



Best Practices in Training Private Providers

I. INTRODUCTION

Training of health care providers is one of the most common interventions used in development strategies to improve the quality of reproductive health and family planning (RH/FP) services in developing countries. Decades of experience have produced an abundance of information, guidelines, and best practices on how to effectively train health providers, but most of this relates to public sector providers. In recent years, however, private sector providers have been recognized increasingly as an important source for delivery of RH/FP and other health services in developing countries, even for the poor. Yet the inclusion of private providers in training interventions or even the acknowledgement of their unique needs in discussion forums on training are still not common practices.

The purpose of this primer is to document and promote best practices gleaned from worldwide experience in training private sector providers. The U.S. Agency for International Development (USAID)-funded Private Sector Partnerships-One (PSP-One) project has reviewed literature and developed case studies of recent private provider training events to collect and analyze lessons learned (see Table I, Training Case Studies, at the end of this primer). The findings will aid donors, program managers, curriculum designers, and trainers to successfully design and implement training of private providers. Again, because

numerous resources exist on general aspects of training, this primer does not address those topics but rather focuses on aspects that are unique to training private providers.

2. HOW ARE PRIVATE PROVIDERS DIFFERENT?

The first step in designing effective training programs for private health providers is understanding how they differ from public sector providers. In this primer, the term “private providers” refers to any formal or informal health provider who works in a private, for-profit (commercial) practice (see Box 1).

Box 1. Who are “private providers”?

In this primer, the definition of “private providers” includes only **for-profit (commercial) providers of preventive or curative health services or products**, such as:

- Individual private providers – e.g., doctors, nurses, midwives, and traditional healers;
- Staff in private, for-profit facilities – e.g., private clinics, hospitals, nursing, and maternity homes;
- Private pharmacists and chemists; and
- Staff in private, for-profit diagnostic facilities – e.g., laboratories and radiology units.

Although the term often is used for all providers outside the public (government) sector, including nonprofit entities such as nongovernmental and faith-based organizations, nonprofit entities are not addressed in this primer because their conditions of practice differ significantly from those of private commercial providers.



Several factors make private providers unique, and have implications for their training. The most salient is that, in addition to being health providers, the providers are business owners or employees of a for-profit business. Unlike public sector providers, who continue to receive their salary while attending training courses, private providers forgo revenue when they are away from their practice, particularly if they are sole practitioners or in a small practice, and this lost revenue cannot easily be recovered. Therefore, private providers must weigh the potential benefits of training against this opportunity cost. This directly influences the marketability of training (and quality improvement efforts in general) for private providers and underscores the need to have appropriate incentives in place to motivate private providers to attend a training event. As will be seen below, these incentives may be tied directly or indirectly to benefits to their practice, such as increased clientele or consumer satisfaction.

A second characteristic is the lack of effective supervisory structures in most private sector settings. Public health systems may not always operate optimally, but they nevertheless can mandate public sector staff to attend a training event. In contrast, many private providers own small, independent practices and even those who work in large private sector facilities such as hospitals and clinics likely have only an internal supervisory structure on site; while these providers may be licensed and regulated by the government, they do not report to a government authority. This means that mandating participation in a training event is usually not an option. Again, a program must rely on other incentives to attract providers to a training event.

The lack of a supervisory or organizational structure poses still other challenges: Prior to training, there is no obvious mechanism to help training organizers identify and access groups of potential training participants. Afterward, there is no structure to facilitate follow-up with participants, ensure application of knowledge learned, and build quality structures to monitor

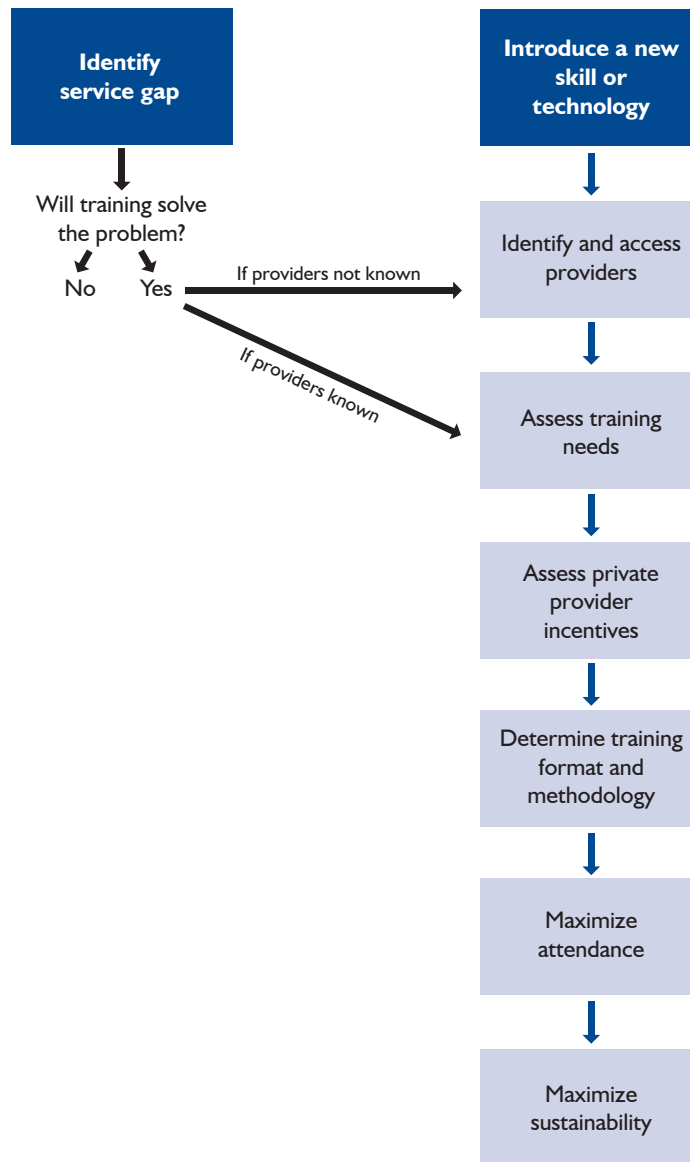
the application of new practices. Nevertheless, there are alternative private sector structures that, even if less robust than public sector systems, may exert some influence on private providers' knowledge, skills, and quality of care, and may help with training. These private sector structures—professional associations, provider networks or franchises, and health insurance or contracting mechanisms—are discussed in section 3.

It should be noted that some private providers also operate in the public sector. Thus, interventions targeting public sector providers, including training interventions, may reach some private providers. However, because different factors influence provider behavior in the different sectors, post-training, the same provider may perform differently in the public and private practices. In private practice, providers are more likely to perceive patients as *customers* they need to satisfy and they may be more sensitive and responsive to patient expectations, even when this requires they deviate from best treatment practices (Bruga and Zwi 1998). For example, in the public sector, a provider may prescribe oral rehydration solution for child diarrhea, whereas in a private clinic he/she may prescribe an antibiotic (Berman and Hanson 1993). Therefore, even public sector-oriented training events should be complemented with interventions specifically targeting private settings.

3. BEST PRACTICES

This section describes the best and most promising practices identified in the case studies for each step in the process of planning and implementing a private provider training. Figure 1 outlines the steps in this process, which can begin when (1) a service gap is identified; or (2) a new skill or technology needs to be introduced into the private sector. Just as in the public sector, it is important to determine if training is indeed the most appropriate intervention to address the private sector service gap (see *Learning for Performance* for guidance on this process, Capacity Project 2007). If it is, the subsequent steps in Figure 1 can be taken to train private providers.

