Technical Report 2: Follow-up Assessment of the Indian Medical Association (IMA)Family Planning Clinical Training Course in Gujarat

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ACKNOWLEDGMENTS

This follow-up assessment was undertaken at the request and in behalf of the Indian Medical Association (IMA). Such interest by a national professional association to improve its on-going work is unusual and is a strong statement of commitment to quality clinical training for private physicians in India. Significantly, it reflects the IMA's appreciation that their first clinical family planning training experience is but the beginning of an on-going 'work in progress'.

LIST OF ACRONYMS

ACNM	American College of Nurse Midwives
DA	Development Associates
IFPS	Innovations in Family Planning Services Project
INTRAH	Program for International Training in Health
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
OCP	Oral Contraceptive Pill
TOT	Training of Trainers
USAID	United States Agency for International Development
UP	Uttar Pradesh

LIST OF APPENDICES

I. EXECUTIVE SUMMARY

From September 20-29, 1995, ACNM/PRIME technical advisor Dr. L. Sibley and INTRAH/ PRIME consultant Dr. B. Buch conducted a follow-up assessment of the Indian Medical Association (IMA) Family Planning Training Program Level II training which took place in the state of Gujarat from June through December 1994. The purpose of the assessment, undertaken on behalf of IMA, was to identify 'lessons learned' from IMA's first experience in clinical training and the implications for the clinical training proposed for Uttar Pradesh (UP). Objectives of the assessment were to:

1) Describe the perceptions of trainees and trainers who participated in the IMA's clinical training program in terms of its achievement of the primary objectives, structure and content, implementation and efficacy;
2) Assess the performance of trainees and trainers who trained or were trained in the program; and
3) Assess the knowledge of trainees.

Data were obtained from a convenience sample of 30 percent of all trainees (N=25) and 60 percent of all trainers (N=12) from the cities of Ahmedabad, Rajkot, and Surat. Data collection procedures included focus group discussion with trainees and trainers, observation of trainees and trainers, testing of trainees and a review of the results of a postal questionnaire. The need to modify the original random sampling method as well as the unavailability of some of the post course test data imposed limitations on the breadth and depth of this follow-up assessment, particularly in regard to the trainees' retention of knowledge. Nonetheless the results and recommendations of this assessment should be useful as guidelines in planning and developing future FP/RH training in Gujarat as well as in other places in India.

Most of the "lessons learned" and the resulting recommendations focus on one or another aspect of the FP/RH training infrastructure as it was experienced in Gujarat and emphasize the need for a well-planned training program grounded in a careful training needs assessment. The assessment's major findings and recommendations are:

1. Quality Assurance Policies and Programs for FP

There is a need for country-wide leadership, through the IMA, to develop FP/RH quality assurance policies and mechanisms, giving priority to developing an understanding of this need and the skills necessary for training documentation and performance monitoring and evaluation. These quality assurance initiatives should proceed at national as well as state, district and local levels.

2. Training Needs assessments and Training Program Objectives

Ideally, FP/RH training needs, objectives and programs should be developed from data gathered in training needs assessments. These training objectives and the baseline data should then serve, among other things, as the basis for establishing specific selection sites and trainees, and for the development of selection criteria for trainers and trainees. The importance of comprehensive TNAs and the data gathered by them can not be overemphasized.

3. Training Program Management

Competency-based training requires careful planning, preparation and coordination among the various constituencies involved, from funding agency to client. Roles, responsibilities and lines of communication should be identified or clarified among program personnel at each level. A program management plan should be built into the training program document to serve as a point of reference.

4. Training of Trainer (TOT) Workshops

To ensure that the trainers are well prepared and competent to teach it is essential that the TOT workshops be reviewed carefully to ascertain that the curriculum is sufficiently comprehensive, the practicum is adequate, and that the knowledge and skills of the trainers are tested prior to their final selection as clinical instructors. Trainers are a critical part of the FP quality assurance effort and they should also receive good training and supportive supervision to ensure that they themselves are *competent* and *confident* of their skills, and that they are imparting correct knowledge and skills to trainees.

II. INTRODUCTION

1. Background

The Family Planning Training Program was developed in 1993 for the IMA through the Family Health Training Project of Development Associates (DA), with major technical inputs by IMA members, and with joint sponsorship of the Government of India and the United states Agency for International Development (USAID). The overall objectives of the Family Planning Training Program are to update and expand the technical knowledge, attitudes and skills of IMA members in contraceptive technology for the provision of comprehensive child-spacing services, and to improve community access to such services. This course in Gujarat was the IMA's first clinical training experience (personal communications with Dr. J.C. Sobti, Dr. I.C. Shah, and Dr. B. Buch 1995).

The Family Health Training Program is described as a competency-based participatory training course emphasizing the technical knowledge and skills required to provide comprehensive child-spacing services. It was designed for progressive levels of study. Level I provides trainees with a technical overview of all contraceptive methods currently available in India, with emphasis placed on the provision of the oral contraceptive pill (OCP) and family planning counseling skills. Eighteen hours of workshop and simulated practice are required for this course. Alternatively, participants may undertake the course through directed home study. Successful completion of Level I results in graduates receiving the IMA's *Diploma of FP Counselor*. Level II involves more extensive training in the provision of intrauterine contraceptive device (IUD) services, including insertion and removal, screening for genital tract infections, as well as infection prevention concepts and measures. It requires an additional 24 hours of workshop and simulated practice – 6 devoted solely to IUD – as well as up to 18 hours of clinical practice. Graduates of this program receive the IMA's *Diploma of FP Consultant*.

During 1993, the Gujarat State branch of the IMA trained 1,400 member physicians in Level I of the Family Health Training Project. Of this number, 147 physicians requested Level II training. One hundred of these applicants, all holding the *Diploma of Family Planning Counselor*, were selected to participate in the Level II training course, which took place from June through December, 1994 in the cities of Ahmedabad, Rajkot and Surat. All of the participants were urban based and they paid Rs./ 100.00 to attend the course. Twenty physicians, previously trained by DA and the Johns Hopkins Program for International Training in Reproductive Health (JHPIEGO) at Mt. Abu-Hill Station, Rajasthan, in May 1993, were the instructors for this clinical course.

