

Improving the Quality of Skilled Birth Attendants/Skilled Health Personnel (SBA/SHP) and Family Planning (FP) providers: evidence from clinical training sites in Madhesh and Lumbini Provinces

BACKGROUND:

The constitution of Nepal, 2015 and the Public Health Service Act, 2018 both emphasize the Government of Nepal's commitment towards equitable delivery of quality health services for every citizen. Competent and motivated health service providers are key to delivering high-quality health services needed to achieve good health outcomes. Accordingly, the Nepal Health Sector Strategy (2016- 2022) and Nepal Health policy, 2019 give great importance to capacity building of the health workforce.

However, there is still a long way to go in ensuring all providers have undergone the relevant in-service training required for their role. Only one-third of health facilities which provide family planning (FP) and delivery services are staffed by providers who have received the appropriate in-service training.¹ Moreover, only 65% and 18% of the Skilled Birth Attendants (SBA) trained personnel scored highly (>85%) in knowledge and clinical skills assessment respectively.² These findings highlight a gap in both the provision of and quality of training for the health workforce.

This technical brief highlights the key processes, findings and lessons learnt in strengthening the quality of Skilled Birth Attendant and FP training in two hospital training sites.

THE CLINICAL TRAINING SITES:

The National Health Training Center (NHTC) and Family Welfare Division (FWD) in coordination with the Ministry of Social Development (MoSD)/Ministry of Health and Population (MoHP) of Lumbini province and Madhesh Province, provided support to two clinical training sites, the Provincial Hospital Lumbini (PHL) and Provincial Hospital Janakpur (PHJ). Currently, Nepal has 25 SBA and FP training sites each out of which 9 each of SBA and FP training sites are in Madhesh and Lumbini Provinces.

The purpose of the training sites is to provide in-service trainings to the health service providers. For this exercise the sites were selected based on the following criteria:

- The training site is approved by NHTC as a SBA/SHP and/or FP training site

- The hospital where the trainings take place has a high volume of clients

UK Funded Nepal Health Sector Support Programme (NHSSP) provided technical assistance for the process to these federal and provincial bodies.

APPROACH:

NNHTC, FWD and NHSSP conducted joint visits to the two sites to provide technical assistance in strengthening the capacity of the training site and the trainers in delivering SBA/SHP and FP trainings. A combination of nationally approved tools were chosen to assess the clinical skills, readiness and management standards (Table 1). However, assessments for non-scalpel vasectomy, mini laparotomy and emergency contraceptive could not be conducted as these services were not provided regularly at both sites. All tools are a combination of the required readiness and skills, except for Minimum Service Standards (MSS) which focusses on the readiness to deliver services. The assessments were conducted using a mixed approach of interviews and observation of service provision or demonstration in simulation models.

Alongside the use of standard tools, individual mentoring by members of the joint support team was used to identify the gaps in knowledge and skills of the SBA and FP trainers. Subsequently, need-based capacity building plus group demonstration using visual aids was adopted for capacity building of the SBA and FP trainers. Eight and nine SBA trainers were mentored on MNH skills at PHL and PHJ respectively. Capacity building in FP for selected SBA trainers who were also FP service providers was also provided, three at PHL and four at PHJ.

On the final day, dissemination of the findings from the assessment to key stakeholders including the hospital leadership and trainers, Provincial MoSD/MoHP, Provincial Health Directorate, Provincial Health Training Center and external development partners was conducted and site-specific action plans for strengthening their quality of SBA/SHP and FP trainings were developed. Follow up and technical assistance to implement the action plans was also provided between the first and second visits.

