

AUGUST 2019

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

REPORT | E2A PROJECT



About E2A

The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until September 2020. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, and PATH.

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This publication was made possible through support provided by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development, under the terms of Award No. AID-OAA-A-11-00024. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

Acknowledgments

The Evidence to Action (E2A) Project gratefully acknowledges the generous support of the US Agency for International Development (USAID) which made possible the development of this report and the work it describes. The Centers of Excellence initiative was a joint effort of E2A and Pathfinder International Burkina Faso, in collaboration with the Ministry of Health and National School of Public Health. This report was authored by Stembile Mugore, former E2A Senior Advisor for Health Sector Performance and Sustainability, IntraHealth International.

The Centers of Excellence activities and results presented in this report were achieved through the efforts of a large team, including: Pathfinder/E2A staff in Burkina Faso and Washington, DC; WHO Burkina Faso; WAHO; and UNFPA. Several individuals played a leadership role in strategy implementation, internship supervision, regional meetings, and program evaluation: Dr. L. S. Wilfried Lionel Ouedraogo, Regional Health Director of Center; Dr. Seydou Ouattara, Regional Health Director of Hauts Bassins; Dr. Irene Wangrawa, Regional Health Director of Cascades; Dr. Denis Yelbeogo, Regional Health Director of Centre East; Dr. Moussa Sana, District Health Chief of Bogodogo; Dr. Noel Nacoulma, District Health Chief of Boulmiougou; Dr. Alkadri Bocoum, District Health Chief of Dafra; Dr. Martine Bonou/Bationo, General Director of ENSP; Gustave Yameogo, Regional Director of ENSP Tenkodogo; Mamadou Napon, Regional Director of ENSP Ougadougou; Nebile Joel Batiene, Regional Director of ENSP Bobo-Dioulasso; Victor Yameogo, Midwives' Private Schools Association; Dr. Zamane, Burkina Faso Gynecologist and Obstetrician's Society; Dr. Bruno Ki, Pathfinder International Burkina Faso; Lydia Saloucou Zoungrana, Pathfinder International Burkina Faso; and Dr. Zackary Congo, Pathfinder International Burkina Faso. Lastly, E2A would like to thank the many health providers and students who participated in the Centers of Excellence for Practical Learning initiative.

Technical, editing, and design support for this report were provided by Rita Badiani, E2A Project Director, Pathfinder International; Eric Ramirez-Ferrero, E2A Technical Director, Pathfinder International; Erica Mills, E2A program Officer, Maren Vespia, Consulting Communications Director; Olivia Moseley, editor, Inkwel Consulting; and Ilayda Oranköy, E2A Communications Coordinator, Pathfinder International.

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Acronyms and Abbreviations

BWEIM	Beginning with the End in Mind
CEAP	Centre d'Excellence d'Apprentissage Pratique (Center of Excellence for Practical Learning)
CSPS	Centre de Santé et Promotion Sociale (Health and Social Promotion Center)
DFH	Division of Family Health
DRS	Director Regional Health Services
ENSP	Ecole Nationale de Santé Publique (National Schools of Public Health)
E2A	Evidence to Action
FP	Family planning
ICP	Infirmier Chef de Poste (Facility Manager)
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
MoH	Ministry of Health
MNCH	Maternal, newborn, and child health
MVA	Manual Vacuum Aspiration
PAC	Postabortion care
PPIUD	Postpartum IUD
RH	Reproductive health
SOGOB	Société des Gynécologues et Obstétriciens du Burkina (Society for Gynecology and Obstetrics)
UFR/SDS	Unité de Formation et de Recherche en Sciences de la Santé
UNESPB	National Union of Private Schools of Health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization

Executive Summary

Overview: From July 2017 through June 2018, Pathfinder International Burkina Faso and the Evidence to Action (E2A) Project collaborated with the Ministry of Health (MoH) and the Ecole Nationale de Santé Publique (National School of Public Health [ENSP]) to pilot *Centres d'Excellence d'Apprentissage Pratique* (Centers of Excellence for Practical Learning [CEAP]) in six facilities in Ouagadougou and Bobo-Dioulasso. The CEAP facilities served as internship sites that built 75 students' family planning service provision skills. Placing emphasis on planning for scale-up from the outset, E2A was invited to assist in developing and documenting the pilot to assess its potential for scale-up. This report documents: the experience of piloting the CEAP initiative; the process the team followed to lay the foundation for scale-up; quantitative and qualitative findings from assessment of the pilot; and recommendations for next steps to enable scale-up of the CEAP innovation. The experience shared may be useful for program designers who are considering sustainable and scalable models for improving systems of training health workers, particularly the elements that are required to implement a center of excellence model.

Background: From 2015- 2018 Pathfinder Burkina Faso, in collaboration with the MoH, has implemented a systems approach to strengthening family planning/reproductive health (FP/RH) service delivery. The service delivery model includes a package of FP/RH services—provider training for provision of quality FP, postpartum FP, and postabortion care (PAC) services—which expands access to a wide range of FP methods, including long-acting reversible contraceptives. The model, implemented in 107 health facilities in Central, East Central, Cascades, and Haut Bassins Regions of Burkina Faso, involves: onsite mentorship of trained providers; strengthening health information systems, logistics, and infrastructure; and support for demand generation activities.

Piloting the Centers of Excellence for Practical Learning: Building on the successes of the service delivery model, ENSP asked Pathfinder to help develop some of the health facilities to become Centers of Excellence for Practical Learning, which would be used as practicum training sites for in-service and pre-service FP training. The CEAPs aimed to address two key problems: the lack of FP competencies among newly graduated health workers and the lack of capacity of health facilities to provide adequate practical training to students during their FP internships.

From July 2017 through June 2018, Pathfinder, ENSP, the Ministry of Health's Division of Family Health (MoH-DFH), and other stakeholders designed a strategy to guide the CEAP initiative and implemented a pilot phase of the intervention to assess its feasibility for scale-up. Through a competitive process six health facilities were selected for participation in the pilot—three in Ouagadougou, Central Region and three in Bobo-Dioulasso, Haut Bassins Region. In addition to the service delivery strengthening activities that were already being supported by Pathfinder, the six CEAP facilities received further capacity building and material support that included: an update of providers' FP/RH skills, training on how to coach students, additional equipment for FP training and service provision, logistical support, and supportive supervision by Pathfinder, ENSP, and MoH personnel. In 5-day workshops, Pathfinder trained 18 midwives in Bobo-Dioulasso and 19 in Ouagadougou to serve as *encadreurs* (coaches) for the student interns.