2. Purpose

The purpose of this follow-up assessment 9 months after the completion of the course was to identify 'lessons learned' from the IMA's Gujarat clinical training experience and to make recommendations for the first clinical training proposed by the IMA for Uttar Pradesh (UP) under the Innovations in Family Planning Services Project. The assessment was undertaken at the request and with the guidance of the IMA, and it had the following objectives:

- Describe the perceptions of trainees and trainers in terms of the achievement of training objectives, the adequacy of the course structure and content, and any issues surrounding program implementation;

- Assess the post-training clinical skills of trainees and trainers with respect to IUD counseling and insertion;

- Assess the post-training knowledge of trainees with respect to IUD counseling and insertion.

III. METHODOLOGY

1. Design and Sample

This assessment was a cross-sectional, descriptive study of a sample of the Level II training course participants. Of the 100 physicians selected for the clinical course, 83 successfully completed it. To obtain a representative sample of these graduates, 25 trainees were randomly selected from this group, proportionate to the numbers trained in each of the three training sites, Ahmedabad, Rajkot and Surat. Unfortunately however, due to the assessment's tight time schedule, as well as to the trainees' work and personal obligations, 56 percent (N=14) of those initially selected were unable to participate. They were replaced with other trainees who were available to participate in the assessment[1], still maintaining proportionate representation of trainees by city. Twelve of the 20 trainers who taught the course also agreed to participate in the assessment, as did the state program coordinator.

2. Procedures

Quantitative and qualitative data were gathered from the sample trainees and trainers using the following instruments:

- Focus groups discussions with trainers and trainees, held separately, utilizing prepared guides (Appendix A);

- Direct observation of trainers and trainees inserting the IUD either under simulated clinical conditions working with the Zoe model or under clinical conditions working with clients; assessed against IMA's adaptation of the *JHPIEGO Checklist for IUD Counseling and Clinical Skills* (Appendix B) used during the course;

- Testing of trainee knowledge using IMA's *Module 9 Post Test* (Appendix C) used during the course;

- Analysis of returns from IMA's *Postal Questionnaire* (Appendix D) for selected personal and service delivery information.

ACNM/PRIME technical advisor Dr. L. Sibley and INTRAH/PRIME consultant Dr. B. Buch conducted the assessment. Dr. Buch, who had been a trainer in the program, assisted primarily in the provision of background materials, a review of the interview guides, discussions with fellow trainers, and coordination of logistical arrangements in each of the three cities. He was also a

[1] There was no significant difference between trainees who had been randomly selected and those who subsequently volunteered with respect to each of the selected characteristics listed in Table 2 (Fisher's exact probability test or Kurskal-Wallis test, as appropriate). *Therefore, it was assumed that the sample is representative of all trainees who completed the course with respect to these characteristics.*

subject in his own locale. The data were collected over a period of 10 days, September 20-29, 1995. In each city the discussions with and observations of the trainers and trainees and the testing of trainees were conducted, with one exception in Ahmedabad, by Dr. Sibley at a central location at one or more of the classroom or clinical training sites.

3. Analysis

Qualitative data obtained from focus group discussions are presented to describe the perceptions of the discussants on the various topics queried. Quantitative data obtained from the postal questionnaire, and from the knowledge and skills testing of trainees and trainers, were analyzed using Epi Info 6.0 or PC-SAS to generate descriptive statistics and perform statistical tests where appropriate.

4. Limitations

It was anticipated that the sample of trainees selected for the follow-up assessment would be a randomly selected group representative of all trainees who completed the Level II course, and that there would be test scores of their knowledge and clinical skills in the IUD method from two points in time to measure their retention 9 months post-training. Neither of these expectations was fully realized. First, the sample was non-random for the reasons described above. Moreover, although there were 25 trainees in the sample, participation in each component of the assessment varied, reducing the effective sample size to less than the original 30 percent of all trainees who completed the Level II course (Table 1). Second, results from knowledge tests administered at the end of the course (*Module 9 Post Test*) were not available in two of the three training locations, making it impossible to compare test results across the 9 month time period for trainees from the two cities. Given these significant limitations, the findings, conclusions and recommendations presented are best viewed as lessons learned which may be instructive in planning future clinical training in Gujarat, in Uttar Pradesh, and in other sites in India.

Table 1. Number of Subjects Participating in Each Component of the Assessment

PARTICIPANTS	Focus Groups		Direct Observation		Testing		IMA Postal Questionnaire	
	N	% of total	N	% of total	N	% of total	N	% of total
Trainers (#)	12		4		0		0	
State Program Coordinator (#)	1		0		0		0	
Trainees (#)	19	23%	20	24%	21	25%	18	22%

Effective sample size, trainers = 60%; trainees = 24% of total.

IV. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

1. Program Outcomes

a) Findings

Twenty-eight percent of the 18 sample physicians who responded to the postal questionnaire reported that they inserted an IUD for the first time during training or post-training at their clinics (4 males, 1 female) and that they averaged 1.3 IUD insertions per month for the post-training period. Although the four males averaged fewer than one IUD per month, it is unclear whether that lower rate was attributable to the type of clinics they worked in or to female clients' preferences for female physicians for this service.

Overall, 33 percent of the follow-up participants (4 males, 2 females) reported having inserted no IUDs, and 28 percent (4 males, 1 female) reported having inserted between one and ten IUDs during the 9 months since their training was completed, giving an average of 1.1 or fewer IUDs monthly. Females reported having inserted more IUDs, but more females also reported that they worked in facilities sponsored by the government with larger client volumes, than their male counterparts (Table 2).

b) Conclusions and Recommendations

The average number of IUDs inserted post-training (1.1 per month) by nearly two thirds of the trainees was low from the perspective of expansion of service delivery for the method. From the perspective of expanding delivery to rural, under-served areas, it was also problematic because all the trainees were from urban areas. They returned to their urban clinics and did not expand services to rural areas. The data suggest that there may be a female client bias against male physicians in that they reported having fewer numbers of IUD insertions post-training than female providers. However, this may simply be a function of physicians' type of practice, i.e., private practice versus government-based practice, the latter having a higher volume of clients receiving IUDs.

