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Maternal and Child Survival Program

Building the Capacity of Service Providers in Delivering Sustainable, High-Quality Family Planning Services

Pakistan Technical Brief

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Introduction

Family planning (FP) services must be client-centered and delivered compassionately to ensure that they are acceptable and used by target populations. Poor-quality counseling and service delivery that fail to address health concerns and side effects experienced by clients discourage them from taking up and continuing to use FP. In Pakistan, human resources for health have been distributed unequally, with skilled providers clustered in urban settings, leaving rural health care facilities devoid of trained providers, particularly FP service providers. Public-sector institutions have limited technical and structural capacity to improve their human capital. With donor-supported projects, staff are trained, but the system lacks sustainable monitoring and post-training follow-up mechanisms. Strenghtening institutional capacity, empowering service providers, and establishing sustainable mechanism of supportive supervision are critical for Pakistan to achieve its Family Planning 2020 commitment of a 50% contraceptive prevalence rate.

During an MCSP-supported capacity-building session, a trainer demonstrates implant insertion and removal on an anatomic model. Photo by Bushra Amjad/MCSP.

Methodology

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP), in collaboration with provincial departments of health (DOHs) and population welfare departments (PWDs), invested in two core interventions in Pakistan to bolster skilled providers: cascaded trainings and supportive supervision. MCSP also developed an innovative and user-friendly digital training information management system to faciliate real-time monitoring and data-driven decision-making for investements in human resources.

Intervention 1: Enhancing Provider Skills on Long-Acting Reversible Contraceptives

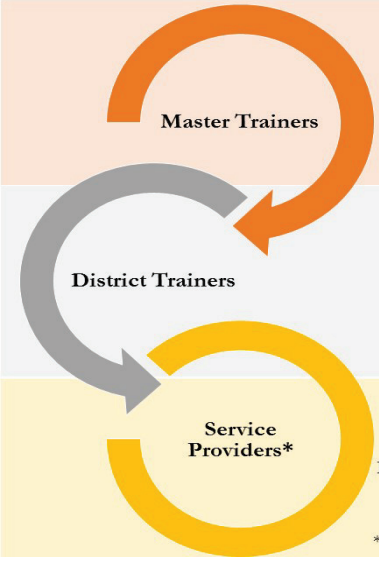
MCSP formulated a training model on long-acting reversible contraceptives (LARCs) using a competency-based training approach. MCSP developed a cohort of 94 provincial-level master trainers from the PWDs in Punjab, Balochistan, and Sindh through comprehensive 6-day trainings. These master trainers further developed a cohort of 362 district-level trainers across 78 districts of Pakistan. These districts included 13 in Sindh, 32 in Balochistan, and 33 in Punjab through 4-day trainings held in MCSP-developed FP training units.

Box 1. Family Planning Training Units

MCSP strengthened tertiary- and district-level public-sector health care facilities by establishing fully equipped skills labs and classrooms in the facilities to serve as family planning training units.

District-level trainers then worked with community- and facility-based service providers to enhance their skills and performance through 4-day trainings, using MCSP-developed learning resource materials and job aids. MCSP directly supported service provider trainings in three intervention districts: Badin, Sindh; Sheikhupura, Punjab; and Quetta, Balochistan. These MCSP-supported trainings ensured that more than 400 facility- and community-based providers had the knowledge, skills, and confidence to provide LARCs to clients in their districts. Figure 1 provides details on the cascaded trainings delivered. (Please see Figure 4 for details on service delivery data at the facilities staffed with MCSP-trained providers.)

Figure 1. Long-acting reversible contraceptives training cascade and number of providers trained



	Length of Trainings	Number of Trainings	Number of Participants Trained
Provincial Level	6 days	8	94
District Level	4 days	30	362
Facility & Community Level	4 days	30	419

* in 3 intervention districts only

Intervention 2. Equipping District Monitoring Teams to Provide Supportive Supervision for Trained Providers

Evidence shows that training is insufficient to improve and sustain quality of care. Effective translation of learning into performance requires supervision of trainees, which involves real-time support on the job.[1] MCSP introduced post-training supportive supervision for trainees, defined as "a process of helping staff to improve their own work performance continuously. It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve knowledge and skills of health staff."[2] Regular supportive supervision, coupled with monitoring and evaluation, leads to early and rapid identification of needs, such as training in counseling skills and infection prevention practices, and in supply restock, that can be promptly addressed through remedial actions or necessary changes, thereby ensuring that services meet high quality standards.

