

In 1991, JHPIEGO, its partners at the MOH GD/MCH/FP, and the HSPH conducted a comprehensive assessment of the FP/RH training sector in Turkey (JHPIEGO Asia/Europe/Near East Office 1991) to document the quantity and quality of training already conducted and make recommendations for future activities. USAID facilitated JHPIEGO's collaboration with other CAs in Turkey during this assessment for two reasons: to obtain a comprehensive picture of the RH training and service delivery system in the country and to ensure that the resulting recommendations would reflect the input of everyone involved.

Assessment results indicated that although two-thirds of married couples were using contraception, 34% were using modern methods and 28% were using traditional methods (withdrawal being most common). To establish and maintain quality services and facilitate a shift from the use of traditional methods to modern methods, several areas required attention, including:

- ◆ Establishment of FP/RH services in existing health facilities
- ◆ Standardization of FP/RH SDGs and preservice education materials
- ◆ Development of FP/RH clinical training sites
- ◆ Development of trainers with updated training skills
- ◆ Development of a preservice education capacity to supply the ongoing need for trained providers because the cost of providing inservice training following graduation would be excessive for the MOH
- ◆ Development of the inservice training system to provide continuing education for existing healthcare providers
- ◆ Strengthening of the FP/RH services rendered in the private sector

In 1992, USAID/Turkey requested that JHPIEGO help the MOH/medical institutions develop NFPSDGs and an inservice FP/RH curriculum for physicians and midwives, as well as manage the current project. This part of the initiative emphasized training healthcare providers. In addition, the initiative stressed developing the organizational and training skills of GD/MCH/FP and GD/HT unit staff.

The program provided selected trainers with additional training (inside or outside Turkey) under the coaching of master trainers in their area of expertise. To date, JHPIEGO has helped the NTT and CTT develop advanced and master trainers who are clinical experts in IP, FP counseling, contraceptive technology, CTS, and ATS. One of the master trainers in the program has provided technical assistance to Jordan. Moreover, a delegation from Morocco visited JHPIEGO in Turkey to share experiences and gain insight into how to best use training teams in their country.

Prior to JHPIEGO involvement, the Turkey FP/RH training program was minimally competency-based. In 1983, the Turkish MOH authorized physicians and nurse-midwives to insert IUDs with legal and regulatory support legislated by the Turkish National Parliament. Twenty-five IUDs and 50 pelvic examinations were required for certification. Standardized checklists were not used for safety and quality assurance. Although the old requirements remain in writing, competency-based training—including training with anatomic models before providing services to clients—has been adopted in practice. According to the NFPSDGs and national skills checklists, physicians, midwives, and medical and midwifery students are certified when competency has been achieved.

From 1992 to 1994, the NTT and CTT, with JHPIEGO assistance, reviewed and revised the inservice training curriculum for general physicians and midwives. The FP/RH curricular component refocused inservice medical training around competency-based methodologies and interactive training approaches. Following the development of the training materials in 1993, activities began with the IUD standardization/clinical skills and CTS courses conducted for NTT and CTT trainers.

Since JHPIEGO began supporting the training program in 1992, the emphasis of the program has gradually moved from a 3-week FP/RH course for physicians and a 4-week course for midwives, to a 2-week competency-based course for physicians and a 3-week course for midwives. National FP/RH trainers were strengthened and two strong national and two provincial training teams were developed.

JHPIEGO assistance helped redefine national training methods. With assistance from the HSPH, in collaboration with five other medical institutions and later with the HPHF, the NTT and faculty members from project-affiliated medical institutions began using competency-based, interactive training methods. These techniques became widely accepted and the new training methods were applied to other subjects within the medical institutions. Because the NTT and CTT worked together to train midwifery faculty at vocational and later at university-based midwifery schools, these methods were readily accepted and have been sustained.

Knowledge of modern contraceptive methods is nearly universal among Turkish women. The IUD and the pill are the most widely know FP methods, followed by the condom and female sterilization. Overall, 64% of married women are presently using a contraceptive method. Of these, the majority use a modern method (38%). The most commonly used modern method is the IUD (20%) (Hacettepe University, Institute of Population Studies and Macro International 1999). Because Turkey has such a high IUD acceptance rate, IUD insertion and removal skills are an essential part of both FP/RH preservice education and inservice clinical training for physicians and midwives. FP/RH training, including IUD insertion and removal, is an elective course offered to medical interns at 16 medical institutions. Those who request this training do so voluntarily. Nineteen midwifery students per year from each school were able receive additional IUD training and achieve competency in IUD insertion with clients. Midwifery students are selected for this additional training based on academic achievement, clinical competency with models, and interest. Competent FP counseling and IUD insertion and removal skills with models are required for all midwifery students in project-affiliated schools. Competency is assessed using standardized checklists.