Care should be given to the development of selection criteria for trainees. It would be important to select those trainees from both urban and non-urban areas who have clinical sites and who potentially have a sufficient volume of clientele at their home clinic for the IUD method. It *may* also be important to give priority to female physicians where possible, if indeed it is confirmed that women clients prefer them for this family planning service.

Table 2. Selected Characteristics of Trainees

CHARACTERISTICS		
	number	**percentage**
Age (Yrs)*	17	
31-40		35
41-50		59
51-60		6
Sex	25	
Female		52
Male		48
Qualification*[b]	25	
MBBS		92
DGO		8
Type of Worksite*	19	
Private		68
Government		26
Private + Government		5
Inserted IUDs Before Training*	18	
Yes		50
No		50
Inserted IUDs After Training*	18	
Yes		74
No		26
Number of IUDs Inserted After Training *[c]	18	
0		33
1-10		28
11-40		11
41-60		6
61-80		0
81-100		0
>100		22

Sources of data: * *Postal Questionnaire*. [a]Observation. [b]IMA list of trainees. [c]Discussion. *Caveat*. Data were missing for 7 trainees for at least one of the three "IUDs Inserted" variables on the *Postal Questionnaire*. Moreover, data obtained from the *Postal Questionnaire* are potentially unreliable. One respondent reported having inserted 10 IUDs post-training on the questionnaire (May) but only 3 IUDs during discussion (September). Another reported having inserted 25 IUDs post-training on the questionnaire but reported none during discussion. Data representing the estimated numbers of IUDs inserted post-training above are based on direct questioning. Trainees' statements were taken at face value.

2. Perceptions of the Program by the State Coordinator, Trainers and Trainees

a) Findings

Nineteen trainees, 12 trainers and the Gujarat state program coordinator participated in focus group discussions. They were encouraged to be analytical and candid, to talk about what worked and what did not work and to give recommendations for change. The findings reported focus primarily on those areas where improvement was thought to be needed. Their responses are summarized below.

The *state program coordinator* and most *trainers* perceived that the selection criteria for trainees were inappropriate for the stated goals given that so many trainees were either not inserting IUDs or inserting very few IUDs post-training and that all were from urban areas. They emphasized that criteria for selection should be established to promote expanded coverage. Examples of new, more goal-appropriate criteria included:

- Trainees should "have motivation" and a clear understanding of program objectives and requirements;
- Trainees must have a facility with sufficient equipment, space and an existing caseload for IUD service delivery;
- Trainees should be selected from areas where community need is greatest (under-served or rural areas);
- Trainees should have personal characteristics that are in keeping with client preference, i.e., they should be female.

Trainees, on the other hand, recommended that:

- Training sites must have a sufficient number of clients for the clinical practica in order to meet learning needs;
- Trainers must be good trainers as well as good clinicians.

Most *trainers* and *trainees* judged the Level II training course to be excellent in terms of:

- The low trainer/trainee ratio, which ranged from 1:3 to 1:8;
- The use of participatory humanistic approach, e.g., working with the Zoe model before working with humans;
- Well designed materials and relevant content.

Most *trainers* and *trainees* also assessed that the division of hours among classroom and simulated practice (about 24 hours) and clinical practice (about 18 hours) was appropriate in terms of imparting knowledge and developing skills in inserting and removing the IUD.

However, many felt that the requisite number of 10 practice insertions per trainee was too low. Many trainees, particularly those new to the IUD method, did not feel competent and confident in their skills upon certification; and all *trainees*, whether new to the IUD or not, stated that they would have liked more supervised clinical practice.

Finally, some *trainers* and *trainees* described great difficulties in achieving the requisite number of 10 cases for each trainee. This problem was attributed to both the use of private clinic sites as practicum sites and to the sex of the trainees. Private clinics were reported to have had an insufficient number of clients requesting the IUD to provide an adequate caseload for the trainees. Regardless of site type, some male trainees were reported to have bee refused by clients and to have had to attend the clinical practicum for a longer time period to achieve the required number of cases.

In general, given the low numbers of IUDs being inserted post-training by trainees and their exclusive urban distribution, the *state program coordinator*, as well as many *trainers* and *trainees*, judged that the program objective of expanded service delivery for the IUD method was not achieved as a result of this first training program. However, some *trainers* and *trainees* expressed the view that the program objective was met if private physicians were trained to counsel and refer clients for a IUD when they were unable to provide that direct service themselves.

b) Conclusions and Recommendations

The need to revise or establish other, more goal-appropriate selection criteria for trainees was supported by the data obtained in the focus group discussions. The perception of a female client bias against male providers, while suggested by the data, remains inconclusive. Certainly there is need to reconsider the selection criteria for training sites, the most important considerations being the sufficiency of client volume for the trainee clinical practice experience. For the training to be competency-based, it would be important to increase the numbers of clinical experiences to meet the dual objectives of trainee *competence* and *confidence* as assessed by both the trainer and trainee. Finally, it would be as important to establish selection criteria for trainers as it is for trainees. Competence in training and clinical precepting are critical elements to the trainees and to the success of the program.

The issue of whether or not the program objective of expanded service delivery points for the IUD can be achieved through training physicians who will counsel and refer clients for the IUD, rather than provide direct IUD services, should be considered an important element in trainee selection criteria.

Ideally, baseline data should be collected through a training needs assessment, which would include an assessment of community preferences with respect to the sex of the service provider. A review and clarification of training program objectives is also recommended. These baseline data and training objectives should then serve, among other things, as the basis for establishing specific selection criteria for trainers, training sites and trainees.

3. Quality Assurance Policies and Programs

a) Findings

The *state program coordinator* and all *trainers* indicated that there had been no plan to document the training apart from pre and post test results or to follow-up trainee performance or the training impact on expanded service delivery. They stated that this follow-up assessment was the first such activity. They also strongly emphasized the need, and their desire, to develop and put into place systematic mechanisms and processes for on-going documentation of training activities, for monitoring and evaluating trainee performance, and for continuing refresher education for both trainers and trainees. They also expressed concern about medical liability issues involved in clinical training, particularly in light of the developing public awareness of the Consumer Protection Act.

b) Conclusions and Recommendations

The concern expressed regarding the lack of systematic training documentation, monitoring and evaluation of trainee performance, and of refresher education to maintain and update skills demonstrates a desire for mechanisms and processes to ensure quality in training and in performance. The need to develop these mechanisms and processes is a challenge for the IMA and their member physicians.

