

# The Centers of Excellence for Practical Learning Initiative: Improving Family Planning Training & Preparing for Scale-Up

**Burkina Faso recognizes that meeting the health needs of its population requires improving the availability and capacities of its human resources for health.**

In 2015, the Ministry of Health (MOH) of Burkina Faso estimated the following density of providers: 18,000 people per doctor and 10,000 people per midwife,<sup>1</sup> which falls significantly short of the World Health Organization's (WHO) Sustainable Development Goals index threshold of 4.45 doctors, nurses, and midwives per 1,000 population.<sup>2</sup> In addition to this deficit of health workers, problems of service quality and availability are evident in family planning statistics. According to results from PMA2020, the contraceptive prevalence rate for all women of reproductive age was 23%, and total unmet need was 25%.<sup>3</sup> In Burkina Faso, midwives make up the bulk of the frontline health workforce, and the Ecole Nationale de Santé Publique (National School of Public Health [ENSP]) identified inadequate practical skills training in the country's midwifery pre-service education as a possible driver of low contraceptive use.

## PILOTING THE CENTERS OF EXCELLENCE FOR PRACTICAL LEARNING

In 2015, Pathfinder International Burkina Faso, in collaboration with the MOH, launched an initiative to implement a systems approach to strengthening family planning and reproductive health (FP/RH) service delivery. The service delivery model includes a package of FP/RH services, including provision of quality contraception services—particularly long-acting and permanent methods—and provision of quality postabortion care services. Inputs to the service delivery model include facility upgrades, provision of equipment and materials, provider training, quality assurance, mentoring and supervision systems, and referrals and community-level information dissemination through community health workers. Building on the successes of the resulting service delivery model, ENSP asked Pathfinder to help develop some of the health facilities to become Centres d'Excellence d'Apprentissage Pratique (Centers of Excellence for Practical Learning [CEAP]), which would be used as practicum training sites for in-service and



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pre-service FP training. The CEAPs aimed to address two key challenges: (1) the lack of FP competencies among newly graduated midwives; and (2) the lack of capacity of health facilities to provide adequate practical training to students during their FP internships.

From July 2017 through June 2018, Pathfinder, ENSP, the MOH's Division of Family Health, and other stakeholders designed a strategy to guide the CEAP initiative and implemented a pilot phase of the intervention to assess its feasibility for scale-up. Beginning in June 2017, the Evidence to Action (E2A) Project, USAID's global flagship for strengthening FP/RH service delivery, brought expertise in scale-up to the CEAP initiative. E2A utilized tools for systematic scale-up from its partner, ExpandNet:

- **Beginning with the End in Mind (BWEIM)** to assess and propose changes to the initial strategy for CEAP implementation
- **CORRECT attributes** to evaluate the pilot's overall potential for scale

BWEIM is based on the premise that projects should be planned from the beginning to enhance their potential for future large-scale and sustainable impact. The tool proposes 12 recommendations, or steps, that project implementers and designers should follow to achieve this objective. The CORRECT attributes—Credibility, Observability, Relevance, Relative

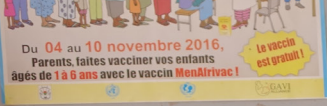


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advantage, Ease of transfer/installation, Compatibility, and Testability—refer to the characteristics that an intervention should possess to increase its likelihood for successful scale-up. As a result of E2A’s involvement, and the introduction of the BWEIM and CORRECT tools, significant changes were made to the CEAP implementation strategy in order to increase the probability of the intervention’s scale-up—including (1) adding a training of *encadreurs* (coaches); (2) reducing supportive supervision from weekly to once per internship round; and (3) reducing the number of pilot facilities from 8 to 6.<sup>4</sup> The revised strategy was then validated with the designers of the original strategy.

Through a competitive process, six health facilities were selected for participation in the pilot—three in Ouagadougou, Central Region, and three in Bobo-Dioulasso, Haut Bassins Region. Two committees established by Pathfinder, ENSP, and MOH reviewed completed application forms, and the committees conducted an assessment of the short-listed facilities that included: (1) observation of the infrastructure and client flow systems; (2) interviews with the facility-in-charge and staff; (3) inventory of equipment and supplies; and (4) review of health facility FP data in the registries and at Pathfinder Burkina Faso. In addition to the Pathfinder-supported service delivery strengthening activities, the six CEAP facilities received further capacity building and material support that included:

- Update of providers’ FP/RH skills,
- Training on how to coach students,
- Additional equipment for FP training and service provision,
- Logistical support, and
- Supportive supervision by Pathfinder, ENSP, and MOH personnel.