Figure 1. Steps to Planning and Implementing a Private Provider Training Program



The following sections discuss each of these steps. Box 2 summarizes the best practices and can be used as a quick reference.

3.1 How do you identify and access private providers?

As discussed in section 2, the unique characteristics of private providers present challenges that can emerge at the very first step in planning a training event: how do you find and select the providers you want to train? While public sector providers work in government facilities and can be recruited through this structure, it is often a challenge to identify the universe of private providers and to access

and recruit them. Many strategies have been successfully applied to overcome this challenge.

The most common strategy is to work with and through **professional associations**. Most countries and provider cadres – physicians, midwives, pharmacists, and others – have some type of professional association, although their levels of activity and authority can vary greatly. Most associations can at least provide a list of members or registered providers for use in identifying the initial selection pool of providers for training and many of them can play a larger and crucial role in the training process. Pharmaceutical companies often hire professional

Box 2. Summary of Strategies and Best Practices for Training Private Providers

HOW DO YOU IDENTIFY AND ACCESS PRIVATE PROVIDERS?

- Work with professional associations
- Select providers contracted by an NGO or the public sector
- Select providers who participate in HMOs or health insurance schemes
- Select providers who are part of a franchise or network
- Obtain a list of registered providers from the public sector
- Begin with a participant roster from previous training activities of other projects
- Partner with pharmaceutical companies to use their sales and detailing force

HOW DO YOU ASSESS THE TRAINING NEEDS OF PRIVATE PROVIDERS?

- Conduct a rapid assessment with target providers, use surveys, focus groups, key informants
- Conduct a desktop review of existing research, statistics, or project reports
- Collect information on optimal training logistics (day, time, location)
- Determine which topics providers are interested in learning about
- Involve representatives of target providers in the entire planning process
- Work closely with professional associations, NGOs, or HMOs
- Hire a local consultant familiar with target providers

WHAT ARE INCENTIVES THAT ENCOURAGE PRIVATE PROVIDERS TO ATTEND TRAINING EVENTS?

Financial incentives:

- For financial management topics, clearly link training content and increased income
- Connect completion of training with membership to network or franchise
- Highlight link between improved service quality and potential to increase number of clients

Professional development:

- Most private providers welcome the opportunity to learn a new skill or receive knowledge updates
- Choose training topic of interest to providers

WHICH TRAINING METHODOLOGIES ARE APPROPRIATE FOR PRIVATE PROVIDERS?

- Minimize time spent away from practice
 - If using existing curriculum, separate, consolidate or otherwise adapt to private provider setting
 - Use peer-support approach
 - Use self-study
 - Use on-the-job training
- If caseload is needed for clinical skills training, use public sector or NGO facilities
- Use associations, NGOs, or HMOs to follow up with providers

HOW DO YOU MAXIMIZE ATTENDANCE?

- Select convenient day, time, and location
- Invite well-known speakers
- Provide continuing medical education credits
- Provide a certificate or diploma
- Provide reference materials such as handbooks and job aids
- Deliver invitations by hand, in person
- Use visually attractive invitations signed by respected leaders (i.e., association president)
- Highlight the benefits of the training in the invitation
- Follow up on invitation individually with providers by phone

HOW DO YOU ENSURE SUSTAINABILITY?

- Apply rigorous selection criteria to filter out less-motivated providers
- Train several staff per facility, including staff with authority to implement training content
- Create capacity of professional associations, NGOs, HMOs, networks, or franchises to take over training
- Charge a fee to participants
- Leverage investment from pharmaceutical companies to fund training events
- Institutionalize training within existing pre-service training programs
- Make training available on-line
- Link training requirement to licensure or relicensure

associations to help introduce a new drug therapy. The advantages to working with professional associations, beyond the issue of provider selection, are discussed throughout this primer.

In Guatemala, the medical and the biochemist associations allowed PSP-One to attend some of their regularly scheduled meetings, where the project conducted sensitization talks about HIV/AIDS and recruited participants for its training course on HIV/AIDS. Population Services International (PSI)/Benin used a similar strategy: PSI organized pre-training information days with the pharmacists' association to orient pharmacists to national RH guide/guidelines, sensitize them on FP/social marketing programs, and recruit potential participants. In Ghana, the licensed chemical sellers' (LCS) association conducted the initial screening of participants for a Ghana Social Marketing Foundation (GSMF) training event, by facilitating the completion of screening forms among its members.

In addition to professional associations, there may be other structures that link private providers and provide a way to identify and reach them. One is **private doctors who are contracted by an nongovernmental organization (NGO)**:

In Honduras, PSP-One used such a structure to gather participants for training on the no-scalpel vasectomy (NSV) technique. The NGO was responsible for selecting participants from among its contracted providers and for contacting and recruiting them. Similarly, in Nigeria, PSP-One trained private providers participating with Total Health Trust, a **health maintenance organization (HMO) enrolled in the National Health Insurance Scheme (NHIS)**.

The Trust provided a list of its participating private providers and played an active role in selecting and contacting potential participants. Other variations of these scenarios include **private providers who are contracted by the public sector** or those who are part of a **franchise or network**. Recruiting through these types of structures ensures that the providers have already met some performance criteria and facilitates the introduction to the providers.

The **public sector** may also be a vehicle for identifying private providers, as nearly all governments have some kind of registered provider list. However, the utility of these lists varies tremendously. In countries where the public sector plays a strong and active role regulating the private health sector, government registers of providers are more likely to be updated and to contain useful information. In Ethiopia, the Private Sector Program (PSP-Ethiopia) worked closely with regional health bureaus (RHBs), which provided PSP-Ethiopia a pre-selected list of potential providers to train. Training planners may refer to **rosters from previous training activities** from their own and other projects/organizations to identify and select trainees for the current training. In Romania, the Banking on Health project reached out to private doctors who had previously been trained on RH/FP by a different project to train them on business and management skills for their private practices. Recently, other innovative strategies for reaching private providers have emerged. In Guatemala, PSP-One brokered partnerships with **pharmaceutical companies** to identify and contact private doctors through their sales and detailing force.

The best strategy for identifying potential trainees will depend on the program objectives, selection criteria (see section 3.6), and the available resources and structures in the country. In many cases, a combination of strategies is most effective. In Guatemala, PSP-One's multi-pronged approach to recruitment – using professional association lists and events and leveraging pharmaceutical companies' reach of private providers – was very successful in attracting training participants.

Despite these options, challenges may remain. For example, even when professional associations exist, they may have relatively few members and limited reach, or may be unwilling to collaborate. Lists and registries provided by associations or by the public sector could be outdated in terms of provider names and/or contact information, and may include both public and private providers,

in a way that makes it difficult or impossible to tease out the private ones. When this is the case, the only solution may be a less efficient approach, conducting a field assessment of the appropriate private health facilities (e.g., clinics, hospitals, pharmacies, labs) in a pre-determined geographic area to define the universe of potential trainees.

3.2 How do you assess the training needs of private providers?

A variety of methods can be used to determine the training needs of providers. In many cases, the instruments can be used to gather information to help decide training logistics.

Many of the training programs studied conducted a **training needs assessment (TNA)**. In Romania, the Banking on Health project commissioned a TNA of the business development needs (particularly regarding finance and training) of private doctors. The TNA used desk research, focus group discussions and key informant interviews, and in-depth market research. The focus group discussions and interviews were conducted nationwide, with 1,215 family doctors in all districts of the country; in addition to surveying training needs, the TNA asked providers for the days of the week and hours when training would best fit their schedules. In Ghana, a TNA conducted by the PRIME project and the Ghana Registered Midwives Association (GRMA) with GRMA member midwives found the need for an RH/FP update, improved counseling and client-provider interaction skills, increasing adolescents' access to services, and introduction and application of the national service policies, standards, and protocols.