The IMA should develop quality assurance mechanisms and processes, giving priority to developing an understanding of and the skills necessary for training documentation and performance monitoring and evaluation. In view of the expressed concern for medical liability and consumer protection, it would also be useful to complement these national efforts through the establishment of a designated IMA committee which would develop additional quality assurance mechanisms and processes at the state, district and local levels utilizing their extensive volunteer network. These quality assurance initiatives might include periodic review of clinical standards, guides and guidelines or supportive supervision and peer review.

4. Training of Trainer (TOT) Workshops

a) Findings

The *state program coordinator* and many *trainers* reported certain problems with course implementation which they believe were due to:

- Inadequate preparation during the training of trainers (TOT) e.g., trainers contributed to curriculum development but never had the opportunity to practice using the curriculum or the lesson plans;

- The long delay between the TOT and first training (about 11 months) leading to demoralization and loss of confidence among trainers;

- The lack or untimely distribution of course materials and equipment to trainers.

They attributed these problems to poor communication between the funding agency and IMA and among IMA program managers at all levels.

b) Conclusion and Recommendations

A proper environment for competency-based clinical training needs to be developed before training begins. This would include at least a delineation of program management structure, roles, responsibilities and lines of communication;; an orientation of prospective trainers and trainees to program objectives and requirements; completed preparation of the curriculum and all supporting course materials; adequate preparation of trainers (as defined by trainers themselves), and perhaps an opportunity for trainers to practice implementing the curriculum.

During a review of program objectives, IMA program personnel should carefully reconsider the requirements of competency-based training including planning, preparation and coordination among the various constituencies involved, from funding agency to client; and then should clarify the roles, responsibilities and lines of communication among program personnel and others in this context. A program management plan should be built into the training program document to serve as a point of reference.

5. Trainers' and Trainees' IUD Skills

a) Findings

Twenty trainees and four trainers were observed inserting an IUD during this follow-up assessment. Half of the trainees and three-quarters of the trainers were observed working on the Zoe model and the rest were observed working on clients. Performance assessments on these IUD insertions are shown in Table 3. The mean and standard deviation values, expressed as a percentage, reflect the number of tasks included in the checklist, as well as the observer's assessment of the adequacy with which each was carried out. They also provide an estimation of the thoroughness and variability of performance.

Overall performance ratings for the IUD insertion component of the checklist were based on the observer's judgment of the overall adequacy with which tasks were carried out. The criteria were clinical competence and client safety based on the performance of *critical tasks*. For example, one might receive a satisfactory rating for performing each task in the insertion component of the checklist except for the task 'Inserts Cu-T using the withdrawal technique'. If the individual used a plunge technique, he or she received an unsatisfactory rating for the entire component

because this is considered to be the "critical task" (due to the risk for uterine perforation). Interestingly, there were no statistically significant differences in overall performance ratings between trainees who worked with the Zoe model and those who worked with clients. Similarly, there were no differences in overall performance ratings between trainees with respect to other selected characteristics including age, sex, location of training, type of work site, provision of pre-training IUD services and the estimated number of IUDs inserted post-training.

Table 3. Performance Assessment of Trainees and Trainers

PERFORMANCE ASSESSMENT	% Not Observed (*Mean ± SD*)	% Satisfactory (*Mean ± SD*)	% Unsatisfactory (*Mean ± SD*)
PRE-INSERTION COUNSELING			
Tasks Performed			
Trainee	38.7 ± 22.2	60.6 ± 21.9	0.6 ± 1.8
Trainer	18.8 ± 17.7	81.3 ± 17.7	--
INSERTION OF Cu-T			
Tasks Performed			
Trainee	30.4 ± 30.0	65.0 ± 27.8	4.6± 8.8
Trainer	24.1 ± 33.6	73.1 ± 33.2	2.8 ± 8.0
Overall Performance			
Trainee		45%	55%
Trainer		50%	50%
POST-INSERTION COUNSELING			
Tasked Performed			
Trainee	21.3 ± 16.5	78.8 ± 16.5	--
Trainer	25.0 ± 20.4	75.0 ± 17.7	--

* The mean and standard deviation values are slightly skewed towards an increase in the percentage receiving a 'Not Observed' due to assignment of 'Not Observed' to tasks included in the checklist which were not indicated in the situation such as collecting vaginal and cervical specimens, performing microscopic exam (where equipment available), and rectal exam; and to those pre- and post-IUD insertion counseling tasks omitted by 10 trainees and 1 trainer who reported that counseling had occurred prior to performance under observation.

Both trainees and trainers performed very well on the counseling portion of the assessment. Fully 90 percent of the *trainees* and 100 percent of the *trainers* received satisfactory performance ratings (while role-playing with the Zoe model only). On the assessment of IUD insertion, only 45 percent of the *trainees* and 50 percent of the *trainers* received satisfactory performance ratings (with both the Zoe model and clients). When those who had inserted 50 or fewer IUDs were compared with those who had inserted more than 50 IUDs post-training, there was no significant difference in their performance ratings. 'Unsatisfactory' ratings were given because specific

tasks were either not performed or were performed unsatisfactorily. These tasks were related to infection prevention measures and insertion technique (Table 4).

b) Conclusions and Recommendations

The cause for the high rate of unsatisfactory performance of IUD insertion among trainers is unknown. Trainers who received unsatisfactory ratings had IUD insertion experience prior to participating in the TOT. Additionally, during the TOT they practiced IUD insertion and removal (working with the Zoe model only). Although training of the trainees did not begin until 11 months after the TOT, that delay does not, itself, explain the trainers' poor performance. It appears that either they learned little from the TOT, or they maintained or reverted to their prior technique following the TOT.