In five-day workshops, Pathfinder trained 18 midwives in Bobo-Dioulasso and 19 in Ouagadougou to serve as *encadreurs* for the student interns. During the pilot, 75 students were dispatched in groups of five to complete a four-week internship. From April 2018 to June 2018, three rounds of internships were conducted in Bobo-Dioulasso, and two rounds of internships in Ouagadougou. Each student had a set of practicum objectives to be achieved for FP service provision, under the guidance of the trained *encadreurs*.

## DOCUMENTING AND EVALUATING THE CEAP INNOVATION

With scale-up and feasibility in mind, E2A and Pathfinder Burkina Faso documented the entire CEAP experience—from conceptualization to implementation to evaluation of the pilot. E2A documented the process of designing the CEAP strategy, as well as its validation and implementation, noting actions and factors that facilitated or hindered the pilot’s success. Focus group discussions (FGD) and key informant interviews (KII) were conducted mid-implementation and at the end of the pilot to document the experiences and perceptions of students and key stakeholders regarding the effectiveness of the CEAPs and to solicit recommendations for scale-up. These stakeholders included head nurses-in-charge and other health care providers, ENSP representatives, and Pathfinder representatives. In addition, Pathfinder Burkina Faso compiled quantitative data on service delivery during the pilot, which included (1) contraceptive uptake by method; (2) attainment of practicum objectives by each student; and (3) pre/post knowledge and skills assessment scores for each student.

1 Burkina Faso Ministry of Health, *Statistical Yearbook*, 2015.

2 World Health Organization, *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals*, 2016.

# KEY QUALITATIVE FINDINGS

## FINDING 1

All FGD and KII respondents agreed that the CEAP innovation was an effective means of increasing capacities of the health workforce to provide FP services. Students and *encadreurs* felt that the internship successfully developed students' FP service delivery competencies (with the exception of immediate postpartum intrauterine device [PPIUD] insertion). In addition, students expressed satisfaction with the quality of coaching they received during their internships, which is also reflected in pre/post knowledge and skills assessment scores.

**“The expectation I had was ... to be really competent in the subject of family planning. To really know the different steps, to know how to tell at a given moment if a woman is eligible for this method or that method, or how to deal with the different side effects—everything related to family planning ... I learned a lot about the different steps related to the techniques as well.”**

—Focus group in Bobo-Dioulasso

## FINDING 2

Respondents reported that, as a result of the CEAP, overall service quality at the facilities had improved, which they attributed to *encadreurs*' improved adherence to clinical practice guidelines in order to teach students and role model compliance with standards of care. The health facility managers noted positive changes in the cleanliness of health facilities, improvements in how facilities were organized, improvement in punctuality among staff, and a general positive change in attitude towards students. Facilities reported improvements in quality of services, and providers reported that, due to their teaching role, they performed procedures according to high clinical standards.

**“With the students, we have to follow the normal technical procedures to allow them to learn. So, we have to leave our bad habits behind ... Especially, even with the PI, we barely wash our hands—we put gloves on directly and quickly finish the work. Whereas with the students, we follow the normal procedures so the students can see.”**

—Maternity-in-Charge, Bobo-Dioulasso

## FINDING 3

Facility managers reported that being a Center of Excellence for Practical Learning improved the reputation of the health facilities in the communities, resulting in increased family planning service uptake. The perceived increase in service uptake is not supported by the quantitative analysis of the service utilization data. However, the increased attention to service delivery quality may have influenced the perceptions and expectations of facility managers.

## FINDING 4

Certain elements of the CEAP implementation plan were included in the strategy, but were not implemented, which may have an impact on scalability. These were: (1) inadequate clarification of the division of roles and responsibilities between Pathfinder, ENSP, and MOH-DFH, including lack of clarity and consensus on which entity was responsible for compensating the *encadreurs*; (2) failure to provide sufficient clinical equipment and anatomical models and to conduct minor renovations of health facilities; (3) lack of compensation for *encadreurs* at facilities, whose workload and working hours increased due to the CEAP; (4) insufficient engagement from ENSP in the planned monthly joint supportive supervision, which some stakeholders perceived as a reflection of ENSP's lack of interest and buy-in; and (5) insufficient client load for students to meet all the practicum objectives and scheduling issues that ultimately reduced the internship duration.