In Guatemala, the PSP-One project conducted a **rapid assessment** of the HIV counseling and testing (CT) training needs of private doctors and biochemists. The project administered a semi-structured questionnaire to 38 doctors and 21 biochemists using convenience sampling in its target geographic areas. Findings indicated low levels of knowledge of HIV CT norms and guidelines, and helped determine the most appropriate days and times for scheduling the

training events. In Jordan, after USAID identified a general area of concern – women's health with emphasis on RH – the Private Sector Project for Women's Health in Jordan (PSP-Jordan) staff designed and administered a questionnaire to identify the topics that private female doctors were interested in knowing more about, and then tailored training sessions to address those topics (e.g., hypertension and bleeding of women during pregnancy).

Other simple tools can be used to conduct rapid assessments, such as a survey, a quality improvement self-assessment tool to identify knowledge gaps, or observations of providers while interacting with patients. In Nigeria, a survey conducted with physicians belonging to an HMO revealed the need to build the providers' skills on FP counseling and to highlight existing motivations for providing this service. Based on these findings, PSP-One designed a training program that covered both FP counseling and the NHIS capitation and reimbursement system.

In some cases, a **desktop review of existing research, statistics, or project reports** can be a very cost-effective way of assessing training needs. However, such information is not always available and up to date.

Regardless of the methods used, it is important to also **involve representatives of the target providers in the entire assessment and planning process**, so that the provider perspective is considered in every aspect of the training. This involvement can be done by contacting a sample of providers directly and/or by working closely with **professional associations, NGOs, HMOs**, or other organizations. For some countries, there may be **consultants** who have experience working with the target providers, and/or may themselves be providers. The challenges to assessing training needs and logistics and to involving target providers in the planning process are similar to those related to identifying and accessing private providers, discussed above. While it may not be feasible to incorporate into the training program

all of the suggestions collected from providers – organizers must balance their input with what is realistic to implement – their contribution to training design and implementation is vital.

3.3 What are incentives that encourage private providers to attend training events?

Having the right incentives in place is crucial to getting private providers to participate in a training event. To ensure selection of the appropriate incentives, identification of providers' motivations for participating should be done during the TNA. Ideally, incentives for private providers should address two levels of participation: (1) physical attendance to the training; and (2) learning the training material and applying it in their everyday practice.

Incentives for maximizing attendance are usually easier to address (see section 3.5). To pique provider interest in learning and applying the material, it is often assumed that the training must offer potential for **financial gain**, which appeals to private providers' profit motive. Several case studies confirmed this, especially when training curricula included financial topics. The private doctors participating in the Banking on Health training in Romania clearly saw how their private practices could benefit from training on financial management and access to credit. Similarly, feedback from the private doctors in Nigeria who participated in the PSP-One HMO/NHIS training showed that they appreciated the link between better understanding and management of the NHIS' capitation payment system and their own revenue stream. In both cases, providers cited financial benefit as the main incentive for participation.

Training programs don't always have such direct financial incentives built in, but the case studies revealed other incentives that encourage private providers to participate in training events.

Franchises and networks can offer members indirect financial benefits such as discounted prices on health products and increased clientele due to higher perceived quality (Chandani et al. 2006). In Ghana, successful completion of the

GSMF training for LCS resulted in membership to the CareShop franchise of chemical shops. The benefits of membership were clear to potential participants: easier access to products through the franchise and branding of their shop with the prestigious CareShop name, indicating high-quality services to customers. Other training programs that resulted in membership to a network include the PSP-One/India training events for obstetrician/gynecologists for the Depot Medroxyprogesterone Acetate (DIMPA) injectable network, as well as their trainings of chemists and indigenous systems of medicine providers (ISMPs) for the *Saathiya* network. However, these benefits work as incentives only if potential participants clearly see the linkage between training, membership, and financial gain; this may require significant educational and advocacy work until the franchise or network brand is well recognized.

It is important to clarify that the “financial incentives” discussed in this section relate to increasing the profitability of the private provider's practice, and should not be interpreted as paying providers to attend a training event. Paying sitting fees is not recommended – while it may increase attendance in the short run, it is more likely to attract providers who are not interested in the training content and therefore not likely to apply it in their practice (see section 3.6 for a discussion of selection criteria and charging a fee to participants).

While financial incentives are important, the most-often cited incentive in all the case studies is the **opportunity for professional development, and improved knowledge and skills**. These incentives are often underemphasized by programs, donors, and governments, which assume the predominance of private providers' profit motivation. In fact, private providers express a need and desire for clinical updates and professional development, and cite frustration over their exclusion from public sector training. In most of the case studies, the mere fact that someone was reaching out to private providers to improve their knowledge

and skills was enough of an incentive for them to participate, as many had not received any training on the particular health topic (or on any topic) since completing their formal education. Some private providers also recognized the link between a new skill, service, or quality improvement in existing services, and the potential to attract more clients; if they do not, training organizers should clearly explain the link.

Although the desire for professional development is an encouraging finding, the learning incentive usually is only effective when the providers find the training topic relevant to their practice. Often, providers do not find RH/FP topics of interest. Therefore, it is important to assess providers' interest in the topic prior to planning the training. If that interest is low, one solution is to add to the curriculum topics that do interest the providers. Ultimately, the incentives must be strong enough to offset any costs or perceived costs for the private providers to participate in the training.

3.4 Which training methodologies are appropriate for private providers?

Many of the methodologies that are used for public sector training events can be used with private providers. However, it is important to include private provider stakeholders when planning and developing a training event to ensure that the curriculum and methodology are appropriate to their unique characteristics (see section 2), especially the need to minimize time away from their practice. When using an existing public sector curriculum, it is imperative to **adapt the curriculum to the specific private provider setting**.

One way to adapt is to **separate the training modules** and deliver them at separate times. For example, instead of conducting training on six consecutive days, a program could hold day-long workshops, one day a week for six weeks. In Honduras, PSP-One adapted the NSV training module used in the public sector in Mexico to the private provider setting in Honduras. The original curriculum involved two weeks of full-

time training that included both theory and practice. Because the Honduran providers could not be away from their private practices for two weeks, the theory portion of the training was given in a 2.5-day workshop (Friday-Sunday), and the practical portion was stretched out over a period of several months and conducted individually with each doctor according to his or her availability. Another common strategy used to adapt public sector curricula to the private sector is **consolidation**. PSP-Ethiopia condensed three modules of a public sector training curriculum that took place over 10 days into six consecutive days. Whenever adapting a public sector curriculum, it is important to consult with public sector trainers and in some cases obtain their approval on the proposed changes to ensure that no essential material is lost.

In terms of training methodologies, most case studies found that a combination of workshops and **participatory adult learning principles** are especially appropriate for private providers as they help minimize “in-classroom” time. For example, in Ghana the PRIME project and GRMA developed a **self-directed learning model** for midwives that included multiple learning approaches: **self-assessments**, printed **self-study** modules, facilitator visits, group **peer-review** meetings, and **paired learning** with a nearby peer. The introduction of each training module took place during GRMA's monthly meetings, where midwives were paired with a partner. In this approach, two midwives who were geographically close to one another completed the training material and then reviewed it together with occasional visits by a supervisor. This self-directed model with support from peers helped compensate for the lack of a constant supervision. It also greatly minimized the time the midwives had to spend away from their practices.