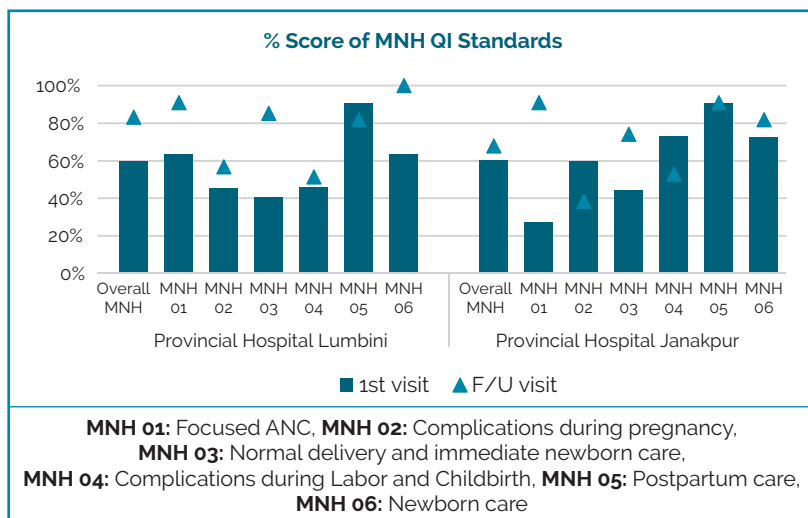
¹ Ministry of Health, Nepal; New ERA, Nepal; Nepal Health Sector Support Program (NHSSP); and ICF. 2017. Nepal Health Facility Survey 2015. Kathmandu, Nepal: Ministry of Health, Nepal.

² Goyet S, et al. On-site clinical mentoring as a maternal and new-born care quality improvement method: evidence from a nurse cohort study in Nepal. BMC Nursing 19. 3 (2020) (On-site clinical mentoring as a maternal and new-born care quality improvement method: evidence from a nurse cohort study in Nepal | BMC Nursing | Full Text (biomedcentral.com) accessed on 24/03/2022.

KEY FINDINGS FROM THE TRAINING SITE CAPACITY ASSESSMENT:

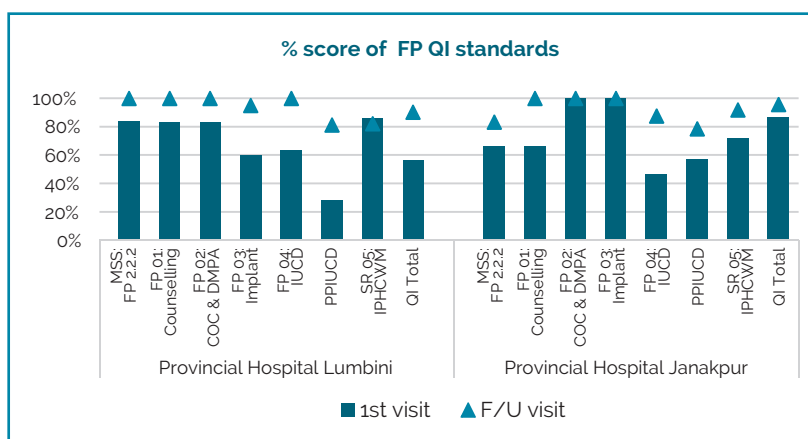
The graphs below show the performance of the two training sites, Lumbini (PHL) and Janakpur Provincial Hospitals (PHJ), based on the selected assessment tools (Table 1). The sites were scored before the training support during the first visit³ and scored again after the support during the follow up visit⁴.

Below is the summary of the key findings from the initial and follow up assessment at the two sites.



The MNH QI assessment, showed marked gaps in standards of services being delivered and were more prominent in PHJ. The common gaps in standard of care delivered were due to unavailability of equipment/drugs, gaps in infection prevention practices, gaps in knowledge and skills of the trainers lack of use of partograph, improper recording and reporting (Figure 2). Improvement was observed in some of the standards in the follow-up visit, but these varied between the two sites.

Figure 1: MNH QI standards met by PHL and PHJ in 1st and FU visits



An increase in almost all standards were observed during follow up compared to the initial assessment. Despite implementation of NESOG/FIGO PPIUCD pilot at the LPH which has led to adequate number of PPIUCD trained service provider, unavailability of the full range of contraceptive options in the labor ward and operating theater and lack of intra C-Section IUCD services led to very low performance standards met for PPIUCD. (Figure 3).