MCSP organized 2-day trainings on supportive supervision for district-level DOH and PWD monitoring teams in 78 districts across the three provinces. These districts included 29 in Sindh, 20 in Balochistan, and 29 in Punjab. In total, the project trained 382 participants on supportive supervision (details provided in Table 1). In the intervention districts, trained supervisors, together with MCSP team members, conducted joint monitoring and supervisory visits to project-trained providers. During each visit, the supportive supervisory team developed an action plan to identify problem areas in conjunction with the facility in-charges and service providers. These plans helped determine timelines for resolving issues and planning follow-up visits. The project also developed a supportive supervisory checklist, in consultation with the provincial DOHs and PWDs, based on clinical and nonclinical FP standards to be used for assessment and supervision of service providers. During visits, supportive supervision teams scored performance on the checklist as follows: 0–20% = very poor, 21–40% = poor, 41–60% = average, 61–80% = good, and

[1] Bluestone J, Johnson P, Fullerton J, Carr C, Alderman J, BonTempo J. 2013. Effective In-service training techniques, frequency, setting and media: evidence from an integrative review of the literature. *Hum Resour Health.* 11:51. doi: 10.1186/1478-4491-11-51.
[2] World Health Organization (WHO). 2008. *Training for Mid-Level Managers (MLM): Module 4: Supportive Supervision.* Geneva: WHO.

81–100% = very good. The three provincial governments are currently working to institutionalize supportive supervision processes that will continue after MCSP's closeout.

Table 1. Distribution of personnel trained on supportive supervision (by province, sex, and cadre)

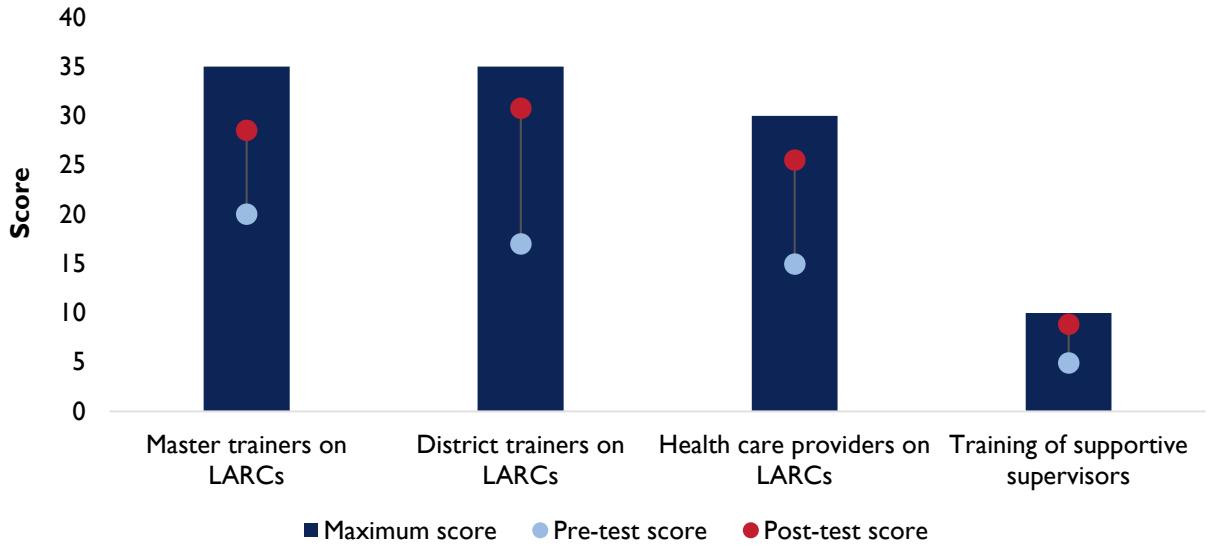
Province	Sex		Cadre			
	Male	Female	Doctors	Community Midwives	Nurse	Others*
Balochistan	65	19	37	0	4	43
Punjab	55	89	48	9	14	73
Sindh	3	151	96	0	16	42
Total	**123**	**259**	**181**	**9**	**34**	**158**

* Others include monitoring and evaluation, administrative, and teaching staff.