Following the training assessment, the MOH confirmed that providing large numbers of healthcare providers with basic FP/RH skills would be costly and not easily sustained. The MOH GD/MCH/FP decided to reorient their strategy to ensure that all medical and midwifery students graduating from Turkish institutions were competent in a basic set of FP/RH skills. The key institutions, MOH and HSPH, were assisted by JHPIEGO in developing and implementing a strategy to strengthen the national training system that addressed the major FP/RH clinical skills in both preservice education and inservice training.

In 1994, representatives from the MOH, HSPH, and key medical institutions established a technical committee to create the Turkish NFPSDGs. The committee used the prototypical JHPIEGO materials that contained information based on the latest scientific research and other international resource material from USAID's Technical Guidance Working Group (1994) and the WHO. In 1994 and 1995, JHPIEGO conducted a variety of training activities (IP, CTUs, IUD standardization, FP counseling, CTS, ATS courses) for medical faculty, MOH training team members, and clinical instructors. These trainers evolved into two training teams: the MOH GD/MCH/FP and GD/HT members constituted the CTT, and the medical faculty members constituted the NTT.

Using the NFPSDGs as a base and the JHPIEGO *PocketGuide for Family Planning Service Providers* as a resource, the technical committee adapted a pocket guide for use by healthcare providers in clinics. The pocketguide was designed as an easy-to-read, problem-solving handbook for clinicians. The document received national approval in 1995.

This technical committee supported the dissemination of the new, standardized clinical information. In 1995, the NFPSDGs were widely disseminated under the aegis of the MOH. The dissemination initiative first targeted FP/RH trainers and healthcare providers. The Turkish guidelines and the pocketguide helped standardize the quality of services among clinical trainers on the NTT. The NFPSDGs and pocketguide formed the basis of the standardized training materials developed for preservice medical and midwifery education (vocational and university-based), and inservice and refresher training (healthcare providers trained in FP/RH within the last five years but needing updated knowledge and skills).

Members of the original technical committee gathered again in 1999 to develop a plan for organizing the first revision of the NFPSDGs. Subcommittees were formed to develop new sections (e.g., postpartum/postabortion FP services) and update the original sections. Responsibilities were assigned and deadlines were outlined. This revised document was printed in 2000. The distribution and dissemination of 9,500 copies was completed in September 2000 with guidance from the MOH.