In Burkina Faso, midwives make up the majority of the frontline health workforce. As such, during the pilot, most of the 75 students who participated in the CEAPs were midwifery students in pre-service education. Students were dispatched in groups of five to complete a 4-week internship. From April 2018 to June 2018, there were three rounds of internships in Bobo-Dioulasso and two rounds of internships in Ouagadougou. Each student had a set of practicum objectives to be achieved for FP service provision under the guidance of the trained coaches/*encadreurs*.

Planning for Scale-up from the Beginning: E2A, USAID’s global flagship program for strengthening FP/RH service delivery, aims to address RH needs by increasing support for, building evidence of, and facilitating the scale-up of best practices that improve FP services. E2A brought its expertise in scale-up to the CEAP initiative starting in June 2017 and began by introducing the team to the ExpandNet tools for systematic scale-up (Beginning with the End in Mind). E2A used these tools and other systematic scale-up tools (e.g., CORRECT attributes) to assess and propose changes to the initial strategy for CEAP implementation and the CORRECT attributes to evaluate the pilot’s overall potential for scale. As a result of E2A’s involvement and the introduction of the Beginning with the End in Mind and CORRECT tools, significant changes were made to the CEAP implementation strategy in order to increase the probability of scale-up of the intervention—including adding a training of the coaches and encadreurs, reducing supportive supervision from weekly to once per internship round, and reducing the number of pilot facilities from 8 to 6. The revised strategy was then validated with the designers of the original strategy.

Documentation and Evaluation: With scale-up and feasibility in mind, E2A and Pathfinder Burkina Faso documented the entire Centers of Excellence for Practical Learning experience—from conceptualization to implementation to evaluation of the pilot. E2A documented the process of designing the CEAP strategy, as well as its validation and implementation, noting actions and factors that facilitated or hindered the pilot’s success. Focus group discussions and key informant interviews were conducted mid-implementation and at the end of the pilot to document the experiences and perceptions of students and key stakeholders—including head nurses in charge and other health care providers, ENSP representatives, and Pathfinder representatives—regarding the effectiveness of the CEAPs and to solicit recommendations for scale-up. In addition, Pathfinder Burkina Faso compiled quantitative data on service delivery during the pilot, which included contraceptive uptake by method, attainment of practicum objectives by each student, and pre/post knowledge and skills assessment scores for each student. The data were analyzed, and this report shares the findings from both the qualitative and quantitative assessments.

Key Quantitative Findings: During their internships, students performed an average of: 7 implant insertions, representing 70% of their practicum objective (90% of the target in Bobo-Dioulasso versus 40% in the Ouagadougou); 5 interval (over 6 weeks postpartum) intrauterine device (IUD) insertions (80% the practicum objectives in Bobo-Dioulasso versus 40% in Ouagadougou); and only one student achieving the practicum target on immediate (within 48 hours) postpartum IUD insertion due to low demand.

Key Qualitative Findings: All FGD and KII respondents agreed that the CEAP innovation was an effective means of increasing capacities of the health workforce to provide FP services. The students and coaches/encadreurs felt that the internship successfully developed students’ FP service delivery competencies (with the exception of immediate postpartum IUD insertion). In addition, the students expressed satisfaction with the quality of coaching received during their internships, which is also reflected in pre/post knowledge and skills assessment scores. Another effect of the CEAP was improved overall service quality at the facilities, which was attributed to coaches/encadreurs’ improved adherence to clinical practice guidelines in order to teach students and role model compliance with standards of care. Facility managers also reported that being a Center of Excellence for Practical Learning improved the reputation of the health facilities in the communities, resulting in increased family planning service uptake.

Main Challenges: There were certain elements of the CEAP implementation plan that were included in the strategy, but were not implemented, which may have an impact on scalability. These were: 1) inadequate clarification of the division of roles and responsibilities between Pathfinder, ENSP, and MoH-DFH, including lack of clarity and consensus on which entity was responsible for compensating

coaches/encadreurs; 2) failure to provide sufficient clinical equipment and anatomical models and to conduct minor renovations of health facilities; 3) lack of compensation for coaches/encadreurs at facilities, whose workload and working hours increased due to the CEAP); 4) insufficient engagement from ENSP in the planned monthly joint supportive supervision, which was perceived as lack of interest and buy-in; and 5) an insufficient client load for students to meet all the practicum objectives and scheduling issues that ultimately reduced the duration of the internships.

Key Recommendations: Process documentation and the quantitative and qualitative assessments of the CEAP pilot have provided information that should guide future scale-up efforts. If the model is to be scaled up, it is recommended that the following elements are put in place to enhance feasibility and scalability:

- Build the capacity of ENSP to enable it to take on a full leadership role of the CEAP intervention and to remain engaged throughout the process.
- Increase or enhance demand generation activities to increase client load to allow students to meet their practicum objectives.
- To keep coaches/encadreurs motivated and engaged in coaching, resolve the question of their compensation.
- Provide CEAP facilities with the commodities, equipment, and renovations they need to accommodate the internship students and activities.

Context and Background

Human Resources for Family Planning in Burkina Faso

Burkina Faso has recognized that meeting the health needs of its population requires improving the availability and capacities of its human resources for health. In 2015, it was estimated that there were 18,000 people per doctor and 10,000 people per midwife^a, which falls significantly short of the World Health Organization's (WHO) Sustainable Development Goals (SDG) index threshold of 4.45 doctors, nurses, and midwives per 1,000 population.^b Furthermore, in addition to the deficit of health workers, problems of service quality and availability are evident in family planning (FP) statistics. According to results from PMA2020 (April 2017), the contraceptive prevalence rate for all women of reproductive age was 23% and total unmet need was 25%.^c The Ecole Nationale de Santé Publique (National School of Public Health [ENSP]) identified inadequate practical skills training in the country's midwifery pre-service education as a possible driver of low contraceptive use.