Photo: Linda Suttenfield

3 L'Institut Supérieur des Sciences de la Population, *Performance Monitoring and Accountability 2020 (PMA2020) Project - 2016 - Burkina Faso* (Ouagadougou & Baltimore: Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, 2017).

4 For a full description of the changes made to the initial strategy, access the full report at [e2aproject.org](http://e2aproject.org).





Photo: Linda Suttentfield

## KEY QUANTITATIVE FINDINGS

### FINDING 5

On average, students were unable to meet the service provision targets for the assigned practicum tasks. Students performed an average of 7 implant insertions (representing 70% of their practicum objective) and 3 interval IUD insertions (representing 60% of their practicum objective). Furthermore, only 1 student was able to achieve the practicum target on immediate (within 48 hours) postpartum IUD insertion due to low demand.

Despite not being able to meet these targets, students' knowledge test scores and scores from the skills assessment using anatomical models improved over the course of the internships. On average, there was a 27% increase in knowledge test scores—from 73% at pre-test to 93% at post-test—and a 53% increase in skills assessment scores—from 59% at pre-test to 91% at post-test.

FIGURE 1: Uptake of Family Planning Use at Intake and Exit by Method (intake n=102, exit n=228)

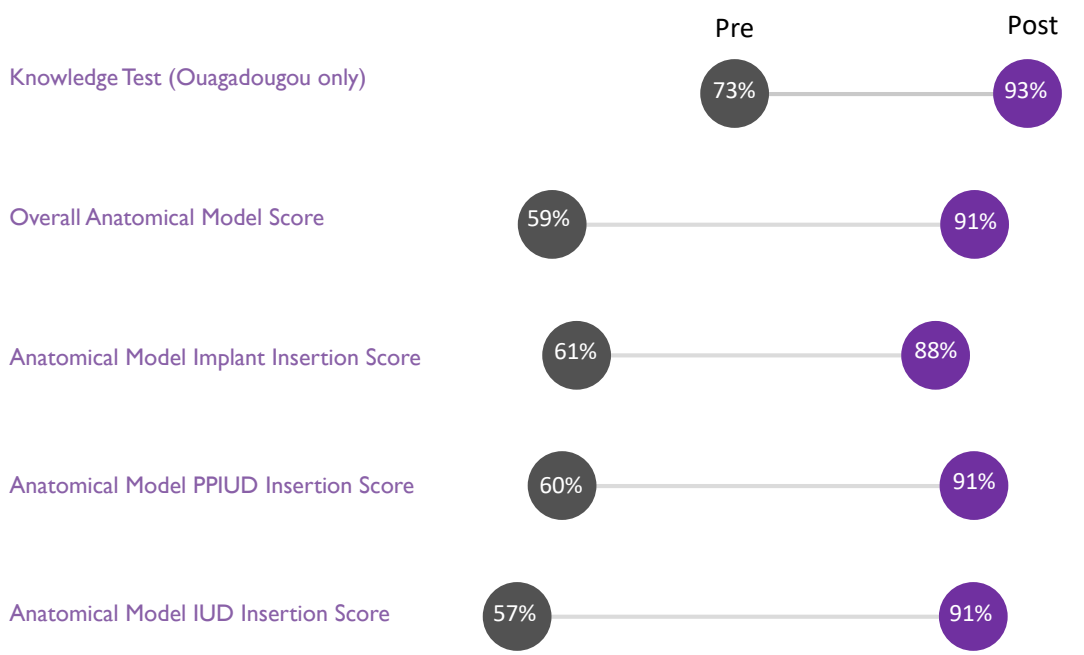




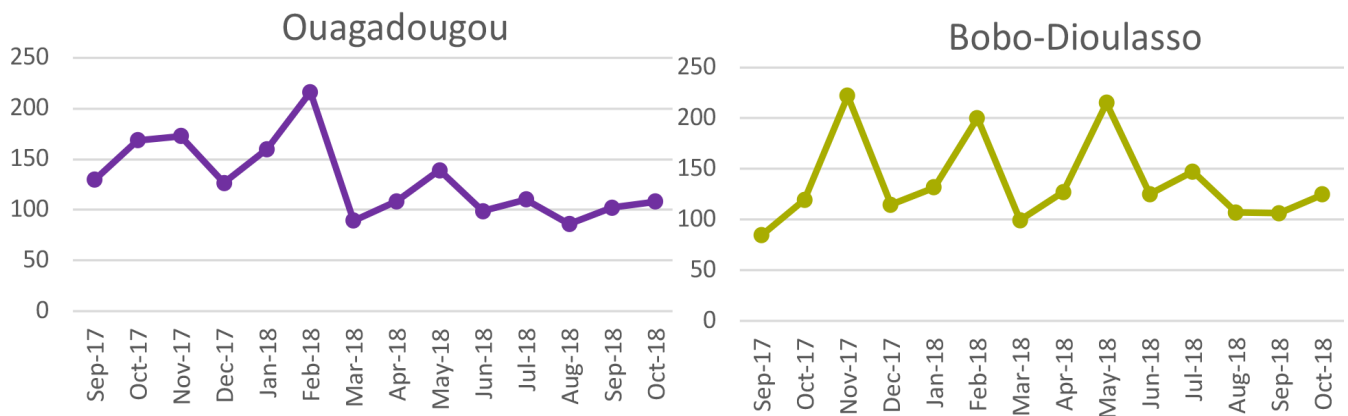
Photo: Aissetou Aye Sawadogo

### FINDING 6

Although the students' competencies improved, review of the service utilization data at the six health facilities showed no clear trends in family planning service uptake when comparing data from the prior year, during the CEAP effort, and after the CEAP's conclusion (see Figure 2). Furthermore, there were no noticeable changes in the number of implant or IUD users during the months students were present at the health facilities and providing these methods. For the health facilities in Ouagadougou,

students were present during June and July. During these months, there were no noticeable changes in the number of implant or IUD users. In Bobo-Dioulasso, students were present at the health facilities from late April to June. There was an increase in the number IUD users during the implementation phase. The use of implants did not appear to deviate from the existing use pattern, which shows an increase in users every three months. This trend continued throughout the implementation of the CEAP initiative.

Figure 2: Average Number of Family Planning Clients Served, by Month and Region, September 2017–October 2018





## LOOKING AHEAD TO SCALE-UP: RECOMMENDATIONS

The CORRECT tool was used—alongside the qualitative and quantitative data—to assess the probability of scale-up for the CEAP intervention.<sup>5</sup> Additionally, participants shared recommendations and input during the final dissemination meeting, which was intended to be an opportunity to develop the scale-up strategy. Through these two exercises, the following recommendations for scaling the CEAP initiative were developed.