The midwife training by the ACQUIRE project in Kenya also relied heavily on the **peer-support** approach. Through peer-support clusters, the midwives provided each other with peer supervision, client referrals, joint problem-solving,

and even loans. PSP-Ethiopia is developing a self-study portion that providers will complete prior to the lectures. The self-study is designed to help minimize the duration of the lectures and engage the providers in the training topic. In Ghana, the GSMF training of CareShop LCS included five modules presented in workshops of 2-5 days each that alternated with one week of **on-the-job training**, when participants were expected to apply in their shops what they learned in the workshops, and to provide and share feedback with their peers.

When clinical skills are being taught, the private sector may not have an adequate caseload on which trainees can practice their new skills. In this situation, in addition to using models for initial practice, a program can arrange to **conduct clinical training in public sector or NGO facilities**, where the caseload is usually greater. Participants in the PSP-Jordan training completed the practical portion at Ministry of Health-approved training sites. In Honduras, participants in the PSP-*One* training conducted many NSVs at NGO facilities, which had a higher patient load than did private sector facilities. Practicums for private provider training can be complicated to arrange and are often the most challenging aspect of organizing a clinical training. It is important to have local staff available to coordinate the providers' schedules and to stay flexible and adjust as needed.

Consistent follow-up with providers after training is another essential component of enhancing effectiveness and keeping providers engaged, in both the public and private sectors. However, it can be especially challenging to do with private providers in the absence of a professional organization or supervisory structure, or sufficient resources. Following the PSP-*One* training of private midwives on a quality improvement tool in Uganda, Uganda Private Midwives Association (UPMA) supervisors provided periodic support to midwives using the tool through monthly association meetings. In Guatemala, the PSP-*One* project sends out monthly newsletters to all training participants

describing project activities and training events to keep them informed and motivated.

3.5 How do you maximize attendance?

To maximize attendance at training events, programs use various strategies aimed at reducing potential barriers and enhancing perceived benefits. **Selecting a training time, duration, and location** that minimizes providers' time away from their practices is essential. A convenient location is one that minimizes travel distance and costs for providers. Some programs also take into account the overall attractiveness of the location and specific training venue. Most of the case studies found that the appropriate time and location often were determined early on, during the TNA, with input from local partner organizations such as professional associations and HMOs. Close monitoring and flexibility is also important, as some barriers to attendance emerge only after the training starts. PSP-Ethiopia found that attendance at workshops was inversely related to travel distance. In response, the program further decentralized training locations to decrease travel distance, and attendance improved. PSP-*One*/India noticed that many chemists arrived at their training workshop on time at 1 pm, but left halfway through, after lunch was served. The project changed the start time of subsequent workshops to after lunch, at 2 pm, and instead of lunch served high tea after the day's training ended.

Having **well-known speakers**, such as a well-respected and regarded peer, also boosts attendance. In PSP-*One* training events in Guatemala, the main lecturer is one of the best-known HIV experts in the country.

Private providers also value the ability to **obtain continuing medical education (CME) credits** for the training. Some countries require a certain number of CME credits to renew a professional license or to maintain membership in a professional association, so providers welcome events that allow them to earn credits. It is important to approach the organization that grants CME credits (usually a professional

association or council) early on, as the approval process may take time. PSP-One in Guatemala and India obtained CME accreditation for their training programs from the medical and biochemist associations, and this proved to be a strong incentive for participation. Similarly, PSP-Jordan's training of private doctors was accredited by the Jordan Medical Council. Whether or not CME credits are given, **awarding a certificate or diploma** that providers usually value and enjoy displaying in their practices encourages attendance. Providers also appreciate receiving **educational materials** such as handbooks and job aids at training events.

The importance of the **mode of invitation** to private provider training events should not be underestimated. While in the public sector a notification from a supervisor might suffice to ensure attendance, a simple notification to private providers most likely will not attract them – the invitation must convince them of the importance of the training. The case studies show that the invitation must **make the provider feel valued**, and **sufficiently highlight the training benefits**. PSP-One/India produced high-quality, attractive invitations for the ISMP and chemist training events, which communicated respect for the providers and prestige for the training. The invitations were signed by the heads of professional associations and hand-delivered by project staff to potential participants. The project staff then **followed up with providers by phone** prior to the training to encourage them to attend. The PSP-One project in Guatemala and PSP-Jordan also successfully used this strategy of personal follow-up by phone to recruit training participants. In Nigeria, PSP-One developed a marketing brochure to promote the Access to Finance training course and describe the benefits that providers could gain from attending.

3.6 How do you ensure sustainability?

Sustainability of training programs is perhaps their most challenging aspect, and may be described at different levels:

- Retention and use of the new skills learned by the participating providers;

- Retention of the new skills at the facility level; and
- Sustainability or continuation of the training program itself.

The level of sustainability that a training program strives to achieve will depend on the program objectives. All training programs should strive to attain at least the first level of sustainability: skill retention at the provider level. This can be especially challenging with private providers, who lack a supervisory structure. A good strategy to overcome this challenge is to apply **rigorous criteria to participant selection**. This immediately filters out participants who are less likely to retain and apply the new skills due to lack of interest, to lack of skill applicability to their practices, or to other barriers. By minimizing waste of resources on participants who will not deliver results, rigorous selection improves training efficiency.

While these selection criteria will depend on the context, it is advisable to include some kind of measurement of provider motivation and commitment to the training content. For example, the main selection criteria for participating in the PRIME project self-directed learning program on RH/FP for midwives in Ghana was regular attendance at GRMA monthly meetings. In Kenya, the ACQUIRE project focused the selection of midwives for voluntary CT training on those with positive attitudes toward the topic. Another way to identify the more motivated providers is to use a “competitive” selection process whereby potential participants go through an application process. Prospective participants in the GSMF CareShop training of LCS in Ghana had to fill out an application form and attend an onsite interview.

Other selection criteria address issues other than provider motivation. In India, the private providers participating in the PSP-One DIMPA training were required to have a separate waiting room in their office/clinic so that clients could be counseled in privacy, as instructed in the training. It is a good idea to work closely with local

organizations such as professional associations, HMOs, or even the public sector to determine the most appropriate selection criteria for a particular training.

The next level of sustainability, skill retention at the facility level, can also be difficult to achieve. Just as in the public sector, high staff turnover in the private sector often leads to the loss of trained staff. To minimize this loss, the PSP-One project in Nigeria is **training several staff per facility**; if one of them leaves, some capacity is retained. The project also includes the medical director of the facility in the training; training such a person of authority helps to ensure that the training content is implemented and sustained at the facility level.

In addition to sustainability at the provider and facility levels, some programs attempt to put in place a sustainability strategy that will allow the training program to continue once project funding ceases. The most common approach to maximize training program continuity is to work closely with **professional associations**, building their ownership and capacity to continue the training on their own. In Ghana, the PRIME project initial training of midwives was imbedded within GRMA, which then conducted an additional training round after the project ended. The same approach was used by PSP-One in Uganda to train members of UPMA on using a quality improvement self-assessment tool.

HMOs and franchises may also have the capacity to take over training activities. The financial incentives that are usually built into these structures may make them more viable providers of sustained training programs than associations, although a strong professional association with an active dues-paying membership may also be able to sustain training activities. In Nigeria, PSP-One worked closely with partner HMOs from the beginning of the program and trained at least one trainer per HMO to conduct future training events. The GSMF training in Ghana was conducted under the CareShops franchise. In Romania, where the Banking on Health training

of private doctors included access to credit, the project was able to leverage interest from **financial institutions** to continue funding the course after project funding ended.