Figure 2: FP QI standards met by PHL and PHJ in 1st and FU visit

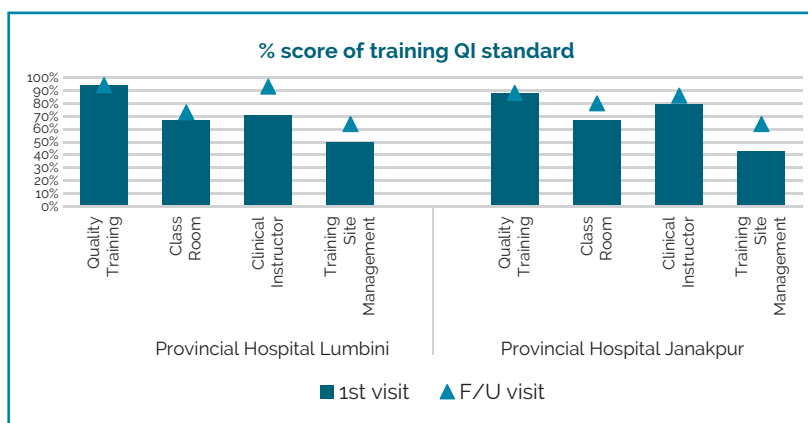


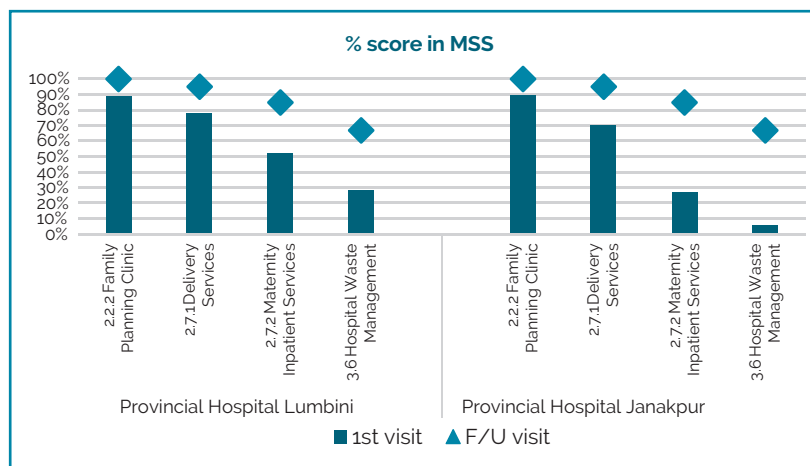
Figure 3: Training QI standards met by PHL and PHJ in 1st and FU visits

QI performance for delivering clinical trainings sessions were quite high in both sites. Inadequate infrastructure such as classroom space, technology (computer, projectors etc) were a limiting factors in both sites which could negatively impact the quality of delivery of clinical trainings. The biggest gap for both sites, however, was in management of training site with problems such as no regular meeting of the hospital training management committee, no system of annual review and development of training calendar, no system of evaluation of trainers in place (Figure 4).

During the follow up improved coordination between the training site and hospital management committee was seen in both sites.

³ Dates of first visit: PHL (5th – 8th August 2021), PHJ (3rd –7th September 2021)

⁴ Dates of second visit: PHL (8th – 10th March 2022), PHJ (14th –16th March 2022)



The MSS scores were relatively high for the family planning and delivery services, however, maternity inpatient services and hospital waste management scores were very low in both hospitals. Insufficient number of trained staff, partographs not being routinely used, lack appropriate infrastructure such as delivery room linked to operation theatres, stock outs of emergency life-saving drugs, inadequate equipment for emergencies and lack of proper waste management practices all contributed to the low scores (Figure 5). An urgent need to address this is evident with both of these sites also being high volume sites.

Figure 4: MSS scores obtained by PHL and PHJ in 2nd and 3rd workshops

LESSONS LEARNT:

Systems for quality improvement of the training sites:

- 1) A combined approach focusing on strengthening the clinical and management competencies of the training sites** has the potential to yield better results than siloed approaches. The enabling environment at the training sites to deliver high quality trainings potentially has as much impact as the clinical competence of the trainers and is more likely to be strengthened through improved management capacities.
- 2) A robust standard based monitoring and supervision mechanism** is needed to monitor and strengthen the existing training sites and trainers. This has been a weak link in the system and leads to inadequate capacities of the trainers and training sites to provide clinical trainings of optimum quality. The Provincial Health Training Centers could potentially play a crucial role in strengthening the monitoring and supervision of the clinical training sites.
- 3) The need to use multiple tools to assess the service specific clinical skills and management competence complicates the process of QI and readiness assessment for training sites.** A comprehensive Reproductive Health Training site approach could facilitate the process of developing an integrated tool and the use of the standard tool.