In Burkina Faso, midwives make up the bulk of the frontline health workforce. The typical training of midwives in public health schools is divided into three yearlong terms: (1) fundamentals of medicine; (2) basic obstetric care, including FP; and (3) emergency obstetric care in the final year. Each year is followed by a practical internship at a health facility. After completing the three-year course of study and passing the final exams, midwives are generally recruited by the Ministry of Health (MoH) and deployed to health facilities, where they are expected to provide the full range of health services, including FP. In rural facilities, the newly graduated midwife may be the only professional health worker.

ENSP identified several key weaknesses in Burkina Faso's pre-service family planning education. While FP is part of the national curricula for health workers, graduates of pre-service education programs lack the necessary knowledge and skills to provide FP services on deployment. During their internships—the crucial period for acquiring practical skills—students are assigned to health facilities that have limited capacity to support them. Too many students are seconded at the same time, providers are not prepared to coach students, and there is a lack of necessary infrastructure and equipment, such as teaching aids.

Introducing and Scaling up the Centers of Excellence for Practical Learning

Pathfinder Burkina Faso, in collaboration with the MoH, has been implementing a project to strengthen family planning/reproductive health (FP/RH) service delivery in Burkina Faso from 2015 to 2018. The service delivery model comprised a package of FP/RH services, including provision of quality contraception services—particularly long-acting and permanent methods (LAPM)—and provision of quality postabortion care services. Inputs to the service delivery model include facility upgrades, provision of equipment and materials, provider training, quality assurance, mentoring and supervision systems, and referrals and community-level information dissemination through CHWs. The strengthening service delivery project was implemented at 107 health facilities in Central, East Central, Cascades, and Haut Bassins Regions of Burkina Faso.

^a Burkina Faso Ministry of Health, Statistical Yearbook 2015

^b World Health Organization, *Health workforce requirements for universal health coverage and the Sustainable Development Goals*, 2016

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

Between February and March 2017, ENSP invited Pathfinder International to help develop the Centres d'Excellence d'Apprentissage Pratique (Centers of Excellence for Practical Learning [CEAP]) Initiative to strengthen practicum training of students during pre-service education, with the eventual aim of scaling up to include all cadres of students who will provide FP/RH services (doctors, nurses, clinical officers) and all pre-service training institutions, and to develop guidance on establishing CEAPs. Pathfinder undertook a participatory process that included the MoH's Division of Family Health (DFH), ENSP, public and private health training schools, professional associations, and other stakeholders to develop the intervention strategy to pilot implementation of the CEAP. The strategy was to be implemented in two phases that were organized based on completion of classroom instruction and the timing of practicum internships. Phase 1 would focus on FP/RH skills and Phase 2 would focus on PAC skills. The second phase was not implemented due to low client load for PAC, which prevented students from meeting their PAC practicum objectives. As midwives represent the bulk of the frontline health workforce, the pilot of Phase 1 focused on this cadre, primarily working with pre-service education schools for midwives in two regions. Given E2A's expertise in systematic scale-up and experience implementing ExpandNet's Beginning with the End in Mind (BWEIM) model,^d Pathfinder sought technical assistance from E2A to assess the feasibility of scaling up the CEAP intervention.

Documenting CEAP in Preparation for Scale-up

Goal

- Introduce the ExpandNet systematic scale-up approach to examine feasibility and enhance scalability by documenting the process, outcomes, and lessons learned from the CEAP model for improving the practical competencies of midwifery students and the quality of FP/RH service delivery.

Objectives

- Determine whether the CEAP is a feasible and scalable model for increasing students' competencies and client uptake of FP services, providing rationale for the MoH and other stakeholders to support its scale-up.
- Determine whether using a CEAP model for pre-service clinical training results in improved student competencies and uptake of FP services.

Beginning in July 2017, E2A worked with Pathfinder Burkina Faso to apply ExpandNet's systematic scale-up tools to assess the feasibility and scalability of the CEAP initiative. E2A and Pathfinder also worked together to document the process of implementing the CEAP strategy, which would inform scale-up. E2A and Pathfinder collaboratively articulated the goal and objectives of the scale-up process.

^d WHO/ExpandNet, *Beginning with the end in mind: Planning pilot projects and other programmatic research for successful scaling up* (Geneva: WHO, 2011). Hereafter: "BWEIM".

Learning Questions for Scale-up Documentation

- What were any significant changes during the implementation of the innovation?
- What service delivery-related activities were planned, initiated, and carried out under the CEAP model?
- Were any service delivery-related activities modified/adapted during implementation to accommodate learning and, if so, why?
- What were the experiences and perceptions of stakeholders (including the user organization, resource team, providers, CEAP coaches/*encadreurs*, and participating students) regarding the effects and benefits of the CEAP model on practical FP training in pre-service education and on FP service delivery?
- Were the CEAPs able to serve adequately as practicum training sites in terms of: provider coaching skills, equipment, infrastructure, client load, and teaching materials?
- What are the implications of implementing the CEAPs for the facilities in terms of service delivery practice, workload, and facility processes?
- What are the key factors, inputs, decisions, and actions that facilitated and/or impeded the implementation of the CEAP model?
- What key lessons were learned from implementation of the CEAPs?
- What are the recommendations for scale-up?

E2A and Pathfinder Burkina Faso agreed to apply the ExpandNet BWEIM framework to generate learning that would inform future scale-up activities of the CEAP in Burkina Faso.

Documentation Methodology: The ExpandNet BWEIM tools and CORRECT attributes were applied to guide documentation and generate responses to the learning questions presented in the text box above. A protocol was developed to guide qualitative assessment to document key stakeholders' observations related to these learning questions.

Desk Review: Documents were reviewed to identify decisions and changes made to the strategy and its implementation and their effect. Reviewed documents included: drafts of the strategy from the development phase through validation; terms of references and reports of selected health facilities; training and supportive supervision reports; notes from all meetings conducted to launch the CEAPs; and findings of the mid-implementation and endline assessments. The desk review identified service delivery-related activities that were planned, initiated, and carried out under the CEAP model. The review also informed some of the questions asked during key informant interviews to elicit information about the factors that influenced or hindered performance.

Qualitative Assessment: Qualitative assessment was conducted through four focus group discussions conducted with the first and third groups of students in Bobo-Dioulasso and the two groups in Ouagadougou. Some of the focus group discussion were conducted at the end of each student internship when the students were still all together in one place. The focus group discussions generated information on the process of the internship, their perceptions of the coaches/*encadreurs*' competencies, and the facilities' capacity to help them meet their practicum objectives. Additionally, feedback was obtained on successes, challenges, and recommendations for continued implementation and scale-up of the CEAPs.