It is obviously essential that trainers have mastered the appropriate (according to specific clinical standards) IUD insertion and removal technique and rationale, as well as infection prevention measures, before they assume the role of clinical preceptor. Although trainers who are also practicing clinicians may develop their own style or technique, consistency in training requires that technique be standardized. Trainees, in addition to needing this initial training in the IUD method, also need some quality assurance mechanisms to assist them in maintaining their competency levels after the training. Continued competency, once mastery is achieved, should be maintained through on-going and sufficient practical experience as well as other quality assurance or continuing education programs.

During the TOT, trainers should have an opportunity to develop their skills working with real clients as well as with the Zoe model. During training, the trainers should receive supportive supervision to ensure that they themselves are *competent* and *confident* of their skills, and that they are imparting correct knowledge and skills to trainees. Following training, it would be also important that supportive supervision and performance evaluation of trainees take place periodically. Professional peer review mechanisms might be established for this purpose through the IMA training network.

Table 4. Tasks That Received 'Unsatisfactory' Ratings

TASKS: IUD Insertion Procedure	% Observed Trainees (N=20)	% Observed Trainers (N=4)
INFECTION PREVENTION MEASURES		
Use of one glove	20	0
Contamination of glove(s)	25	25
Instruments improperly sterilized/tray in disarray[1]	5	25
Swabbing vagina (cervix?) prior to speculum exam (confounding)	15	25
Not swabbing cervix with antiseptic before insertion of Cu-T	10	25
Bi-manual exam performed before speculum exam (confounding)	5	25
Loading Cu-T outside of sterile wrapper	10	0
Contamination of uterine sound	20	0
Contamination of Cu-T	5	0
Fresh blood on floor not cleaned up after one client/before next	5	0
INSERTION TECHNIQUE		
Pre-loading Cu-T>1 hour before insertion[1]	25	25
Not sounding the uterus prior to insertion of Cu-T	10	25
Failure to measure uterine sound/set gauge on Cu-T	5	0
Use of plunge technique to insert Cu-T	25	25
Failure to observe cervix post-insertion/arrest active bleeding	5	0

[1]That instruments were improperly sterilized – there was a shortage – and the instrument tray was in disarray, as well as that the Cu-T was pre-loaded >1 hour prior to insertion were reportedly due to the volume of clients seen by trainees and a trainer in one setting as a result of the assessment itself.

6. Trainees' Knowledge of the IUD Method

a) Findings

Twenty-one trainees took the follow-up post-test. Their average score was 72 percent, with a range from 54 to 85 percent (Table 5). The lowest scores were in the areas of infection prevention and IUD follow-up. However, the average test score is difficult to interpret. The original instrument had not been pre-tested; a sufficiently large number of trainees answered certain questions incorrectly – suggesting poor test items and/or poor training; and standard deviation and range values for responses to many questions were generally very large – to indicate that trainee knowledge, testing ability or both were highly variable. Taken together, these findings and interpretations lead one to suspect that the test may not be a good measure of what the trainees actually know. Finally, there was no standard scoring procedure or cut-off score for the original pre/post course test, in addition to the absence of test results in two of the

three training locations, so that it was impossible to address the issue of knowledge retention at follow-up.

b) Conclusions and Recommendations

There is need to pre-test knowledge and skills assessment instruments, to establish minimal acceptable levels of performance and to standardize test scoring procedures. That this was not done prior to training in Gujarat raises questions about the trainers' understanding of testing generally.

The testing of health care providers for the purpose of certification is a common procedure to assure quality of care and consumer protection. It can also be a mechanism for the improvement of training course method and content and a tool for providing feedback to individual trainees. It is recommended that during the TOT, time be devoted to these issues as well as to the pre-testing of assessment instruments, establishing minimal acceptable performance levels, and standardizing test scoring procedures.

Table 5. Test Content By Test Scores

TEST CONTENT	Score % Correct Response (*Mean ± SD)	Score % Correct Response (*Range)	Index[a]
Counseling for IUD:			
Question 1a-e*	94.2 ± 6.4	85.2 - 100.00	77
Question 7a-f*	52.4 ± 17.1	33.3 - 100.0	
Question 8a-c*	88.9 ± 7.2	81.0 - 95.2	
Question 9	81.0		
Question 10	90.5		
Screening for IUD:			
Question 2a-g*	73.4 ± 20.8	33.3 - 100.00	75
Question 3a-d*	91.7 ± 7.1	81.0 - 95.2	
Question 11	09.5	-	
Question 14	85.7	-	
Infection Prevention Measures:			
Question 4a-f*	66.7 ± 22.7	38.1 - 90.5	67
Question 5a-e*	68.6 ± 30.4	23.8 - 100.0	
Question 12	28.6	-	
Question 16	95.2	-	

TEST CONTENT	Score % Correct Response (*Mean ± SD)	Score % Correct Response (*Range)	Index[a]
Management of Complications:			
Question 17	100.0	-	87
Question 18	85.7	-	
Question 19	81.0	-	
Question 20	81.0	-	
IUD Follow-Up:			
Question 6a-e*	62.9 ± 22.7	42.9 - 95.2	63

[a] The index represents the average correct response, expressed as a whole percentage, where each of 53 multiple choice/true-false test items is treated as a potential response (correct or incorrect). Note that scores for questions related to knowledge of infection prevention measures and IUD follow-up are low. While the former appear to be consistent with observations of infection prevention measures performed (or not performed) by trainees during IUD insertion, they are not. The kinds of questions asked were related to key prevention activities whereas the kinds of behaviors observed were primarily related to contamination of hands and instruments and confounding of physical evidence because of improper sequencing of steps/tasks and have to do with the 'embodiment' of knowledge. Thus, the relationship between the low test scores and unsatisfactory performance in this area is unclear.

V. SUMMARY OF RECOMMENDATIONS

Findings from this follow-up assessment of the Gujarat Family Planning Training Program provide evidence to identify several "lessons learned" which may be instructive for the future development of FP/RH training in India. Most of the "lessons learned" and the resulting recommendations focus on one or another aspect of the FP/RH training infrastructure as it was experienced in Gujarat and emphasize the need for a well-planned training program grounded in a careful training needs assessment. Major recommendations were focused primarily in the following four areas:

1. Quality Assurance Policies and Programs for FP

There is a need for country-wide leadership, through the IMA, to develop FP/RH quality assurance policies and mechanisms, giving priority to developing an understanding of and the skills necessary for training documentation and performance monitoring and evaluation. These quality assurance initiatives should proceed at national as well as state, district and local levels and might include a variety of efforts from periodic review of clinical standards, guides and guidelines or supportive supervision and peer review, to continuing-education workshops.