## APPENDIX B

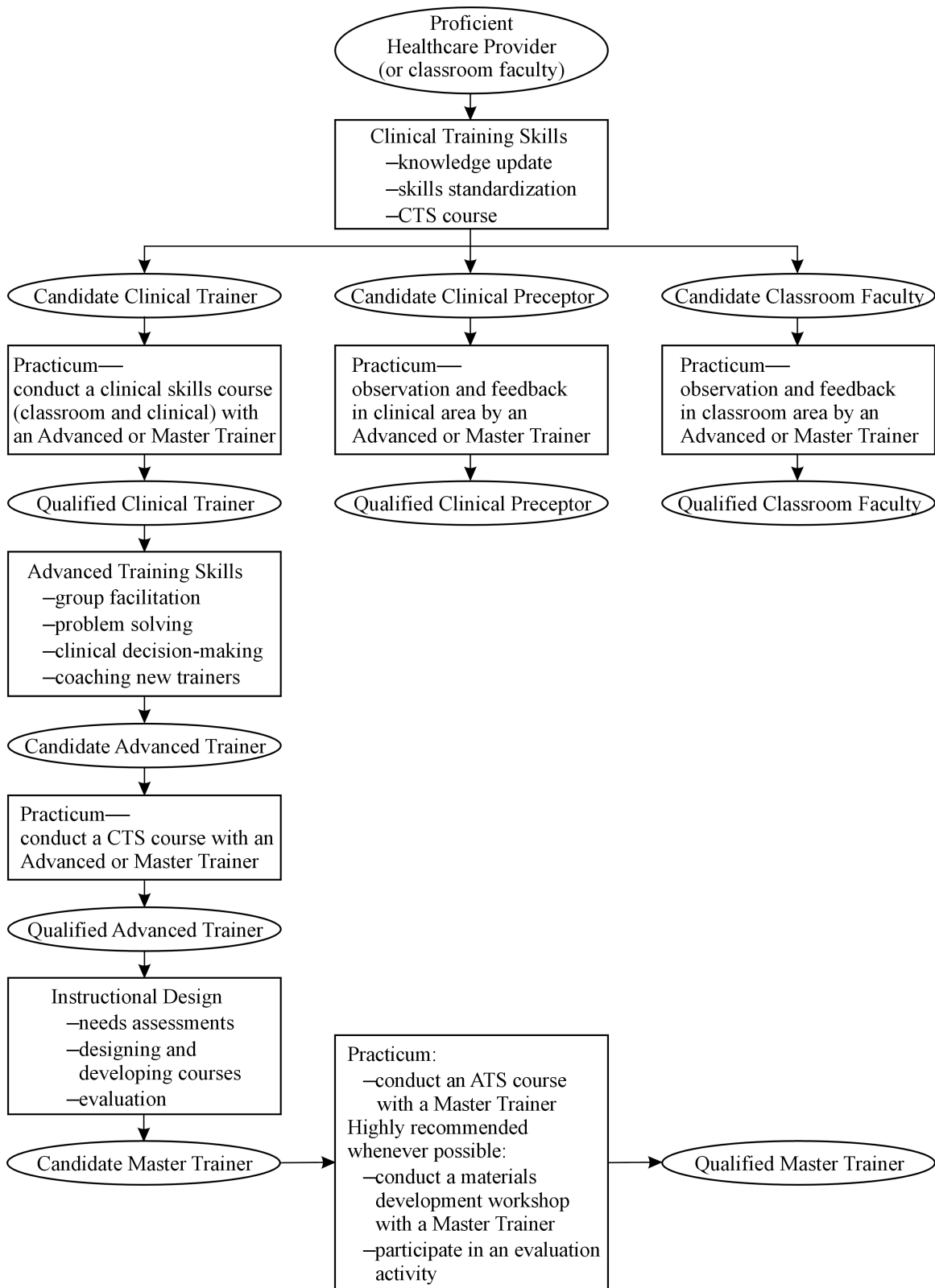
### Definitions Relevant to the Turkey Faculty and Trainer Development Pathway

Trainer Level	Definition
Clinical Trainer	A trainer who can transfer clinical skills to healthcare providers. A clinical trainer must demonstrate proficiency in the clinical FP/RH service(s) for which s/he will be providing clinical training as well as competency in CTS. This individual is competent in both classroom presentation skills and clinical skills demonstration, and coaching and assessment with <b>models and clients</b> . In other words, the trainer is prepared to facilitate both the classroom and clinical portions of a clinical skills course. These trainers may be active in either the preservice education or inservice training arenas.
Advanced Trainer	A trainer who can transfer clinical skills to healthcare providers in an area(s) of specialty (e.g., IUDs, IP, MNH); conduct CTS courses for any area of FP/RH; and coach candidate clinical trainers and candidate advanced trainers as they complete their practicum. The advanced trainer should also be knowledgeable and experienced in conducting various types of training courses in RH. Generally, a JHPIEGO advanced trainer was a proficient healthcare provider first, then became a clinical trainer (e.g., IUDs, IP, MNH) and completed an ATS course and a practicum (i.e., conducted a CTS course with a qualified advanced or master trainer).
Master Trainer	A trainer who can transfer clinical and advanced training skills as well as clinical skills to healthcare providers, clinical trainers, and advanced trainers. The master trainer should also be knowledgeable and experienced in adapting or developing courses (instructional design), conducting various types of training courses in RH, and evaluating training. The master trainer may assist with the development and/or implementation of training programs, assist JHPIEGO in developing new approaches to training, refine prototypic JHPIEGO materials, or serve as a master trainer in a specific activity, including coaching candidate clinical, advanced, and master trainers during their practica. Generally, a master trainer first has been a proficient healthcare provider, then a clinical and advanced trainer, and completed an instructional design course and practicum (i.e., conducted an ATS course or workshop with a qualified master trainer). It is strongly recommended that the candidate master trainer also conduct a materials development workshop with a master trainer and participate in needs assessment and evaluation activities as part of their qualification process, or as soon thereafter as possible in order to further enhance her/his skill development.
Classroom Faculty	A faculty member who can impart <b>knowledge</b> to others, but who does not train others in clinical skills in a clinic or hospital setting. They may be able to demonstrate certain clinical skills with models in the classroom. These health professionals usually function in preservice settings, most commonly in nursing and midwifery schools, and are frequently called "tutors."
Clinical Preceptor	A proficient healthcare provider who can transfer clinical skills to others. The clinical preceptor's work usually focuses exclusively on the clinical area. Although classroom presentation skills were included in the CTS course s/he attended, they were not assessed and, as a result, the clinical preceptor is not qualified to impart knowledge to others in a classroom setting as a clinical trainer does (i.e., by virtue of the preceptor's position, s/he does not do classroom teaching [lectures] and, therefore, has not been assessed and qualified in presentation skills). These individuals are frequently found in preservice programs, but are also active in inservice programs; they may be called "clinical instructors."
Note:	Trainers become <i>candidates</i> at a trainer level after finishing the required course work. They are then <i>qualified</i> once they complete the practicum/requirements specified for that trainer level and gain six months experience at that level.