Although structures such as professional associations, HMOs, and franchises/networks usually have membership fees and a budget, this is often not enough to cover the costs of training activities. **Charging a fee to the training participants** provides some cost recovery. Doing this is only feasible when private providers recognize the value of the training. PSP-Jordan charged a small fee to doctors to cover clinical supplies required for training related to Pap smears and ultrasounds. In Ghana, GSMF charged a fee to participating LCS, which eventually covered an increasing share of the training costs. Even if charging a fee is not feasible initially, it should be explored in the mid to long term, once the training is well known and valued.

In Romania, the NGO that implemented the Banking on Health training of private doctors used an exit survey to determine how much doctors would be willing to pay for the training if it were offered on a fee basis, and determined it was a price that would cover the training costs. The HMOs working with the PSP-One project in Nigeria plan to charge a training fee to doctors, once the HMOs take over the program and it is valued and recognized more broadly. (The HMOs currently cover the part of the training costs that eventually will be covered by provider fees.) To prepare the private providers for this approach, the project requires providers to pay their own transport to the workshop and does not pay the per diems or “sitting fees” that are usually paid to providers in public sector training programs. In addition to enhancing the financial sustainability of a training program, charging a fee for participation can also act as a rigorous selection criterion, as providers who are willing to pay are much more likely to be genuinely interested in the training topic and in applying their new knowledge and skills.

When existing structures and training fees cannot sustain training, private investment may be an option. PSP-Jordan and the PSP-One

projects in Guatemala and India have successfully leveraged **investment from pharmaceutical companies** for their current training programs; they hope to expand this investment to cover an increasing proportion of training costs. The companies' incentives for contributing can be to market their products through the training, or contribute to their corporate social responsibility program. The marketing incentive may provide a more sustainable source of funding, as it relates to the company's commercial interests, but it may also be more difficult to accomplish.

The PSP-One project in Guatemala is also exploring two other strategies to ensure that the HIV training program for doctors and biochemists continues beyond the life of the project. Project staff are currently in talks with professional associations and universities to explore the possibility of **institutionalizing the course within the pre-service training programs** at the universities, making it part of the medicine and biochemistry programs. The project is also considering developing an **online version** of the training modules, and housing it on the professional associations' Web site so that it is widely available to anyone with an Internet connection.

Perhaps the most robust sustainability strategy for training programs, and also one of the most difficult to achieve, is **making it a training requirement for licensure or relicensure**. In Ghana, the National Pharmacy Council was interested in making the GSMF CareShop training a requirement for obtaining a LCS license. To date this has not been achieved, as it requires a change in legislation. In Nigeria, PSP-One is devoting significant effort to obtain CME credits for its training program and link this CME requirement to relicensure of doctors.

These strategies to improve sustainability of training programs for private providers each have limitations, and it remains to be seen whether any of them show results in the long term. The most common strategy, working

with professional associations, may work well at first, but experience shows that the level of engagement and commitment often diminishes in the face of competing priorities, change or lack of leadership, or lack of resources. The most promising new strategies appear to be those that are tied to financial incentives, such as working with HMOs and franchises, using the commercial interest of private companies (often pharmaceutical) to invest, and tying training to licensing requirements.

4. SUMMARY: COMMON ELEMENTS OF SUCCESSFUL PRIVATE PROVIDER TRAINING

This primer illustrates the many issues to consider at each step of planning and implementing a successful private provider training program. Perhaps the most universal element found in the PSP-One case studies is addressing private **provider motivations and incentives**. Because private providers cannot be obliged to attend training, they must be persuaded. When motivation is properly assessed and incentives are effectively incorporated into every aspect of the training and communicated to providers, the chances of achieving success are greatly increased.

Another common element is **collaboration with local organizations or structures**, such as professional associations, NGOs, or HMOs. Such collaborations greatly facilitate each step in implementing a private provider training program:

- Identifying and accessing providers;
- Assessing their training needs;
- Assessing and applying appropriate incentives;
- Implementing the best training methodologies;
- Maximizing attendance; and
- Achieving sustainability.

Finally, the case studies showed the importance of conducting a **needs assessment** and of consulting with, and **involving the target private providers** in the planning process.

Doing so will ensure that the first element, motivations and incentives, is properly addressed.

Many strategies are discussed in this primer for developing a successful private provider training program. As no two programs are the same, the key to success is to assess each context and apply or adapt the relevant strategies. It is important to note that training alone may not suffice to achieve improved quality of RH/FP and other health services offered by private providers (Peters et

al. 2004). As stressed earlier, it is important to assess whether training is the appropriate solution for an identified service quality gap (see Figure 1). Programs should examine all of the factors that may influence private provider behavior and service provision (Brugha and Zwi 1998) and determine which interventions, such as health financing or policy and regulatory reform, instead of or in addition to training, are likely to have a positive impact on quality of care.

Table I. Summary of Training Case Studies

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: Benin Year: 1998 Organization/Project: PRIME and Population Services Intl. (PSI)/Benin Local Partner: National Association of Pharmacists Trainees (#): Pharmacy agents (80) Topics: Contraceptive Technology Update (CTU), quality of care and access to services as applied to pharmacy setting Duration: 3 half-days</p>	<p>A short assessment indicated that pharmacists were not available for training and that pharmacy agents are the most present personnel in the pharmacy during the day. PRIME and PSI/Benin then conducted an “information day” for 76 private pharmacists to discuss RH, inform them of upcoming pharmacy agent training, and encourage them to send their staff to the training.</p>	<p>Combination of self-study and standard classroom sessions (3 half-days). Training documents sent to participants prior to training to read before each session to reduce time away from work.</p>	<p>Participants received training materials, lunch following half-day training session, and transportation. Main incentives were found to be value of knowledge acquired, understanding that improved service quality could bring more clients to shop, and being part of a network that was to receive PSI support.</p>	<p>The involvement of PSI/Benin trainers and availability of training materials was the main strategy for sustainability. PSI trainers were coached by IntraHealth staff for some refresher courses for the pharmacy agents. PSI/Benin trainers have conducted further refresher courses without outside assistance.</p>	<p>Use a <u>training approach</u> that <u>minimizes time away</u> of providers from their work site; involve pharmacists or the association in providing incentives for excellent learners.</p>
<p>Country: Ethiopia Year: 2007-2008 Organization/Project: Private Sector Program PSP-Ethiopia Local Partner: Regional health bureaus (RHBs) Trainees (#): Physicians, nurses, and lab techs (306) Topics: Prevention and treatment of TB and HIV care Duration: 6 days</p>	<p>Assessment conducted in 180 private facilities in 3 regions to determine interest in and need for training, to expand access to affordable HIV and TB health care. RHBs have a list of all registered private health facilities. Facilities that met pre-determined selection criteria were included in the assessment; a second set of criteria shortlisted the facilities and those participants were sent a letter of invitation.</p>	<p>In-classroom lectures with on-the-job training and mentoring. PSP-Ethiopia also plans to add self-study prior to lectures. Lectures are scheduled on 6 consecutive days (considerably shorter than similar workshop offered to public sector staff). Location of workshop decentralized to regions to minimize travel times.</p>	<p>Participants received per diem, transportation costs, training materials, resource materials such as national guidelines and manuals, and certificate of attendance signed by project and RHBs. Certificates were found to be strong incentive. Competitive process to participate also conveyed value to training.</p>	<p>PSP-Ethiopia is working closely with RHBs to build their capacity to continue training staff.</p>	<p>Make the <u>training location</u> as <u>near and convenient as possible</u> to minimize cost to participants; a <u>pre-workshop self-study portion</u> on background topics is a good strategy to reduce training time and allow in-classroom time to focus on core topics of interest.</p>