Findings

MCSP's capacity-building model enhanced provider knowledge and skills, as indicated by a 69% average increase in post-training scores versus pretraining scores. Figure 2 shows the scores for each type of training.

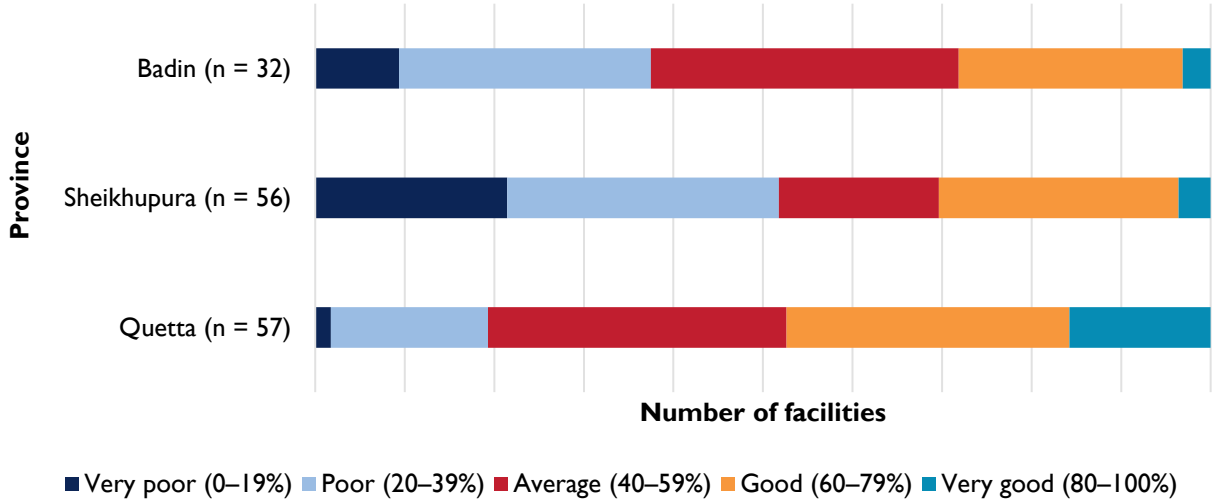
Figure 2. Pre- and post-test scores for MCSP-supported trainings