Key informant interviews were conducted by Pathfinder, ENSP, and MoH regional and district health managers. Coaches/*encadreurs* were interviewed to elicit their perceptions of: adequacy of their training

to prepare them for the role of coach; process of the CEAP; supportive supervision from Pathfinder, ENSP, and MoH; capacity of the facilities to be CEAPs; and successes, challenges, and lessons learned. Students participating in the CEAP were interviewed about the training and coaching they received, and their perceptions of the successes and challenges of the CEAP. In addition, care providers who were not involved in supervising student trainees and managers of CEAP health facilities were interviewed to elicit their feedback on the adequacy of the facilities to be CEAPs, their observations of the process, adjustments that were made to the internal facility practices, and their perceptions of the effect of the CEAP on workload and service quality. ENSP representatives were specifically asked about the CEAP strategy, their participation or lack thereof in strategy development and implementation, and their thoughts on the CEAP's scalability. Finally, Pathfinder staff were asked questions related to the learning questions listed above, as well as roles of key stakeholders, successes and challenges, lessons learned, their opinions on feasibility and scalability, and requirements for scale-up.

Type of Respondent	Number of Interviews at Each Health Facility in Ouagadougou, Central Region			Number of Interviews at Each Health Facility in Bobo Dioulasso, Haut Bassins Region			Totals
	Dassasgho	Trame d'accueil	Zagtouli	Secteur 24	Guimbi	Sarfalao	
Facility Name:	Dassasgho	Trame d'accueil	Zagtouli	Secteur 24	Guimbi	Sarfalao	
Encadreurs	2	2	2	3	3	3	15
(ICPs) Head Nurses in Charge	1	1	1	2	2	2	9
Other Health Care Providers	1	1	1	1	1	1	6
ENSP Representatives				2			2
Pathfinder Representatives	6						6
Total Individual Interviews							38
Focus Groups with Students	2 totaling 29 students			1 totaling 15 students			3 totaling 44 students

Quantitative Assessment: Tools were developed by Pathfinder and ENSP to track student attainment of practicum objectives, as well as pre/post knowledge and skills assessment scores for each student. In addition, Pathfinder monitored FP service uptake by method.

Data Collection and Management: The technical documentation point person maintained detailed notes throughout data collection. The interviews were recorded with permission of interviewees. Recorded interviews were transcribed in French and transcripts were initially coded manually to reflect emerging themes. The transcripts were reanalyzed, and analysis was conducted using NVivo software. The protocol for this assessment was exempted from Institutional Review Board (IRB) review by PATH's Research Determination Committee.

Examining the CEAP Strategy Through the BWEIM Lens

Drafting and Refining the Strategy

Initial Draft of the CEAP Strategy: At the request of ENSP in Bobo-Dioulasso, Haut Bassins Region and through consultations with the national division of ENSP and DFH, Pathfinder developed the first draft of the CEAP strategy in March 2017. The initial strategy outlined the broad objectives and guidelines for the CEAP implementation. The CEAPs were intended to help the MoH increase the number of providers with the knowledge and skills needed to provide family planning services. The CEAPs would cover a wide spectrum of pre-service education students, including doctors, midwives, and other health workers. The plan was to draw CEAP learners from among student volunteers who were still in pre-service training and who had just completed pre-service training (who were still waiting for deployment to a facility), as well as from providers who were already in-service and wanted refresher training or to acquire specialized skills (e.g., in postpartum FP or PAC). Each CEAP was expected to take on five learners for 1–2 months. During Phase 1, students were expected to acquire skills in both FP (including provision of implants and intrauterine devices [IUDs]). Phase 2 was intended to be focused on PAC, including treatment with manual vacuum aspiration (MVA) and counseling on and provision of postabortion contraceptive methods, if the client voluntarily accepted.

The criteria for facilities to become Centers of Excellence and Practical Learning were defined in the strategy. These included: facilities must have 3–4 providers with FP competencies, including provision of long-acting reversible contraceptives (LARCs) and PAC; have a high family planning client load; and meet at least 80% of the Pathfinder standards for quality of care.

Introduction of the ExpandNet Systematic Scale-up Tools: In July and August 2017, E2A facilitated a 3-day workshop for the Pathfinder technical team to review the initial strategy (including monitoring indicators and tools) and revise based on the application of ExpandNet’s BWEIM tool, CORRECT attributes, and Most Significant Change Methodology.^e BWEIM is based on the premise that projects should be planned the beginning to enhance their potential for future large-scale and sustainable impact. The tool proposes 12 steps that project implementers and designers should follow to achieve this objective (see below). The CORRECT attributes (Credibility, Observability, Relevance, Relative advantage, Ease of transfer/installation, Compatibility, and Testability) refer to the characteristics that an intervention should have to increase its likelihood of successful scale-up.

Using these conceptual frameworks, the team revised the initial strategy and developed a plan to document the CEAP implementation processes, implementation challenges and successes, and the application of systematic scale-up approaches to enhance scalability. This was done with the intent of providing actionable guidance to national partners on the feasibility and scalability of the CEAP concept and to contribute to the global literature on the scale-up of FP/RH initiatives.

BWEIM and the CORRECT Attributes

Beginning with the End in Mind (BWEIM) is a guide containing 12 recommendations on how to design pilot projects with scaling up in mind, as well as a checklist that provides a quick overview of the scalability of a project that is being planned, proposed, or in the process of implementation. The guide is

^e The Most Significant Change (MSC) approach involves generating and analyzing personal accounts of change and deciding which of these accounts is the most significant—and why.

intended for use by researchers, policy-planners, programme managers, technical-assistance providers, donors, and others who seek to ensure that pilot or other programmatic research is designed in ways that lead to lasting and larger-scale impact^f.