# APPENDIX C

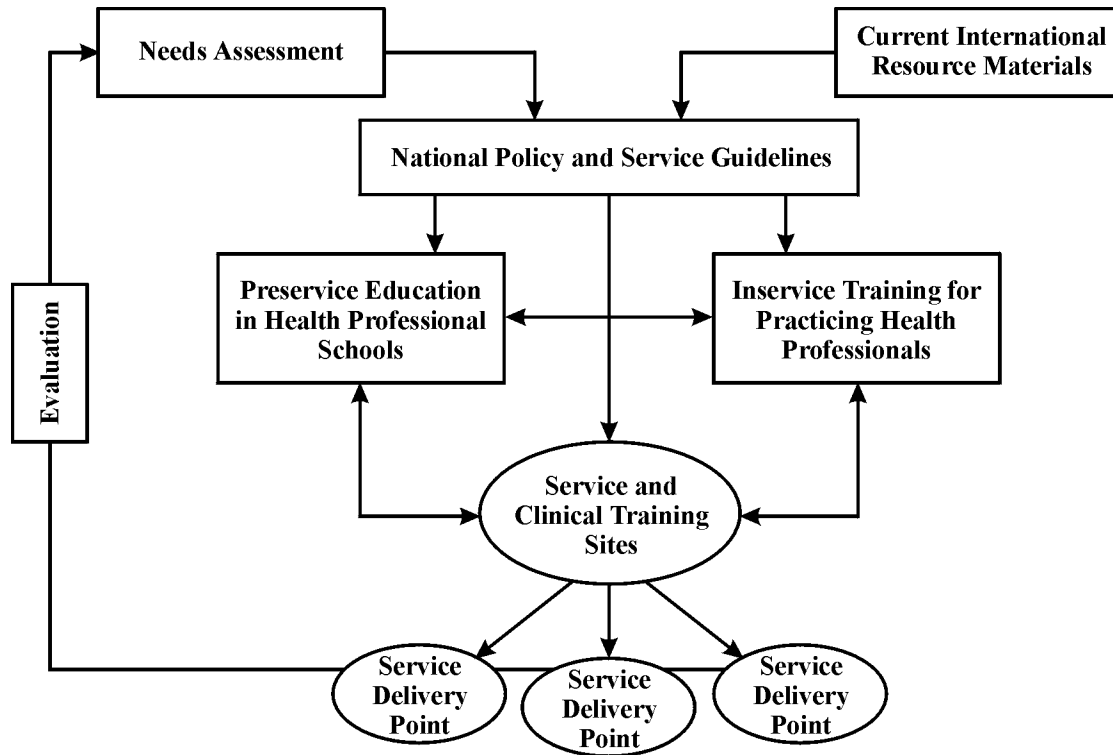
## JHPIEGO's Faculty and Trainer Development Pathway





# APPENDIX D

## JHPIEGO Framework for Strengthening Reproductive Health Systems in National Programs





## **APPENDIX E**

### **Summary of Key Findings from *Evaluation of Field Trips for Post-Training Followup (Turkey)***

In 1997, the JHPIEGO/Turkey office measured the results of the field trips conducted for post-training followup. The followup visits examined whether participants had the required skills at the end of the learning intervention. The visits also assessed the quality of care and quality of training conducted at the training centers, assuring they met national standards. For the JHPIEGO/Turkey inservice intervention, the MOH national and provincial supervisors monitored the quality of care during practicum visits to develop inservice trainers. In the target provinces, CTT members completed workshops to enable provincial trainers to conduct standard supervision followup visits to the centers where trained healthcare providers were assigned. The results of the followup visits were reported to the MOH and the JHPIEGO/Turkey office for monitoring purposes.