2. Training Needs Assessments

Ideally, FP/RH training needs, objectives and programs should be developed from data gathered in training needs assessments. These training objectives and the baseline data should then serve, among other things, as the basis for establishing specific selection sites and trainees. Care should be given to the development of selection criteria for trainers and trainees. It would be important to select those trainees from both urban and non-urban areas who have clinical sites and a sufficient volume of clientele for the IUD method. It *may* also be important to give priority to female physicians where possible, if indeed it is confirmed that women clients prefer them for this family planning service.

3. Training Program Management

During a review of program objectives, IMA program personnel should carefully reconsider the requirements of competency-based training including planning, preparation and coordination among the various constituencies involved, from funding agency to client; and then should clarify the roles, responsibilities and lines of communication among program personnel and others in this context. A program management plan should be built into the training program document to serve as a point of reference.

4. Training of Trainer Workshops

To ensure that the trainers are well prepared and competent to teach it is important that the TOT workshops be reviewed carefully to ascertain that the curriculum is sufficiently comprehensive and the practicum is adequate. The following specific points should be emphasized:

- To practice and enhance their clinical skills, it is important that the trainers have an opportunity to work with clients as well as with the Zoe model during the TOT.
- During the training, trainers should also receive supportive supervision to ensure that they themselves are *competent* and *confident* of their skills, and that they are imparting correct knowledge to trainees.
- Following training, it would be also important that supportive supervision and performance evaluation of trainees take place periodically. Professional peer review mechanisms might be established for this purpose through the IMA training network.
- The testing of health care providers for the purpose of certification is a common procedure used to assure quality of care and consumer protection. Testing can also be a useful mechanism for the improvement of training course method and content and a tool for providing feedback to individual trainees. It should be incorporated into the TOT.
- To assure the validity and reliability of the performance assessment process it is recommended that, during the TOT, time be devoted to the pre-testing of assessment instruments, establishing minimal acceptable performance levels, and standardizing test scoring procedures.

It is the authors' hope that these recommendations and "lessons learned" from the follow-up assessment of the Gujarat clinical training course will be considered and adopted, as appropriate, in future FP training courses in India.

APPENDICES

APPENDIX A

Discussion Guides for Trainers and Trainees

Trainers' Interview/Discussion Guide:

1. In the training course you conducted, did you utilize the course exactly as developed by participant at the Mt. Abu Workshop? If not, please describe how you adapted it to your local setting. Please tell why you made these adaptations in: a. curriculum; b. training methods; c. training materials.

2. Describe both the *criteria* and *process* (by whom, how, when, where) by which participants were selected. In your opinion, were both the selection criteria and process appropriate? If not, what changes would you make?

3. Describe both the *criteria* and *process* (by whom, how, when, where) by which training sites were selected. Would you recommend the same for UP? If yes, why? If not, why not?

4. What were the *main* objectives of the IUD clinical training? Do you believe these were obtained? If not, why?

5. What was the division in number of hours between theory, simulated practice and actual practice? In your opinion, was this division sufficient to impart both theoretical and practical knowledge and skill? If not, why not? What changes would you recommend?

6. How was the clinical practicum with clients *arranged* and *implemented*? Did this system work well logistically? If not, what changes would you recommend?

7. Was the number of actual IUD insertions sufficient for each participant to achieve *competence* and *confidence*? How many insertions were required for the strongest participant to achieve this end? How many for the weakest?

8. What was the trainer to participant ratio? Was it adequate? If not, what ratio would you recommend?

9. What training materials were given to participants during and at the end of the course? In your opinion, were these materials useful as learning guides and references?

10. Describe the plan or mechanism that you used for systematic training documentation, monitoring and supervisory follow-up of participants. If no such plan or mechanism exists, what would you recommend to assure quality in performance, to identify the need for refresher training and to measure impact of the training on clients?

11. Has any refresher been planned? At what interval after training would you recommend?

12. As the trainer, were you alone responsible for the organization, management and implementation of the training course in your locale? If not, please describe any assistance you received from state or national IMA headquarters. Was such assistance sufficient in the sense that it enabled you to effectively carry out the training course to the standard that you yourself desired?

13. Who actually designed this training program? Who were key decision makers in its implementation? What input did you as a trainer have into the design? If you were to redesign the course based on your 'on-the-ground' experience, what would you do differently, if anything?

14. Do you feel you were adequately prepared during the TOT to conduct the training course? If not, what kind of additional training would you have like to have had?

15. In your opinion, what were the main strengths of the course? What were the main weaknesses?

Trainees' Interview/Discussion Guide:

1. From your perspective, what were the main objectives of the IUD clinical training? Do you believe that these objectives were met during the course? If not, why not?

2. What was the division in number of hours between theory, simulated practice with Madame Zoe and practice with actual patients? In your opinion, was this division sufficient to impart both theoretical and practical knowledge and skill you expected to receive during the course? If not, why not? What changes would you recommend?

3. What was the trainer to participant ratio during the classroom portion – theoretical and simulated practice – of the course? Was it adequate? If not, what ratio would you recommend?

4. How was the clinical practice with actual patients *arranged* and *implemented*? Did this system work well logistically for you as a participant? If not, what changes would you recommend?

5. In your opinion, was the number of IUD insertions with actual patients sufficient for each of you to achieve competence and confidence? About how many IUD insertions did you do before you felt competent and confident to do IUD insertion independently i.e., without assistance or supervision?

6. What course materials were you given during and at the end of the course? In your opinion, were these materials useful as learning guides and references? Do you use them now in your practice?

7. Have you received any ongoing supervision or support from the trainers since you completed the course? For example, if you wanted to discuss or consult on a difficult case, to practice on Madame Zoe model to refresh your hand skills, or even arrange for additional supervised practice on actual patients. If not, what kind of supervision or support would you like to have from the trainers? What would you recommend for the UP program?