Innovations with the following “**CORRECT**” attributes are most likely to be successfully expanded/scaled up:

- **Credible** in that they are based on sound evidence and/or advocated by respected persons or institutions
- **Observable** to ensure that potential users can see the results in practice
- **Relevant** for addressing persistent or sharply felt problems
- **Relative advantage** over existing practices so that potential users are convinced the costs of implementation are warranted by the benefits
- **Easy to install and understand** rather than complex and complicated
- **Compatible** with the potential users’ established values, norms and facilities; fit well into the practices of the national programme
- **Testable** so that potential users can see the intervention on a small scale prior to large-scale adoption.^g

Revision and Development of Final CEAP Strategy: As mentioned above, during this workshop, the original strategy was reviewed against the BWEIM and CORRECT attributes tools as a first step toward assessment of feasibility. E2A and Pathfinder Burkina technical staff conducted a thorough analysis of the strategy through the lens of the systematic scale-up tools and sought to align the strategy to BWEIM’s 12 steps. The following presents the findings from the workshop’s application of the 12 BWEIM steps and presents the findings from the assessment of each step implementation from design of the pilot, review of the implementation process and qualitative assessment findings at mid-point and endline.

Step 1: Involve key stakeholders in a participatory process

Success of any pilot for scale-up is enhanced when ownership and buy-in among all key stakeholders are fostered from the beginning. Feasible roles, responsibilities, and commitments for each stakeholder need to be determined in the design stage. There are two key organizational structures that should be established to support implementation and make strategic decisions for scale-up:

- The **user organization** is the group of actors that is expected to adopt and scale up innovation (in this case, the Centers of Excellence for Practical Learning). The user organization enables decision making for institutionalization, resource allocation, and scale-up. They are also expected to develop any policies and guidelines needed for: establishing CEAPs for pre-service education; executing geographic scale-up of the CEAP model to other regions; and expanding the intervention to include other cadres of health students in pre-service education and in-service training (e.g., medical officers, nurses, clinical officers). In this case, ENSP and DFH at central, regional, and district levels were critical members of the user organization.
- The **resource team** facilitates and guides implementation of the strategy and promotes scale-up. The resource team also includes other key stakeholders that collaborate on implementation of the strategy or during the scale-up process.

^f ExpandNet, Beginning with the End in Mind (insert full citation)

^g ExpandNet, Nine steps for developing a scaling-up strategy (insert full citation)

Assessment of the Step Implementation: Pathfinder facilitated a series of consultations with stakeholders, including two meetings during the strategy design phase through the Technical Working Group for Maternal, Newborn, and Child Health (MNCH). The Director General of ENSP was assigned the leadership role, whereas Pathfinder continued to be responsible for the development of the strategy. After the initial strategy was revised, Pathfinder organized meetings to review and validate the strategy (i.e., to verify its technical soundness). The validation meeting was held in December 2017 and included representatives from ENSP, MoH, central and regional health managers from Central and Haut Bassins Regions, DFH, UNFPA, WAHO, WHO, Society for Obstetrics and Gynecology, the Midwives Council and Association, and other partners. During the validation meeting, E2A provided an orientation to participants on the ExpandNet scale-up tools and the objectives and process of the documentation.

Step 2: Ensure the relevance of the proposed innovation

According to WHO/ExpandNet, “the innovation refers to health interventions and/or other practices that are being scaled up... [it can be] a package of interventions, often consisting of several components, or new technologies and the means to provide them, as well as changes in the approach to health service delivery or community interventions.”

The project also used WHO/ExpandNet’s *Beginning with the End in Mind* tool, which is based on the premise that projects should be planned and organized from the beginning to enhance their potential for future large-scale and sustainable impact. “The proposed innovation should be relevant in multiple ways. It should address important public health problems and have the potential for significant public health impact. It should also be based on sound evidence, considered preferable to alternative approaches, and feasible in the local settings where it is to be implemented.”

Assessment of the Step Implementation: The innovation sought to address the persistent problem of shortages of health workers skilled in FP service provision. While FP is included in the pre-service education curricula, students from these programs were graduating without the knowledge and skills needed to provide services. The facilities where students were assigned for practicum were not prepared to guide students in skills acquisition and a high number of students from different schools were assigned to the same facilities at the same time (up to 40 at once). The health facilities lacked: the necessary capacities in terms of skills to coach students to acquire skills, space, sufficient client load for students to provide all contraceptive methods (including LARCs), and clinical and anatomical models for skills practice.

Pathfinder was already supporting the facilities through the service delivery project to build providers’ clinical skills in FP, including postpartum FP, PAC, and provision of a wide range of contraceptives (including implants and IUDs); conducting demand generation activities through community health workers; strengthening health information and logistics systems; and improving onsite mentorship. Since a platform for the proposed CEAP already existed this innovation was assessed to be feasible. The revised strategy specified the following additional forms of support to be offered under the CEAP innovation:

- Selection of 6 health facilities on a competitive basis against criteria that included availability of trained FP/RH providers, high client load for all methods, adequate infrastructure
- Skills update for facility providers in FP/RH
- Training of 5–6 midwives (coaches/*encadreurs*) per facility in coaching skills
- Provision of additional clinical equipment and anatomic models

- Facility renovations
- Logistics support
- Supportive supervision by ENSP, Pathfinder, and MoH for the coaches/*encadreurs*
- Remuneration for the coaches/*encadreurs*

Through stakeholder consultations and input on the ExpandNet scale-up process, Pathfinder added to the strategy training of coaches/*encadreurs* and reduced the joint supportive supervision from weekly to once per internship round, as weekly visits were not feasible for MoH and ENSP due to their other duties.

Initially the innovation was to be implemented in 8 health facilities, but due to capacity considerations, the stakeholders decided to reduce the number to 6 and to pilot the innovation in Ouagadougou and Bobo-Dioulasso for ease of monitoring and support. In addition, the team determined that the practicum objectives for each learner were unrealistic for the health facilities. For example, each learner had been required to insert 25 implants and 15 IUDs and treat 10 PAC clients with MVA. This meant that for the students to meet practicum objectives, each Center of Excellence for Practical Learning needed a minimum of 125 and 75 clients per month for implant and IUD insertion, respectively, and 50 clients needing treatment for incomplete abortion. None of the health facilities supported by Pathfinder had this client load. The team accordingly decided to reduce in the number of practicum objectives and to increase practice on anatomical models.