LARCs = long-acting reversible contraceptives

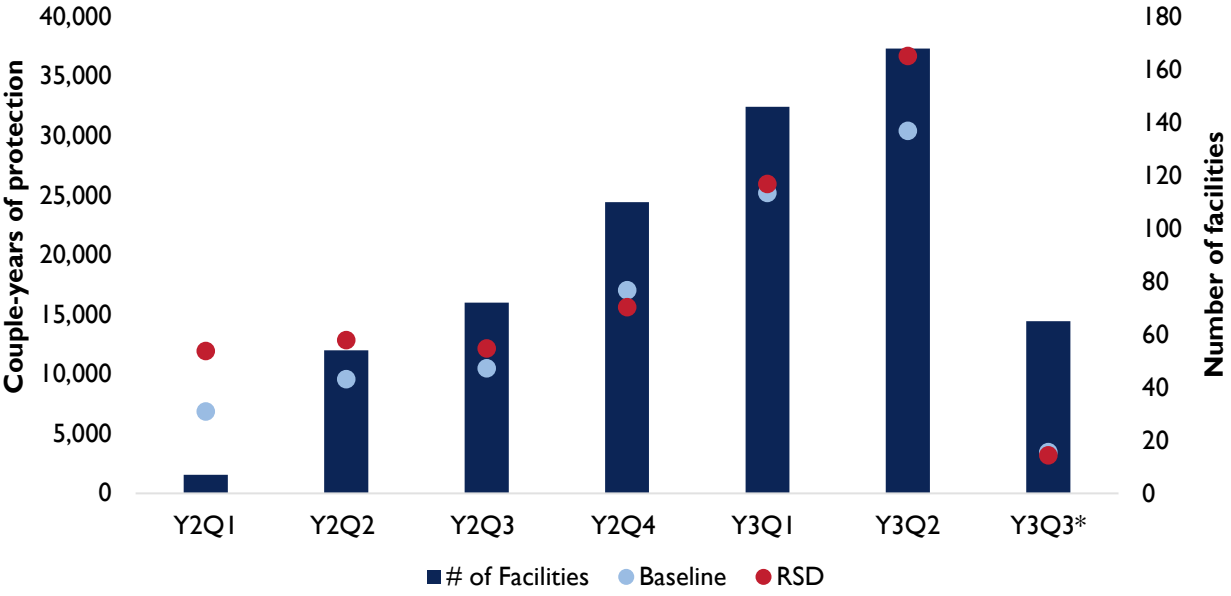
Monitoring teams conducted supportive supervisory visits at all health facilities where MCSP-trained service providers had been deployed (57 facilities in Quetta, 56 facilities in Sheikhupura, and 32 facilities in Badin). Out of 145 facilities visited, 37% (53) scored over 60% on compliance to FP standards, as shown in Figure 3. Action plans were developed and implemented in all facilities, and will support underperforming facilities to improve their scores.

Figure 3. Results from supportive supervision visits by province (January–March 2019)



MCSP gauged the performance of trained providers by changes in couple-years of protection (CYP) generated at their facilities. The project compared baseline service statistics[3] to routine service delivery statistics on a quarterly basis to assess any change in performance. As indicated in Figure 4, during the course of the project, quarterly CYP generation at facilities with MCSP-trained staff showed considerable variation. The average change in CYP during the life of project was approximately 23% (range = -8% to 71%) as compared to the baseline of respective facilities.

Figure 4. Comparison of baseline and routine couple-years of protetection during MCSP implementation*



*Includes data from Quetta only.

[3] Service delivery statistics from July–September 2017 for each facility were considered baseline data. When a facility had an MCSP-trained provider, its routine data for each quarter was compared with baseline data to assess any improvement in service delivery statistics.

Recommendations

- The DOHs and PWDs should ensure that supportive supervision becomes an integral component of post-training monitoring visits by district health monitoring teams. This helps to address immediate needs and improve provider performance by instilling confidence and motivating them.
- Provincial departments should ensure optimal utilization of provincial- and district-level trainers to build the capacity of other service providers in nonintervention districts.
- Provincial departments can adopt and optimize the utilization of the training information management system to identify their human capital and allocate resources according to needs, reducing the incidence of transfers of trained individuals, thereby avoiding interruptions in provision of services at under-resourced facilities.
- For providers to translate their learning into practice, continuous and uninterrupted supply of FP commodities at facilities is needed. The government must address frequent commodity stock-outs at facilities by:
    - Building the capacity of district health managers on supply chain mechanism, periodic forecasting, and orientation on the electronic requesting system
    - Strengthening transport system from the central warehouse to facilities for efficient delivery of commodities

Conclusion

The capacity-building model used by MCSP in Pakistan improved public-sector provider performance by enhancing service providers' knowledge and skills, and the institutional capacity of the DOHs and PWDs to deliver LARC services. The intervention was successful in enhancing skilled human resource distribution (described earlier in this brief) by improving competencies of providers in MCSP's intervention districts. MCSP strengthened the local health care system by providing a pool of trainers at all levels, thereby reducing dependency on external support and ensuring sustainability. A comprehensive and robust monitoring system is warranted to maximize appropriate utilization of the human capital.

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