NTT, CTT, provincial training team members, and JHPIEGO staff/consultants continued joint followup and supervision visits to monitor the quality of care at the clinic, the quality of skills training, and the quality of CTS. JHPIEGO staff provided technical assistance to the GD/MCH/FP to develop a model standardized followup system including standardized forms and skills checklists. Trainers and supervisors used coaching techniques to assess the quality of care. Problem-solving techniques were used to assist participants make needed changes in their clinic to implement skills they have learned.

The objectives of the followup visits were to reinforce post-training knowledge and FP/RH clinical skills, assist in the problem-solving process for implementing new information and skills, standardize services, and offer feedback and coaching.

An evaluation of the results of the followup visits was conducted to measure the effectiveness of the activities. The results of the assessment indicated the following:

- ◆ Significant improvement in the quality of care occurred between the first and the third visits. As a result of this information, project staff have adhered to a programmatic policy of planning three post-training followup visits per clinical training center.
- ◆ In almost all clinics, knowledge and skills associated with standardization training were in use and conformed to the standards.
- ◆ Client satisfaction was assessed, and clients were found to be content with the FP/RH services.
- ◆ The followup visits were greatly appreciated by the staff, particularly the supportive coaching and problem-solving techniques used by the trainers.
- ◆ It was helpful to have the focus on client assessment and increasing consciousness of the participants about the importance of a client-centered approach.
- ◆ The focus on IP problem-solving helped implement new protocols.
- ◆ Client assessment was adequate at 88% of the clinics at the first visit, but decreased to 78% by the third visit because of staff turnover.
- ◆ The percentage of clinics adhering to standard IP practices increased from 13% to 94% after the followup visits.
- ◆ The standardization of IUD insertion was adequate in 96% of the clinics after followup.

- ◆ Separate counseling rooms were established and 68% of the clinics were providing quality counseling by the third visit. Followup counseling, however, needed improvement in most clinics. Method-specific counseling was adequate at all clinics by the third visit.
- ◆ Generally, physical and medical barriers decreased by the third visit.



## **APPENDIX F**

### **Summary of Key Findings from *Evaluation Report for JHPIEGO Project Activities in Turkey 1993–1996 (Preservice Medical)***

In 1996, JHPIEGO/Turkey staff members, HSPH, and project-affiliated medical institutions conducted an assessment of the progress made by 13 medical institutions toward strengthening FP/RH training. The objectives of the project were to strengthen the quality of FP/RH training in medical institutions, standardize FP/RH training among medical institutions, and achieve standardization of clinical training between medical institutions and MOH clinics.

A NTT was developed consisting of faculty members and clinical instructors. These trainers were prepared to train interns in their last year of medical school by conducting 2-week standard FP/RH courses, including FP counseling and IUD insertion and removal, using interactive and competency-based methods.

The project was launched in 1992 with the support of the MOH and JHPIEGO. The strategy was to establish a NTT, develop standard training materials, provide FP/RH training for trainers in project-affiliated medical institutions, improve the quality of MOH clinical training sites for students, evaluate the results of the pilot project, and expand it nationwide. By 1996, 13 institutions and 14 collaborating MOH clinics had participated and four additional medical institutions joined by 1998.

A baseline survey in 1992 was conducted at the beginning of the project during institutional and facility assessment visits to participating medical institutions. Training of faculty members included clinical standardization courses for IUD and CTS and advanced training/group dynamics courses. The MOH and JHPIEGO developed master trainers who conducted their practicum when they coached other trainers to become clinical and advanced trainers. The faculty and trainer development pathway was adapted and approved.

The standard three followup visits were conducted at each clinical training center to provide post-training coaching and problem solving. Faculty members, MOH representatives, and JHPIEGO consultants conducted these visits. FP/RH training materials were developed for interns.