Step 3: Ensure consensus on expectations for scale-up

“It is important to clarify what stakeholders’ expectations are and to ensure that they are considered in the design of the project... It is important to: 1) have a formal discussion among key stakeholders about expectations for scale-up, and document the agreements reached; 2) ensure that the planning and implementation process of the project reflects the shared vision for scaling up; and 3) plan to modify expectations as necessary to reflect learning during the project’s implementation and any changes in the broader environment.” (BWEIM, p4-5)

Assessment of the Step Implementation: During consultation meetings with ENSP, MoH-DFH, and the Head of the Medical School Department of Obstetrics and Gynecology, who was also head of the Society for Obstetrics and Gynecology (SOGOB), stakeholders expressed a desire for at least two CEAPs per training institution and for the CEAPs to include internships for other cadres of students (such as medical officers, Ob/Gyn interns, nurses, and clinical officers). However, during stakeholder consultations, decisions were made to start off with a pilot with a focus on midwifery students, who make up the bulk of the health workforce deployed to FP/RH service provision upon graduation. The pilot was intended to generate lessons learned that could enhance the future success of the CEAP initiative. Additionally, ENSP, Pathfinder Burkina Faso, and MoH-DFH did not have the capacity to introduce the innovation to many schools for multiple cadres of students. Scale-up in terms of geographic expansion, development of guidelines and policies for practicum training during pre-service education, and guidelines for developing the CEAPs were not elaborated in the strategy.

Step 4: Tailor the innovation to the sociocultural and institutional settings

“Innovations that build on existing patterns of social organization, values and local traditions are more likely to be adopted and to last. It is therefore important to design interventions in such a way that they

are consistent with community values and social institutions. Likewise, a good match with the organizational culture of the health service delivery system is important.” (BWEIM, p5)

Assessment of the Step Implementation: Pre-service education in Burkina Faso has a fixed syllabus, standardized training periods, and consistent requirements for graduation. For family planning, 20 hours of classroom theory and practice and 10 hours of clinical practicum are allocated. Any change to one component of the curriculum has implications for the other components. Although care was taken to design an innovation that was in alignment with the practices of the health system, including training, several key issues related to pre-service education that could hinder scale-up were not taken into consideration in the CEAP strategy. For example, the number of students per class averaged 45–60 and all were required to complete an internship; however, the CEAP strategy assigned only 5 students for a period of 4 weeks to each facility. It was not clear in the strategy how the rest of the students were expected to meet their required FP learning objectives and where they were to be assigned while their colleagues were at the CEAPs.

As the timing and duration of the training and practical internship component in pre-service education is fixed, the students could only be assigned to the CEAPs between April and June for a period of 4 weeks. ENSP required that students attend afternoon classes in order to complete the syllabus. This particularly affected the internship for Ouagadougou, where the students were not ready for the internship at the expected start of the FP/RH practicum in April. As a result of this delay, only two groups of students from ENSP-Ouagadougou could be assigned for one month per each group. In addition, the students had to leave the CEAPs early to travel back to ENSP in time for the afternoon classroom sessions, which affecting the meeting of practicum objectives.

Service providers at the health facilities are assigned other duties such as immunization, MNCH, nutrition, and HIV prevention and treatment, as well as working limited hours in lieu of night duty and time on call for maternity and emergencies. The strategy did not take these working practices into consideration and assumed full-time availability of trained coaches/*encadreurs* to coach students. The coaches/*encadreurs* and their colleagues found themselves working long hours (including during their breaks and time off) to coach students and to reduce disruption of other services. They received no additional compensation for their efforts. There had been an agreement that there would be no other students assigned to the CEAP during the internship period, but the private training colleges did send students for internships during the same period. The health facilities found it difficult to turn away the other students because they understood their need for learning and possibly also because private students pay the health facility staff for the internship.

The district health management teams are expected to provide supportive supervision to the health facilities monthly, ENSP is expected to follow-up students during the internship at least once, and Pathfinder has mentors and supervisors who provide supportive supervision and onsite mentorship at least once a month as needed. Supportive supervision from the district health management teams and ENSP is rarely implemented due to resource constraints including financial and human resources. Despite this reality, the strategy doubled the frequency of the supportive supervision and expected that it would be conducted by a joint team. While this could have been feasible with financial support and transportation provided by Pathfinder, the district health management teams and ENSP had human resource limitations and competing priorities. The strategy did not take into account the prevailing practices, human and financial resources required for supervision and for coaching on *encadreurs*, organization of students for learning, and facility service delivery systems.

Step 5: Keep the interventions as simple as possible

“It is important to keep in mind that the simpler the intervention is, the more easily it can be implemented in the future. All proposed components should be reviewed, examining whether they are essential and how the overall package can be kept simple while still having a reasonable expectation of success.” (BWEIM, p6)

Assessment of the Step Implementation: Even though care was taken to ensure that the innovation built on the existing training system, inadequate attention was paid in the strategy to the capacity of the training system to accommodate the innovation. For example, even though the innovation was found to be feasible, a number of key elements of the innovation were not implemented due to limited capacity and resources, some of which may never be scaled up in these two urban centers, let alone in smaller rural regions. The elements of the innovation that were not implemented included renovation of facilities, provision of equipment and anatomic models, joint supportive supervision, and payment of the coaches/*encadreurs*, as there was no budget for these items. Joint supportive supervision was a new role for ENSP, and they faced capacity challenges in playing this role.

Step 6: Test the innovation in the variety of sociocultural and institutional settings where it will be scaled up

Whenever possible the innovation should be tested in the variety of social, cultural, or regional settings in which scaling up is to take place. The innovation should also be tested in the type of service delivery points and in the institutional settings where it is to be scaled up.

Assessment of the Step Implementation: The strategy outlined that the innovation would be tested in six high-volume family planning facilities with high numbers of staff in the two biggest cities of Burkina Faso, Ouagadougou and Bobo-Dioulasso. These sites were selected to test the innovation in settings that would allow students to access the CEAP and meet their practicum objectives with ease. However, the strategy did not outline a process for testing the innovation in facilities that are in smaller towns and rural areas, where the client loads are smaller, there are fewer providers, and there are notable infrastructure limitations. The limitations of this strategy were that these factors and what it would take to develop CEAPs in smaller towns and rural areas are *unknown*—these factors could create challenges for feasibility and scale-up.