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: Ghana Year: 1999-2001 Organization/Project: PRIME Local Partner: Ghana Registered Midwives Association (GRMA) Trainees (#): Midwives (59) Topic: Adolescent RH and client-provider interaction Duration: 5 months (about 1 module per month)</p>	<p>A TNA was conducted in 1997 by partner organizations. Midwives who regularly participate in GRMA monthly meetings were recruited.</p>	<p>A “self-directed learning” model administered through GRMA combined practice exercises, self-assessments, paired learning with a nearby peer, facilitator visits, and monthly group peer-review meetings. This approach minimized the time for group learning to once a month meetings, after a 2-day kick-off meeting.</p>	<p>Participants received print materials (6 modules), information, education and communication (IEC) and FP supplies, and facilitator visits. Main incentive for participation was found to be increased knowledge that was then used to attract both new clients as well as a new type of client (adolescents).</p>	<p>The training program was to be institutionalized within GRMA. It is known that GRMA conducted one more round of training for an additional 52 midwives and offered the original 6 modules plus a new one GRMA developed on HIV CT.</p>	<p>Conduct TNA so that the training program responds to identified needs; involve all stakeholders in the design of the training program; build on an existing structure (GRMA and its monthly meetings), which can provide the trainers and supervisory/facilitation visits; build in peer support to keep participants engaged.</p>
<p>Country: Ghana Year: 2002-2004 Organization/Project: Ghana Social Marketing Foundation (GSMF), SEAM project Local Partner: Licensed Chemical Sellers (LCS) Association Trainees (#): Licensed chemical sellers (approx. 230) Topics: CareShop franchise business model, business and management, drug management, managing simple ailments, business planning Duration: 16 days distributed over 10 weeks</p>	<p>GSMF used an extensive TNA conducted by a prior project and developed content to respond to those needs. They worked closely with the LCS and local traditional political structure (village chiefs) to present CareShop concept and screen potential applicants, using an application process to screen and recruit participants.</p>	<p>Content was organized into 5 modules of 2-5 days each. Modules were offered during the week (Monday through Friday or a portion of the week in consecutive days), 4 hours/day. After each module, there was a 1-week break when participants were expected to apply what they learned (on-the-job training), then provide feedback the following week. The first module was offered for free, after which those interested could choose to pay and continue the training to be part of the franchise.</p>	<p>Participants received hotel accommodation, food, training materials, and protocols. A certificate and membership in the CareShop franchise were awarded upon completion of training. Participants also received signage to brand their shops as CareShops and a license number. Quality of the training program and CareShop branding were found to be the main incentives for participation. Participants paid a token fee.</p>	<p>Decentralized training to minimize costs (eliminated need for hotel accommodation), so that token fee charged to participants covered most of the training costs incurred by GSMF.</p>	<p>Clearly explain the profit-related benefits of the training to interest private providers; understand the incentives for providers – one of the main benefits of the CareShop membership is free product delivery to the shops – this was a strong incentive for rural LSCs, less so for peri-urban LSCs, as they can easily obtain products elsewhere.</p>

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: Guatemala</p> <p>Year: 2007-present</p> <p>Organization/Project: PSP-One</p> <p>Local Partner: Professional associations</p> <p>Trainees (#): Doctors (267+) and biochemists (86+)</p> <p>Topics: HIV CT</p> <p>Duration: 4 hours</p>	<p>Rapid assessment conducted through interviews with doctors and biochemists indicated the need to improve their knowledge of HIV CT norms and protocols. Used multi-pronged approach to identify and recruit participants: obtained a list of providers from professional associations, then “snowballed” from there to reach additional providers; conducted “sensitization” talks in association meetings where much recruiting also occurred; and partnered with pharmaceutical companies to leverage their sales/detailing force to distribute invitations to trainings to the private providers they normally visit.</p>	<p>Standard workshop, with very participatory approach including case studies, question and answer, and a game show-like device that lets the doctors select their answer from a remote, which then displays the collective answers on a screen.</p> <p>Project staff consulted with the providers on time/day that is convenient for them, as well as location and type of workshop setting. Selected times when physicians were not working, like Wednesday afternoons. When feasible, planned training to coincide with an existing event/conference.</p>	<p>Participants received training materials (presentations, reference materials) and a snack. CME credits were given for all workshops. Main incentives were found to be well-known experts who led the workshops and participants’ own interest in learning more about HIV.</p>	<p>Modules are being handed over to professional associations, so that eventually they can take this training on. Project staff is part of a public-private commission that is determining the best way to incorporate this information into the pre-service medical curriculum. Project is also working with a doctor who is designing a course (“Diplomado”) on this topic for private providers, which will most likely charge for participation. Finally, project will make the modules available online.</p>	<p>Conduct a <u>TNA</u> to learn topics of interest to physicians; <u>keep sessions short</u> (not more than 4 hours); use <u>well-known experts as speakers</u>; tailor workshops to different <u>physician specialties</u>; <u>follow up individually</u> (as by phone) with providers to ensure that they show up to the training.</p>
<p>Country: Honduras</p> <p>Year: 2006-2007</p> <p>Organization/Project: PSP-One</p> <p>Local Partner: ASHONPLAFA (NGO)</p> <p>Trainees (#): Physicians (9)</p> <p>Topics: No-scalpel vasectomy (NSV)</p> <p>Duration: Approx. 2 months for each physician to complete, depending on caseload</p>	<p>A decision was made to introduce the NSV method into the private sector. The contracting NGO selected doctors based on their location, skill, and motivation.</p>	<p>Phase 1: Standard workshop format for theoretical part (2.5 day workshop on weekend)</p> <p>Phase 2: Master trainer observed 5 local physicians who had been previously trained as they performed NSV, and then certified them as trainers.</p> <p>Phase 3: Trainers then assisted/observed the 9 trainees perform NSV until they felt that the doctors were ready to be certified as trained, using a checklist and their own judgment. This phase took several months and close coordination to complete, since caseload for NSV is low. In some instances trainees had to leave their practice and go to the NGO facilities where there is a higher caseload.</p>	<p>Workshop was held at a nice location, and all lodging, meal, and transportation costs were covered. Main incentives for participation were found to be interest in learning a new clinical skill; personal invitation from the NGO’s Medical Director, who is in charge of contracting for sterilization services; knowing that the NSV they perform will also be covered under the contract with NGO (i.e., possibly more revenue due to this additional service).</p>	<p>With the preparation of certified trainers, there is now in-country capacity to train other providers in NSV. One of the trainers has already trained an additional public sector doctor as requested by the Ministry. One trainer was also certified as a supervisor, so that he can monitor the quality of the NSV services provided by the 9 trained doctors.</p>	<p>Consult with <u>providers prior</u> to scheduling the workshop; <u>follow up with them prior</u> to <u>workshop</u> to ensure attendance; <u>choose a nice and central location</u> for the workshop; <u>stay flexible</u> when implementing clinical skill training – it takes intensive coordination to ensure that both the trainer and trainee are available and present wherever and whenever there are patients; <u>schedules change constantly</u>; <u>enforce strict selection criteria</u> to select out providers who are not truly motivated to use the new skill.</p>