8. Is this the first time that you have been asked to evaluate both the course and also to be evaluated for the *retention* of knowledge and skills you gained during the course? At what interval(s) after the training would you recommend for this two-way evaluation to occur?

9. As far as you know, has any refresher course on IUD been planned for you? At what interval after the training course would you recommend a refresher based on your experience and perceived need?

10. Since the training course, have you counseled for IUD? Have you also inserted IUDs or do you mainly refer the patient to another doctor? To whom (what type of doctor) do you refer?

11. If you do not insert IUD, please tell what the constraints are.

12. In your opinion, what were the main strong points of the course? What were the main weak points? Most important, what new knowledge or skill did you learn that was of greatest value to you in your practice?

APPENDIX B

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS

(To be completed by Trainer)

Place a √ in case box if task/activity is performed satisfactorily, an X if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the task or skill according to written procedure or guidelines without requiring assistance from trainer

Unsatisfactory: Does not perform the task or skill according to written procedure or guidelines or requires assistance from trainer

Not Observed: Task or skill not performed by participant during evaluation by trainer

PARTICIPANT _____ Course Dates _____

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS (COPPER T)

TASK/ACTIVITY	CASES				
IUD INSERTION					
Pre-Insertion Counseling					
1. Greets woman respectfully and with kindness					
2. Asks woman about her reproductive goals					
3. If IUD counseling not done, arranges for counseling prior to performing procedure					
4. Determines that the woman's contraceptive choice is the IUD					
5. Reviews Client Screening Checklist to determine if the woman is an appropriate candidate for the IUD					
6. Assesses woman's knowledge about the IUD's major side effects					
7. Is responsive to client's needs and concerns about the IUD					
8. Describes insertion process and what to expect					
INSERTION OF COPPER T IUD					
Pre-Insertion Tasks					
1. Obtains or reviews brief reproductive health history					
2. Washes hands with soap and water					
3. Asks client if she has emptied her bladder					
4. Palpates abdomen and checks for suprapubic or pelvic tenderness and adnexal abnormalities					

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS (COPPER T)

TASK/ACTIVITY	CASES				
5. Tells client what is going to be done and encourages her to ask questions					
6. Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands					
7. Performs speculum examination					
8. Collects specimens of vaginal and cervical secretions if indicated					
9. Performs bimanual examination					
10. Performs rectovaginal examination if indicated					
11. Removes gloves and properly disposes (single-use) or immerses (reusable) in chlorine Solution					
12. Performs microscopic examination if indicated (and if equipment is available)					
13. Washes hands thoroughly with soap and water and dries with clean cloth or allow to air dry					
14. Loads Copper T inside sterile package					
IUD Insertion					
15. Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands					
16. Inserts vaginal speculum (and vaginal wall elevator if using single valve speculum)					
17. Swabs cervix and vagina with antiseptic					
18. Gently grasps cervix with tenaculum or Vulsellam Forceps					
19. Sounds uterus using “no touch” technique					
20. Inserts the IUD using the withdrawal technique					
21. Cuts strings and gently removes tenaculum					
Post-Insertion Tasks					
22. Places used instruments in chlorine solution for decontamination					
23. Disposes of waste materials according to guidelines					
24. Removes reusable gloves and places them in chlorine solution					
25. Washes hands with soap and water					
26. Completes client record					
POST-INSERTION COUNSELING					
27. Teaches client how and when to check for strings					
28. Discusses what to do if client experiences any side effects or problems					
29. Assures client that she can have the IUD removed at any time					

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS (COPPER T)

TASK/ACTIVITY	CASES				
30. Observes client for at least 15 minutes before sending her home					
IUD REMOVAL					
PRE-REMOVAL COUNSELING					
1. Greets woman respectfully and with kindness					
2. Asks client her reason for removal and answers any questions					
3. Reviews client's present reproductive goals					
4. Describes the removal procedure and what to expect					
REMOVAL OF IUD					
1. Washes hands thoroughly with soap and water and dries with clean cloth					
2. Put new examination (disposable) or HLD or sterile (reusable) gloves on both hands					
3. Performs bimanual exam					
4. Inserts vaginal speculum and visualizes cervix					
5. Swabs cervix and vagina with antiseptic					
6. Grasps strings close to cervix and pulls gently but firmly to remove IUD					
Post-Removal Tasks					
7. Places used instruments in chlorine solution for decontamination					
8. Disposes of waste materials according to guidelines					
9. Removes reusable gloves and places them in chlorine solution					
10. Washes hands with soap and water					
11. Records IUD removal in client record					
POST-REMOVAL COUNSELING					
12. Discusses what to do if client experiences any problems					
13. Counsels client regarding new contraceptive method, if desired					
14. Assists client in obtaining new contraceptive method or provides temporary (barrier) method until method of choice can be started					

Comments (summary):

Recommendations: ___ Certified If not, why:

Trainer's Signature_____Date_____

APPENDIX C

MODULE 9
IUD-(Level III)
PRE/POST TEST

Participant Name _____

Instructions: Circle the letter(s) for all that apply.

1. In counseling a woman about the advantages of the TCu IUD you would inform her that the IUD (circle all that apply)
    a. is permanent
    b. is highly effective
    c. has few side effects
    d. does not interfere with sexual intercourse
    e. is effective in preventing anemia

2. Which of the following conditions are precautions which influence the suitability of IUD usage for a woman? (circle all that apply)
    a. pregnancy
    b. 3 or more children
    c. at risk for STDs
    d. marital status
    e. history of candidiasis
    f. retroverted uterus
    g. current pelvic infection

3. Prior to IUD insertion a pelvic exam is performed to (circle all that apply)
    a. determine uterine position and size
    b. rule out anteflexion
    c. rule out pregnancy
    d. rule out presence of infection, masses and tumors

4. Prior to an IUD insertion all metal instruments used should be (circle all that apply)
    a. decontaminated with soap and water
    b. decontaminated in 0.5% chlorine solution for 10 minutes
    c. cleaned with formaldehyde and water
    d. cleaned with detergent and water
    e. high level disinfected by boiling in a covered pot for 20 minutes
    f. high level disinfected by autoclaving (unwrapped) for 20 minutes at 106kPa pressure at 121 degrees