Significant differences in implementation across sites—from the method of selecting students to participate in the pilot, to the duration of the internships, to the actual process of coaching students—affected fidelity to the innovation design during the pilot. The differences between implementation of the innovation in the two regions will increase the complexity of initiating vertical scale-up (i.e., development of policies, guidelines, and standards for the CEAPs). In addition, requiring staff to work longer than normal hours and to work during their time off will not be sustainable at scale, especially if there is no financial or material incentive for them to do so.

If the stakeholders commit to generating additional evidence, it will be important to simplify the innovation and implement it as consistently as possible. It will also be necessary to address the factors that could hinder scale-up and successful service delivery. Some health-system-level changes will relate to the following: (1) creating training guidelines and systems for student internships during pre-service education; (2) managing and leading the internship program; (3) financing implementation, logistics, anatomical models, and equipment; and (4) conducting activities to increase demand generation as part of the service delivery system.

Specific recommendations for ensuring the scalability of the CEAP initiative include the following:

### GOVERNMENT LEADERSHIP FOR STRENGTHENING AND SCALING UP THE CEAP PILOT

Meaningful buy-in and leadership from ENSP and MOH (i.e., the User Organization<sup>6</sup>) are needed for the CEAP model to be scalable and sustainable. Implementing partners that support this initiative should limit their role to technical assistance for capacity building of the User Organization and Resource Team,<sup>7</sup> advocacy, and facilitating participatory documentation from pilot testing to generate the evidence needed to support scale-up.

### ADVOCACY FOR SCALE UP

Advocacy for both horizontal and vertical scale-up<sup>8</sup> should also be directed at donors and implementing partners that are supporting reproductive health in different regions and are involved in influencing policy at the national level. Advocacy meetings led by the Director General of ENSP, as the entity responsible for pre-service education, should include capacity building for all stakeholders, facility staff, and *encadreurs*—on using the ExpandNet tools for systematic scale-up and generating evidence of feasibility and scalability.

### RESOURCES

To facilitate smooth scale-up and enhance standardization across facilities that are developed into CEAPs, there is a need to ensure adequate financial and human resources. Cost estimates of this pilot should be provided to ENSP and MOH for their consideration—as they make decisions regarding scale-up of the CEAP initiative.