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: India Year: 2007-2008 Organization/Project: PSP-One India Local Partner: None Trainees (#): Ob/Gyns (1,000) and nurses (500) Topics: CTU with emphasis on DIMPA (depot medroxyprogesterone acetate) injectable method Duration: 3 hours</p>	<p>TNA done through focus group discussions, field test of Quality Improvement (QI) tool that identified performance gaps, and observations. Project staff identified all Ob/Gyns who were working in private clinics in a set geographic area and field reps followed up at their office to invite them to the training and explain about the DIMPA Network.</p>	<p>Three-hour workshop (day of the week and location selected in consultation with providers) using structured training material facilitated by technical training director. Follow-up from workshop with on-site technical support visits to support counseling and use of injectable method.</p>	<p>Participants received meals, training materials; FP Global Handbook, other job aids, DIMPA case register and client follow-up cards, and certificate and recognition as DIMPA-trained doctor. Workshop took place in a nice location. Main incentives were found to be perceived value of skill/knowledge, presence of experienced, knowledgeable, and well-known doctor and trainer, and interactive sessions.</p>	<p>Ob/Gyn association expressed interest in continuing the training and tying it to certification, but needs outside funds to do this. Some discussion on offering CME credits for the training and charging a fee to physicians; however, since CME is not mandatory for relicensure, there is little incentive for physicians to pay to learn.</p>	<p>Keep the sessions short (not more than 3 hours); <u>make sessions interactive to enable physicians to learn how to use the international materials and tools and to develop the skill of continuous learning on their own.</u></p>
<p>Country: India Year: 2007-2008 Organization/Project: PSP-One Local Partner: Chemists and ISMP Associations Trainees (#): Chemists (150) and ISMPs (150) Topics: Youth-friendly communication skills, overview of contraceptive methods appropriate for youth, basics of sexually transmitted infections and HIV/AIDS Duration: 2 days</p>	<p>Formative research identified a special need for contraceptive knowledge and communication skills of chemists and ISMPs for adolescents and married youth (age 18-25). PSP-One mapped the target geographic area and obtained lists of providers from professional associations. Project determined a % of providers it wanted to train and associations helped with outreach to select providers. Project field team visited each provider to personally invite him/her to the training, and followed up with a phone call the night before training.</p>	<p>Two 3-4 hour workshops on consecutive days in the afternoon (Thursday-Friday or Friday-Saturday), offered separately for each provider cadre. Experienced training consultant was in charge of training logistics and designed workshop to be offered during "less busy" time for participants. Site was conveniently located at local restaurants or cafes.</p>	<p>Participants received lunch and product samples. Main incentives were found to be professional interest to increase knowledge and perception of opportunity to attract more clients by becoming a member of the Saathya network of youth-friendly FP services, which included branding and promotion of facilities.</p>	<p>Sustainability of effort was not an issue at the time the project was implementing this training as a lot of funding was available.</p>	<p>Invest time and effort to personally invite participants; involve and <u>work closely with professional associations</u> to help with attendance, particularly with the chemists; use <u>interactive training techniques</u> to keep the trainees engaged and participating; use a well-known, recognized professional to add credibility to the training.</p>

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: Jordan</p> <p>Year: 2004-present</p> <p>Organization/Project: Jordan Private Sector Project for Women's Health (PSP)</p> <p>Local Partner: Professional medical associations and Jordan Medical Council</p> <p>Trainees (#): Physicians (600+)</p> <p>Topics: FP updates and IUD insertion</p> <p>Duration: 3-4 days</p>	<p>USAID project identified goal of increasing couple-years protection. Project staff designed questionnaire to identify topics on women's health that physicians were interested in knowing more about.</p> <p>Initial project (Commercial Market Strategies) developed a list of physicians in private practice; subsequent project continued to use list. List updated by contacting professional medical associations and Jordan Medical Council (which registers all new graduates) and word of mouth.</p>	<p>Standard workshop format with interactive sessions for FP training, 4 hours on Friday. For IUD insertion, 3 days: 1 day of theory and 2 days of practicum. Practicums were arranged at facility near doctor's location (approved training site of the Ministry of Health) so participants would not have to travel far. Private physicians were asked for preferences on when to offer courses; they indicated Fridays (their day off) and to be kept short (not more than 4 hours). Courses were offered at 3 locations (north, central, and south of country) to minimize travel.</p>	<p>Participants received training materials, lunch and coffee breaks, and lab coat and other materials for their practice. Course was accredited by Jordan Medical Council. Main incentive for participation was found to be perception that course content was valuable and would help them provide better care to their patients. Participants felt they would get more clients because they would provide better care and be able to offer more services such as IUD insertion.</p>	<p>Discussions with two organizations initiated to continue with this type of training and providing certification: Jordan General Practitioners Association and Jordan Medical Council, which currently provides the site where training is conducted and signs the certificate of participation. A pharmaceutical company that has a product associated with the training may support some trainings courses.</p>	<p>Keep the content focused on <u>knowledge that is of interest to providers</u>; conduct a <u>TNA to determine which topics interest them</u>; keep the <u>sessions short and practical</u>; <u>emphasize the need for continuous learning</u> and why it's important; managing the practical portion of clinical training is more difficult than the theoretical (workshop) training due to <u>close coordination needed</u> with doctors' schedules to leave their clinics and go where the patients are.</p>
<p>Country: Kenya</p> <p>Year: 2001-2006</p> <p>Organization/Project: PRIME and ACQUIRE</p> <p>Local Partner: National Nursing Association of Kenya</p> <p>Trainees (#): Nurses and midwives (635)</p> <p>Topics: Prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT), post-abortion care (PAC), and FP and contraceptive technology update</p> <p>Duration: 2-6 weeks depending on the topic</p>	<p>Projects and USAID/Kenya selected target geographic areas and providers based on known performance gaps. Potential participants were contacted to assess their interest in the training topics and selection criteria focused on those who had positive attitudes toward the topics.</p>	<p>Standard approach of classroom presentations with clinical skills training at government hospital, 5 days per week for 2-6 weeks. Follow-up to assist participants form a "peer-support cluster." Activities of peer-support cluster included 1) peer supervision; 2) continuous professional development; 3) financial loan program with repayment by members after loan received; 4) referral of clients among members; 5) joint problem-solving; and 6) legal support to members. Participants had to arrange and pay for another nurse/midwife to manage their practices while they were away.</p>	<p>Participants received transportation, meals, accommodation, and kits to implement course content (books on FP, test kits for VCT, Nevirapine for PMTCT). Main incentives for participation were found to be a certificate awarded upon completion and increased recognition and value in their community due to the new and improved services provided.</p>	<p>New project (APHIA II) will continue to support this initiative of peer-support clusters, as it was perceived as beneficial and low cost to support.</p>	<p>Ensure that <u>content is perceived as being valuable</u>; support development of <u>meaningful relationships</u> between peers to further add value to providers in private practice.</p>