Quality of healthcare services being delivered at the training site:

- 4) A continuum of care approach with integration of FP and MNH services is needed for uptake of postpartum family planning services** at the high-volume service delivery sites where very often MNH services and FP services are being delivered by different personnel. Pregnancy offers the opportunity of multiple contacts of a woman with the health system. These contacts need to be utilized for counselling women on postpartum family planning.
- 5) Constraints in human resources leads to inability to use standard clinically proven interventions** (eg. Use of partograph was poor with shortage in HR cited as the key reason for inability to use partograph). This might lead to poor modelling of clinical practice in the trainees (only 20.2% of MNH service providers could interpret partograph²) or inability to perform skills despite knowledge (75% average score in knowledge compared to 48% average score in clinical skills amongst SBA). This is further compounded by rotation system of personnel trained in FP and SBA/SHP to other departments, which is often practiced by hospitals, leading to shortage of trained personnel to provide these services.
- 6) Safe motherhood and Neonatal Health Roadmap 2030 recommends establishing onsite birthing units at the high volume delivery sites** to reduce overcrowding at these sites and to potentially provide higher quality of care. Since the training sites are usually the high-volume sites, establishing onsite birthing units at these sites has the potential to not only improve the quality of care at the site but also the quality of trainings provided at these sites.

Coordination mechanisms between the training sites, Province Health Training Centers (PHTC) and the palikas:

- 7) Weak linkages exist between the palikas and the training sites/PHTC/NHTC** for training needs assessment/request and training delivery. Capacity building of the PHTC and the training sites on management aspects such as development of annual training plan could strengthen the linkages between the training sites, PHTC and the palikas.
- 8) Inadequate human resources at the PHTC** especially because of vacant sanctioned position hinders the ability of PHTC to provide support to the quality improvement efforts at the training sites. Sanctioned position at the training sites for planning and management of the training site and trainings could strengthen the linkages of the training site to the PHTC, NHTC and the palikas.

⁵ Nsi.edu.np. 2022. [online] Available at: <http://www.nsi.edu.np/images/category/Assessing_the_Quality_of_SBAs_in_Rural_Nepal.pdf> [Accessed 27 April 2022].

S.N.	Thematic Area Tools	Total Standards
1	Family Planning	
1.1	FP 01: Counseling	6
1.2	FP 02: COC (Pills) & DMPA (Depo injection)	6
1.3	FP 03: Implant	20
1.4	FP 04: IUCD (Intrauterine Contraceptive Device)	19
1.5	FP 05: NSV (No Scalpel Vasectomy)	9
1.6	FP 06: ML LA (Mini laparotomy under Local Anesthesia)	12
1.7	FP 07: EC (Emergency Contraceptive)	3
1.8	PPIUCD (Postpartum Intrauterine Contraceptive Device)	32
	FP Sub Total	107
2	Maternal and Newborn Care (Skill Birth Attendant/SBA-MNC)	
2.1	MN 01: Focused Antenatal care (FANC)	11
2.2	MN 02: Complications During Pregnancy	15
2.3	MN 03: Normal Delivery and Immediate Newborn Care	27
2.4	MN 04: Complications During Labor and Childbirth	26
2.5	MN 05: Postpartum Care	11
2.6	MN 06: Newborn Care	11
	SBA-MNC Sub Total	101
3	SR 05: IPHCWM	14
4	Training	
4.1	Quality Training Improvement	16
4.2	Classroom	15
4.3	Clinical Instructor	14
4.4	Training Site Management	14
	Training Sub Total	59
	QI Tools Total	
Minimum Service Standards (MSS)		
Code	MSS Area	Standards
2.2.2	Family Planning Clinic	17
2.7.1	Delivery Services (Maternity Services)	34
2.7.2	Maternity Inpatient Services (Maternity Services)	27
2.7.3	Birthing Centre Service (Maternity Services)	NA
3.6	Hospital Waste Management	18
	MSS Sub Total	96
	QI and MSS Grand Total	377

Table 1: Assessment tools used