### ROLES AND RESPONSIBILITIES

During the stakeholder mapping exercise that will take place in the scale-up strategy development phase, there must be a clear delineation of roles, responsibilities, and capacity-building needs at all levels. Furthermore, clarity regarding financial responsibilities and expectations among all stakeholders and development partners is critical from the outset.

### RE-ESTABLISH AND RE-DEFINE THE USER ORGANIZATION AND RESOURCE TEAM

To facilitate scale-up, there is a need to re-engage with stakeholders and, through a participatory approach, (1) establish a clearly defined User Organization and Resource Team; (2) agree on terms of reference; and (3) agree on mechanisms for sharing information and problem solving. The Resource Team should be led by ENSP with sub-Resource Teams in Bobo-Dioulasso and Ouagadougou.

5 To read more about the assessment of the pilot intervention through the lens of each of the CORRECT attributes, access the full report at [e2aproject.org](http://e2aproject.org).

6 “The User Organization” refers to the institutions or organizations that seek or are expected to adopt and implement the innovation on a large scale. (ExpandNet, *Practical guidance for scaling up health service innovations*, 2009.)

7 “The Resource Team” refers to the individuals and organizations that seek to promote and facilitate wider use of the innovation (*Ibid.*).

8 “Horizontal scale-up” refers to expansion or replication of an innovation. Innovations may be replicated in different geographic sites or can be extended to serve larger or different population groups. “Vertical scale-up” refers to the policy, political, legal, regulatory, budgetary, or other health systems changes needed to institutionalize the innovation at the national or sub-national level. (ExpandNet, *Nine steps for developing a scaling up strategy*, 2010).

## GEOGRAPHIC VARIATIONS

Prior to implementing the action plan developed during the final stakeholder meeting, it will be important to anticipate and plan for geographic variations and related challenges, such as smaller facilities, lower service demand and utilization, fewer trained FP providers, fewer lecturers at ENSP, transport limitations, concerns related to the personal security of health workers, and inaccessibility of the health facilities.

## INTEGRATION OF PRACTICUM TRAINING TOPICS

ENSP should explore alternative opportunities for students to acquire FP skills, such as integration of practicums (e.g., FP and immunization, nutrition, or community health) since extending the duration of the practicum for FP alone could reduce the duration of other areas of classroom and/or practicum training, which could affect the quality of training. All CEAPs should have the necessary equipment and anatomical models for training and service provision.

## INTEGRATION OF SERVICE COMMUNICATION WITH SERVICE DELIVERY

ENSP should also explore ways to engage students during their practicum to conduct information sharing and demand creation as part of the intervention—to inform communities (women, men, and leaders) about the services, strengthen students' interpersonal skills with clients, and ensure students and facility mentors follow up clients after service provision.

## SUSTAIN QUALITY OF CARE AT THE HEALTH FACILITIES

The CEAP should periodically spot check the performance-to-standard of facility staff and *encadreurs* during times when students are not present—to ensure improved quality is the “new normal” that is sustained.

## LEADERSHIP AND MANAGEMENT

There will be a need for capacity building for facility managers on leadership and management of a CEAP, including (1) allocation of duties for the *encadreurs* and facility staff; (2) logistics management; and (3) demand generation.

## INTERNSHIP DURATION

ENSP should consider the implications of having an average of 30–45 students undergoing the internship over the course of 12 weeks, instead of the 10 hours currently allocated in the curriculum. ENSP would be the best institution to address the issue of increasing the duration of the internship, as this may have implications for the time allocated for other clinical areas of the pre-service curriculum.



Photo: Linda Sutfenfield

## CONCLUSION

**By responding to a shortage of human resources for FP, the CEAP initiative explored the possibility of developing providers' FP competencies during pre-service education by making changes and improvements to the practicum component of pre-service training. While there were many challenges experienced during implementation of the CEAP strategy, there is evidence that the pilot achieved its objective of developing students' practical FP competencies during pre-service education.**

Stakeholders in Burkina Faso are coming away from this process with a greater awareness and capacity to think ahead—to sustainable scale-up from the beginning of a project—and to utilize existing tools to conduct similar analyses in the future. However, given the implementation challenges and lessons learned, many factors must be addressed before considering scale-up, such as fostering local ownership and leadership, establishing structures to promote scale-up, and fostering a better understanding of what must be done to implement the innovation with scale-up in mind from the beginning. Considering these crucial recommendations is a good place to begin further exploration of scaling up the CEAP strategy to improve the family planning competencies of Burkina Faso's health workforce.

**THE EVIDENCE TO ACTION (E2A) PROJECT** is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

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