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: Nigeria</p> <p>Year: 2007-present</p> <p>Organization/Project: PSP-One</p> <p>Local Partner: Health maintenance organizations (HMOs)</p> <p>Trainees (#): Physicians, nurses, and HMO coordinators (643)</p> <p>Topics: Managed care (capitation system), FP, nutrition, prevention & Rx of malaria, family wellness</p> <p>Duration: 2 days</p>	<p>Need determined by conducting a survey with providers and analyzing encounter data forms from HMOs. Organizers worked closely with the HMOs to select private providers registered with the National Health Insurance Scheme working in target regions and invited the trainees through the HMOs.</p>	<p>Workshop on 2 consecutive days, usually between Tuesday and Thursday, as Mondays were “busy” days and staff finish early on Fridays. Tried to have training at trainee worksites to minimize travel time and transportation costs.</p>	<p>Participants received certificate of participation, CME credits, training materials, communication materials for their clinics, and snacks. Main incentives for participation were found to be opportunity for professional development and for better income through better understanding of HMO capitation payment system.</p>	<p>Project is working very closely with the HMOs, which covered some of the cost of the workshops and are interested in taking over the training. Professional associations (medical and dental) are also interested. HMOs are considering charging a fee to participants in future trainings.</p>	<p>Involve local organizations (HMOs and professional associations) for sustainability; include someone with authority in medical facility in the training to increase chances that new material will be implemented; set minimum attendance standard to receive certificate (75% of sessions in this case).</p>
<p>Country: Romania</p> <p>Year: 2006-2007</p> <p>Organization/Project: Banking on Health (BoH)</p> <p>Local Partner: Romanian Society for Education in Contraception and Sexuality (SECS) and National Institute for Health Research and Development (NIHRD)</p> <p>Trainees (#): Family doctors (140)</p> <p>Topics: Financial management including access to credit</p> <p>Duration: 3 days</p>	<p>Project conducted a TNA using multiple methods: 1) focus groups, 2) desk research, and 3) key informant interviews as well as 4) in-depth market research with family doctors, Ob/Gyn practices, rural pharmacies, distributors, and medical clinics. Family doctors and other providers of RH/FP in rural and underserved areas were identified as most in need of support in the areas of access to finance and financial management skills in order to sustain and improve their delivery of quality services. Based on these findings, BoH developed a course with contributions from SECS and NIHRD.</p>	<p>Standard workshop with time for case examples that included FP examples/ case studies. Workshops were scheduled at a time that was convenient for participants and did not take them away from their practice. BoH arranged training with 2 options so to be flexible: Option 1: 3 full days (Friday, Saturday, Sunday) or Option 2: 4 4-hour segments (3:00-7:00 pm – times when doctors are not required by the government to be in their practices).</p> <p>Trainers were medical practitioners by training, and had been training these same family doctors in the area of RH/FP. Thus, they knew the participants and were able to speak to them in terms they could understand and relate to their specific circumstances in the training room.</p>	<p>Participants received lunch, coffee, and snacks. The trainers and training organization were well known and respected. Guest speakers from local financial institutions were available at the end to answer questions and provide loan applications to participants.</p> <p>Main incentive was that the training responded to a long-neglected need for financial and business skills to enable physicians in rural communities who are serving the poor to grow and improve their practices into viable businesses.</p>	<p>Sustainability strategy included: identifying an institution (College of Physicians) to accredit the training course so that providers could earn CME credits; determining how much the providers were willing to pay for the training if offered on a fee basis, and the logistics and subtopics that would make the course attractive.</p> <p>The implementing NGO (SECS) achieved accreditation for the course with the College of Physicians and determined that the price</p>	<p>Private providers are interested in business management and particularly financial management training; training in these topics (finance, financial management, accessing loans, etc.) in a non-threatening environment among other doctors can be very empowering to private providers; conduct a TNA with focus groups of potential participants and key informants to tailor the structure and content of the course to their needs; there are pros and cons to using doctors as trainers for financial topics: they can relate to the participants, and “speak their language,” but they can be challenged by the technical</p>

(Romania Cont'd)

Basic Information	Training Needs Assessment (TNA) and Recruitment	Training Structure and Logistics	Incentives	Sustainability of Training Program	Lessons Learned
<p>Country: Uganda Year: 2004-2005 Organization/Project: PSP-One Local Partner: Uganda Private Midwives Association (UPMA) Trainees (#): Midwives and supervisors (189) Topics: Use of quality improvement (QI) self-assessment tool and problem-solving process Duration: 1 day for midwives, 3½ days for supervisors</p>	<p>Participants were selected from the family doctors who attended a previous course on basic FP (this was a prerequisite for participation).</p>	<p>Standard 1-day classroom training with follow-up by supervisors to support midwives in problem-solving. The training process was built around the concept of self-empowerment with follow-up and support from UPMA.</p>	<p>Pleasant workshop site, participants received lunch and transportation allowance, training materials, and QI tool for their clinics. Knowledge that UPMA supported the training and approach to quality.</p>	<p>the physicians were willing to pay would cover their costs. BoH was able to leverage interest from 3 financial institutions in Romania to continue funding the training course. To date, the NGO's reliance on the donor-funded business model has prevented it from following through on initial contacts made with commercial sponsors and offering the course on a commercial basis to doctors.</p>	<p>content of the material and overly rely on resource speakers; when possible, obtain early buy-in from accreditation agencies and potential commercial sponsors to boost long-term sustainability; ensure that implementing organization has a long-term vision of incorporating the course into their strategy to achieve the sustainable offering of the course; a well-tailored training course can have long-term business growth results as is evident in the financing and business improvements made by doctors after the course.</p>
<p>Country: Uganda Year: 2004-2005 Organization/Project: PSP-One Local Partner: Uganda Private Midwives Association (UPMA) Trainees (#): Midwives and supervisors (189) Topics: Use of quality improvement (QI) self-assessment tool and problem-solving process Duration: 1 day for midwives, 3½ days for supervisors</p>	<p>UPMA identified that service quality needed to be addressed, so PSP-One developed the QI tool and the training on the tool. All members in specific UPMA branches were invited to participate in a 1-day workshop. Midwives located by hiring motorcycles with driver and sending notes of invitations.</p>	<p>Standard 1-day classroom training with follow-up by supervisors to support midwives in problem-solving. The training process was built around the concept of self-empowerment with follow-up and support from UPMA.</p>	<p>Pleasant workshop site, participants received lunch and transportation allowance, training materials, and QI tool for their clinics. Knowledge that UPMA supported the training and approach to quality.</p>	<p>PSP-One trained 6 UPMA trainers to build the organization's capacity to conduct additional training. UPMA has a structure of regional representatives organized by branch (district) who can provide follow-up to trained midwives. UPMA is committed to the process and looking for funds to conduct more training and print more copies of the QI tool.</p>	<p>Ensure that participants find training topic useful; involve local partner (professional association) and obtain their support to help access trainees and convey additional value to training.</p>

REFERENCES

Brugha R, A. Zwi. 1998.

Improving the quality of private sector delivery of public health service: challenges and strategies. *Health Policy and Planning* 13(2): 107-120.

Berman, Peter, Kara Hanson. 1993.

Consultation on the private health sector in Africa: Summary of Proceedings, September 22-23, 1993, Washington, DC. Boston, MA: Data for Decision Making Project, Harvard School of Public Health. <http://www.hsph.harvard.edu/ihs/publications/pdf/No-15.PDF>

Capacity Project. April 2007.

Learning for Performance: A Guide and Toolkit for Health Worker Training and Education Programs. Chapel Hill, North Carolina: IntraHealth International. http://www.capacityproject.org/index.php?option=com_content&task=view&id=113&Itemid=129

Chandani T, S Sulzbach, M Forzley. April 2006.

Private Provider Networks: The Role of Viability in Expanding the Supply of Reproductive Health and Family Planning Services. Bethesda, MD: Private Sector Partnerships-One Project, Abt Associates Inc. <http://www.psp-one.com/content/resource/detail/2941/>

Peters D, G Mirchandani, P Hansen. 2004.

Strategies for engaging the private sector in sexual and reproductive health: how effective are they? *Health Policy and Planning* 19(Suppl. 1): i5-i21.

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Banyan Global

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IntraHealth International

O'Hanlon Health Consulting

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