The evaluation provided an overall summary of the activities completed between 1993 and 1996. Knowledge and skills assessments were conducted for some of the 110 trainers and for all 35 interns trained between September 1995 and January 1996 using Lot Quality Assurance Sampling principles. The endurance of skills competency over time was measured for intern graduates. The results of mailed surveys were used to measure the number of interns who were actively participating in FP/RH activities after graduation. Clinical skills forms as well as classroom presentation, demonstration and coaching skills forms were used for the assessments. Evaluation tools were field tested and revised twice before the final version was deemed acceptable.

The results of the assessment indicated that within 3 years, 13 medical institutions had been included in the project and a total of 110 trainers from universities and MOH clinics were trained and qualified. Faculty participant satisfaction was high and trainers demonstrated competency in clinical and training skills. These trainers, in turn, trained 1,352 interns in 168 standard 2-week FP/RH courses. The great majority of interns (97.8%) were qualified at the end of the course for FP counseling and IUD insertion skills. The IUD insertion skills acquired during the intern course were

found to persist at an acceptable level for 1 year. The assessment process showed that, thereafter, mastery could be again achieved provided the service provider had the opportunity to practice before the first interaction with the client.

The results of the counseling skills assessment indicated that this part of the training needed to be reinforced. More effective use of the FP flipchart would improve the standardization and quality of counseling. For interns, the focus of their efforts should be transferred from how they can provide FP/RH services when they start working in a clinic to how they can establish and then conduct FP/RH services. Problem-solving activities related to establishing FP/RH services were added to the course.

Recommendations made from the evaluation included the development of a strategy for future funding, M&E of intern activities, and the development of a more prompt transfer system of certificates to qualified interns.

## **APPENDIX G**

# **Summary of Key Findings from *Evaluation Report of Strengthening Family Planning Training Project Conducted in Eight Vocational High Schools and Two University-based Midwifery Schools 1998–1999 Educational Year (Preservice Midwifery)***

In 1999, JHPIEGO/Turkey staff members and project-affiliated midwifery schools conducted an assessment of the progress made by eight vocational and two university-based midwifery schools to strengthen FP/RH education. The assessment tracked the changes in the quality of midwifery student performance, classroom and clinical training at the schools, and the quality of services at affiliated clinics. Standardized followup visits were made to clinical training sites to assess the quality of care and clinical coaching skills of clinical instructors. The cost of preservice education and inservice training was compared. Standardized clinical checklists were used for the assessments, including counseling, pelvic examination, and IUD insertion and removal. Quality of care as reported by clients was assessed and feedback was provided to clinical trainers and midwifery students.

The followup team provided feedback on the quality of training and services for faculty members from the schools, GD/HT, and GD/MCH/FP. The structure of subsequent visits was based on earlier findings. At the end of the school year, JHPIEGO staff/consultants evaluated students on FP counseling and IUD insertion using standardized skills checklists.

The evaluation revealed that 11 faculty members, 2 clinical instructors, and 182 midwifery students completed FP counseling and multi-method training, including IUD services with clients. Approximately 20 students per school were selected for their interest, good interpersonal skills, and diligence to complete training in IUD insertion with clients. All 182 midwifery students received certificates allowing them to provide IUD services for clients following graduation. All midwifery students achieved knowledge and skills competency.

The findings also indicated that a friendly rivalry developed between the schools, clinics, and provinces. Educators and clinicians, working together, became models for each other and for students. Team spirit flourished. More schools wanted to join the program, and faculty members adapted participatory, competency-based training methods.

Between followup visits, the MOH staff made telephone calls to identify needs and provide assistance. Counseling and training rooms were created. At times, there was overlap between the clinical training with midwifery students, the clinical training with interns, and the inservice training, resulting in insufficient direct care by students for that period.

Changes in the quality of care in the clinical training centers included standardization of FP counseling and IUD services. Improvements in care were accomplished during the third week of training courses when master trainers and clinicians worked together in the clinics, student practice sessions took place with educators and clinicians, and followup visits were conducted. Examples of improvements in care included the use of contraceptive demonstration kits developed for the counseling sessions. Client interviews showed appreciation for the improved treatment, willingness to refer relatives and neighbors, motivation to travel to the improved services, and appreciation for receiving more information during counseling sessions.

During the evaluation of preservice midwifery education, JHPIEGO/Turkey staff included a cost study comparing preservice midwifery education and inservice midwifery training. The results indicated that training a midwife before her graduation costs 15.3% of the cost of providing inservice training.