5. Key infection prevention activities for IUD insertion include (circle all that apply)
    a. washing hands in soap and water
    b. cleaning the lower genital tract with soap and water
    c. cleaning, then decontaminating, all instruments used
    d. proper contaminated waste disposal
    e. training and supervision of cleaning staff in infection prevention

6. Reasons for follow up visits after an IUD insertion can include (circle all that apply)
    a. First check up 1 week after insertion
    b. first check up 3-6 weeks after insertion
    c. woman wants device removed because she doesn't like it
    d. routine semi-annual exam
    e. removal when the IUD has been in place for 1 year

7. The following are warning signs that you should teach to an IUD client, that indicate she may be having a problem with her IUD and should seek medical attention (circle all that apply):
    a. cramping with menses
    b. increases length of menstrual cycle
    c. sexual partner has abnormal penile discharge
    d. string is longer than usual
    e. abdominal pain in right upper quadrant
    f. pain with intercourse

8. IUD clients should be counseled (circle all that apply)
    a. before the insertion
    b. after insertion
    c. during each follow up visit
    d. all of the above

Instructions: The following statements are true or false. Tick off the answer that you think is correct.

9. A woman, herself, is best at selecting her contraceptive method. True_____ False _____

10. Douching daily after an IUD infection is recommended to prevent PID. True _____ False _____

11. A physical exam for an IUD client must include abdominal, speculum, bimanual and breast exams. True _____ False _____

12. You must use high level disinfected or sterile gloves to place a Copper T IUD in its inserter. True _____ False _____

13. A tarnished IUD in a sealed, undamaged package can be used. True _____ False _____

14. An IUD can be inserted in a woman who is ovulating. True _____ False _____

15. The "push" technique should be used when inserting Copper T IUDs. True _____ False _____

16. The "no touch" technique should be used when inserting IUDs. True _____ False _____

17. An IUD client who has moderate bleeding for 7-10 days after insertion should have the IUD removed immediately. True _____ False _____

18. If PID is diagnosed in a woman with an IUD, the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive. True _____ False _____

19. If an IUD is partially expelled, it should be removed and a new IUD can be inserted immediately.
True _____ False _____

20. If a woman becomes pregnant with an IUD it should be left in place, unless a problem develops.
True _____ False _____

APPENDIX D

QUESTIONNAIRE FOR THE PARTICIPANTS TO F.P. CONSULTANTS COURSE IN GUJARAT

Name:

Age:

Address:

Clinic:	Residence:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Phone: _____	Phone: _____

Qualification: _____

Nature of practice: Private only/Private + Govt./Private + other Job
Attachment to Hospital: Yes/No
Area: Urban/Semi-Urban/Rural

What are the F.P. Planning methods you offer to your clients?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you have facility to offer following at your clinic or Nursing Home?

Counseling Yes/No
IUD Insertion Yes/No

For which methods do you refer your clients?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please give the date of your joining the F.P. Consultant course: Month _____ Year _____

Please give the date of your completing the above course: Month _____ Year _____

TRAINING IN IUD:

Classroom Training:

Who were your trainers?

1. _____
2. _____
3. _____

How many hours of classroom sessions did you attend during the course? _____

Was the classroom training conducted using participatory methods? Yes/No

Were you supplied with the relevant training material? Yes/No

Give the list of the training material you were supplied with.

1.
2.
3.
4.
5.

Was the time allotted for classroom sessions enough? Yes/No

Was the Audio Visual Material used effectively during the training? Yes/No

Do you want anything more to be added in training material or A.V. Aids? Yes/No
Please specify.

_____
_____
_____

What would you suggest to improve the quality of classroom training?

_____
_____
_____

CLINICAL TRAINING

Did you practice on ZOE Model before you went on to the clients? Yes/No

How many time approximately? _____

Were you assessed on model before you were allowed to provide the services to the clients? Yes/No

How many times? _____

How many days/hours you had to spend for clinical training before you were declared qualified? _____

How many insertion procedures you had to perform before you were declared qualified? _____

Where did you take your clinical training? (Give name of the Trainer and address of the clinic)

Service Delivery:

Were you inserting IUD before you attended this course? Yes/No

If YES, Did the training make any difference? Yes/No

If NO, have you initiated providing IUD service to your clients? Yes/No

If YES, how many insertion procedure have you done since completing the course? _____

What do you charge your clients for insertion procedure? _____

Give the names of the instruments that you use for IUD insertion.

1.	2.	3.	4.
2.	6.	7.	8.
9.	10.	11.	12.

Names of the types of IUDs you are using?

1. _____
2. _____
3. _____

From where do you get the IUDs?

Prescribe to the client/stock in your clinic/get from government supplies.

How much time it takes to counsel a client for F.P. methods in general and IUD in specific?

_____

How do you explain the mechanism of action of IUD to your client?

_____
_____
_____

What is the efficacy of IUD in preventing pregnancy? _____%

How long IUD is effective once it is inserted? _____

On what day of menstruation cycle would you insert an IUD in a client? _____

What are the advantages of IUD which you found acceptable to your clients?

_____
_____
_____
_____
_____

What are the disadvantages of IUD that you tell your clients?

_____
_____
_____
_____

What are the conditions when you will not insert an IUD in a client?

_____
_____
_____
_____

What are the instructions that you give your clients after inserting an IUD?

_____
_____
_____
_____
_____

After how many days you fix up an appointment with your client for follow-up?

_____

What are the conditions when you decide to remove the IUD in a client before the expiry of its effect?

_____
_____
_____
_____
_____

How will you manage a client who is having 12 weeks amenorrhoea with IIUD in uterus?

_____
_____
_____
_____
_____

How do you maintain records and information about individual clients?

_____
_____
_____
_____

Describe the steps involved in processing the instruments after they are used in one client and before using same instruments for another client? (please describe all the steps in short)

_____
_____
_____
_____
_____
_____
_____
_____

If you have still not started providing services at your clinic what are the constraints?

1. _____
2. _____
3. _____
4. _____
5. _____

What would you suggest to improve the quality of clinical training?

_____
_____
_____
_____
_____

Thank you for providing with this information.