Step 7: Test the innovation under the routine operating conditions and existing resource constraints of the health system

“Pilot projects often succeed because the innovation is implemented with special human, financial, and technical resources that are not always available for large-scale implementation. Testing in the day-to-day operational realities, and within the resource constraints of the health service system where the innovation is to be scaled-up, is therefore essential.” (BWEIM, p6)

Assessment of the Step Implementation: The strategy outlined that the innovation would be embedded in the already-supported program. This meant that the innovation would not warrant additional staff—it would only require a different way of supporting students’ training, training of coaches, and supportive supervision. The innovation was planned to utilize the existing staff at the facilities to be trained as coaches/*encadreurs* and was aligned to the student learning cycle of classroom instruction followed by practicum. The selected facilities were already being utilized for pre- and in-service training by various cadres of health workers in FP/RH, MNCH, nutrition, and PAC and had a high

client load for FP. ENSP was to conduct follow-up on students during the practicum at health facilities, which is not routine according to guidelines. In addition, the district health management teams and Pathfinder would conduct joint supportive supervision, which was not typical. ENSP has tools for use to track student learning that have to be completed by the facility coaches/*encadreurs*, however Pathfinder provided additional tools to track student acquisition of practicum objectives and assess student learning. The coaches were not aware that they were expected to complete these forms and they found them cumbersome and an increase to their workload. Also, additional inputs to develop the facilities as CEAPs, such as training of trainers for coaches/*encadreurs*, joint supportive supervision, renovation of facilities, and documentation, as well as readiness to quickly build capacity in response to any changes in staffing including leadership had resource implications that were not factored in the strategy and created implementation challenges that will need to be addressed with resources allocated in any scale-up strategy. Lastly, the DFH has a multi-stakeholder FP/RH technical working group that was consulted during strategy development but never constituted as a resource team to sustain support for implementation of the innovation and user organization to lead the scale-up strategy with focused roles on the CEAP initiative. In an environment that has high mobility of providers and changes in leadership at MoH and ENSP there was no anticipation and readiness to quickly build capacity in response to any changes in staffing, including leadership.

Step 8: Develop plans to assess and document the process of implementation

“It is important to assess and document the process by which interventions are implemented in the course of the pilot or other programmatic research. Documenting what steps were taken to achieve results will help determine what needs to be done to implement interventions on a larger scale later on.” (BWEIM, p7)

Assessment of the Step Implementation: Pathfinder Burkina Faso sought the support of E2A to document the process and outcomes of the CEAP project. This was initiated at the review and revision stage of the initial strategy. The strategy envisioned that E2A would document the entire scale-up implementation process, including orientation meetings held at each facility, mid-implementation and endline qualitative assessment, and meetings held to disseminate findings. Findings from the mid-implementation assessment were shared with stakeholders, who included in-charges and caches/*encadreurs* from the six health facilities, Pathfinder, district and regional health management teams, and providers in each region. Key issues discussed during these meetings—such as compensation of coaches/*encadreurs*, facility renovations, lack of anatomic models, limited involvement of ENSP, and multiple tools to track student learning—were not resolved due to lack of roles clarification among the three key stakeholders (Pathfinder, ENSP, and MoH).

Step 9: Advocate with donors and other sources of funding for financial support beyond the pilot stage

“Advocacy with donors and other sources of funding should include requests for support for scale-up-related activities beyond the pilot phase. In particular, support will be needed to fund the special inputs that are required to facilitate the transition from pilot to larger-scale implementation.” (BWEIM, p8)

Assessment of the Step Implementation: The strategy specified and included the engagement of donors and development partners such as WHO and UNFPA. In addition, Pathfinder Burkina Faso shared the strategy with USAID. While UNFPA and WHO participated in the meetings, there appears to have been no engagement with them in the context of support for implementation of the innovation in areas within their mandate, such as logistics to avoid contraceptive stockouts or provision of supplies.

Step 10: Prepare to advocate for necessary changes in policies, regulations, and other health systems components

“Successful scaling up of innovations often requires changes in policies, laws, regulations, budgets, standards, service protocols, and other health systems components. Although the process of institutionalization typically has to wait until the project demonstrates the desired results, planning to take steps to initiate these necessary changes should be part of the project design process.” (BWEIM, p8)

Assessment of the Step Implementation: During the workshop there was an expressed awareness of the need to develop policies and guidance for the CEAP. It was decided that plans for policy and guideline formulation were to be informed by the feasibility and scalability of the CEAP innovation and sustained engagement of the MoH and ENSP as the user organizations. Limited involvement of policymakers at ENSP and DFH in implementation could have consequences for buy-in and scale-up, particularly given the resource implications for compensation of coaches/*encadreurs*, joint supportive supervision, facility renovations, and procurement of additional equipment and anatomic models, as well as changes in duration of the FP practicum and number of students per facility

Step 11: Develop plans for how to promote learning and disseminate information

“The process of implementing a project provides multiple opportunities for learning. Many insights will emerge about what works, when and how. While safeguarding the need for robust evidence, it will be important to adjust the innovation where necessary as testing proceeds or circumstances change, and to adapt measurement and documentation accordingly. Piloting is not only testing and demonstrating a model but also refining it through an ongoing learning process.” (BWEIM, p9)

Assessment of the Step Implementation: The strategy design included rigorous mechanisms to review progress, share findings, and solve problems collaboratively. Quantitative tools developed by Pathfinder and others provided by ENSP were used to track each student’s attainment of practicum objectives, pre/post knowledge and skills assessment scores, and routine monthly FP service uptake by method. E2A hired a dedicated staff member for qualitative documentation. Documentation was conducted with rigor and findings shared with Pathfinder, E2A, ENSP, and MoH through written reports and presentations at mid- and endline meetings, which were also attended by coaches/*encadreurs* and facility managers. The meetings also included presentation of quantitative service delivery data. Plans for dissemination and application of the learning to develop a scale-up strategy were included in the initial strategy. While findings were shared extensively and in a timely manner, the lessons learned were not applied to develop corrective solutions for some of the challenges. Findings were disseminated with broad recommendations to scale-up, but a scale-up strategy was not developed due to lack of participation by ENSP, DFH, and national-level MoH, both of which are critical to any institutionalization and scale-up.

Step 12: Plan on being cautious about initiating scale-up before the required evidence is available

“Promising initial project results often lead to pressure to scale-up the innovation before its feasibility and outcomes have been fully demonstrated. Proceeding without sufficient evidence can lead to scaling up interventions that do not work or require further refinement. Stakeholders should reach a common understanding about what is required to test the effectiveness of the innovation and its implementation.” (BWEIM, p9)

Assessment of the Step Implementation: Once Pathfinder and other stakeholders were well oriented on the systematic scale-up approach and the documentation objectives, they appreciated the importance of generating adequate evidence. The strategy did include provisions for the collection of both qualitative and quantitative data to comprehensively document the scale-up experience and to provide an evidence base for future decision-making about the Centers of Excellence for Practical Learning initiative. Pathfinder in particular understood the need for involvement of ENSP and DFH throughout the process and for these two entities to own and lead implementation of the initiative, problem solve, provide resources, and develop the scale-up strategy. The final dissemination meeting recommended the need for more evidence, including testing the innovation in pre-service education schools in other regions. E2A provided a list of recommendations and elements required for successful scale-up. The planned second phase on PAC was not implemented and the findings from the documentation of FP/RH though not acknowledged could have influenced the decision.

The Process of Implementing the CEAP Pilot

This section describes the process of implementing the CEAP pilot and discusses changes that were made to the strategy and to the roles and responsibilities of stakeholders, including Pathfinder, coaches/*encadreurs*, facility and district health managers, and ENSP over the course of implementation of the pilot.

Activity 1: Strategy Validation Meeting: Pathfinder consulted with a range of stakeholders to collect their input and suggestions for successful implementation of the CEAP initiative. The results of these national consultations led to the drafting of a CEAP strategy. A national workshop chaired by the Director General of ENSP was organized in Ouagadougou to review and validate the Centers of Excellence for Practical Learning in Family Planning and Post-Abortion Care Strategy. The different categories of decision makers and actors involved in the training of health workers at the national level took part in this workshop to ensure the technical soundness of the strategy: ENSP (General Directorate, Ouagadougou and Bobo-Dioulasso Regional Directorates), MoH (Regional Director of Health Services [DRS] of Central East, Center, and Haut Bassins), Burkina Faso National Union of Private Health Schools (UNESPB), SOGOB, Burkina Faso Association of Midwives and Nurses, Pathfinder, and E2A. It was at this workshop that stakeholders agreed that the CEAP initiative would begin as a pilot.

Activity 2: Selection of the Centers of Excellence for Practical Learning: Between December 2017 and March 2018, Pathfinder, ENSP, and MoH established two committees to select health facilities to be developed into CEAPs. The 10-member Ouagadougou and 8-member Bobo-Dioulasso committees had representatives from MoH-DFH, Pathfinder, ENSP public schools, ENSP private schools, and district health authorities. The committees were headed by the DRS, Central and Haut Bassins. The teams met to review the criteria and process for selection of the CEAPs and developed a facility assessment tool. A request for expressions of interest and an application form to be completed by each interested health facility was sent out to all facilities in the two regions through the regional health management teams. The completed forms were reviewed by ENSP, Pathfinder, and MoH. Facilities were shortlisted based on whether they met the criteria. The respective teams visited each facility and conducted an assessment that included: observation of the infrastructure and client flow systems, interviews with the facility in-charge and staff, inventory of equipment and supplies, and review of health facility FP data in the registries and at Pathfinder Burkina Faso. The team met and selected six *Centres de Santé et Promotion Sociale* (Health and Social Promotion Centers [CSPS]) to become CEAPs. These health facilities had been used for many years as practicum training sites for students from pre-service education institutions and for learners doing in-service training in FP, MNCH, PAC, and postpartum FP by various NGOs providing FP/RH training in Burkina Faso. These facilities however had never been formally prepared to be practicum training sites. The following is a list of facilities by region:

Haut Bassins Region, Bobo-Dioulasso	Central Region, Ouagadougou
CSPS, Guimbi Quattara	CSPS Dassasgho
CSPS Sector 24	CSPS Zagtouli
CSPS, Sarfalao	CSPS Ouaga 2000

Activity 3: Training of Coaches/Encadreurs: A total of 37 midwives (at least 6 midwives from each selected CEAP facility) were trained to be coaches/encadreurs by Pathfinder trainers in 5-day training workshops in March 2018. Of the 37 midwives, 19 were from Ouagadougou and 18 were from Bobo-Dioulasso. The selected midwives were already experienced FP providers with skills to provide a broad range of contraceptives, including IUDs and Implants. They had some previous experience teaching students but had never been formally trained as coaches/encadreurs. The training developed their knowledge and skills in the following areas:

- Principles of adult learning
- How to prepare for student internships
- Managing students during the internship, including problem solving and conflict resolution
- Demonstrating FP procedures
- Coaching
- Giving feedback
- Assessing students
- Report writing

Activity 4: CEAP Launch Meetings: Soon after the training of the coaches/encadreurs in March 2018, Pathfinder, the DRS, and district health managers jointly conducted a half-day orientation meeting at each facility. Meeting participants were facility managers, the trained coaches/encadreurs, other health facility staff, members of the health management committees, and ENSP-Bobo-Dioulasso. The national division of ENSP did not participate in any of the meetings. The orientation meetings aimed to mobilize stakeholder support for the CEAP initiative and to clarify the roles and responsibilities of Pathfinder, regional and district health management teams, facility managers, and other health facility staff. Several red flags were raised by participants during these meetings, such as the level of motivation and retention of trained coaches/encadreurs, the need for facility renovations, and the need for additional clinical equipment.

Activity 5: Selection of CEAP Students: The pre-service education curriculum for midwives allocates 20 hours for family planning classroom instruction and simulated practice in the skills lab and 10 hours for clinical practicum. Students must complete the classroom module on FP before being assigned to a clinical practicum. During the strategy validation meeting, stakeholders agreed that the students would be selected by ENSP on a lottery basis to give every student a chance. ENSP-Bobo-Dioulasso selected 45 students based on performance. The students from ENSP-Bobo-Dioulasso were first-time pre-service education students. ENSP-Ouagadougou selected 30 students using a “lottery system” from among both first-time pre-service education students and those who had previous health professional training and were receiving post-graduate education in midwifery. ENSP-Bobo-Dioulasso selected the students based on high performance in FP/RH knowledge tests, as they perceived that high-performing students would be more motivated to learn and would enhance the success of the pilot.

Activity 6: Baseline Assessment: In March 2018 (six months prior to the start of the first internships), E2A and Pathfinder conducted a baseline assessment of the facilities to document the CEAPs' readiness for the internships, availability of equipment, availability of contraceptive supplies and commodities, adequacy of infrastructure and staffing, and service delivery data. Some of the information (e.g., number and type of staff, provider training in family planning, provider experience in FP/RH service provision, and availability of equipment, supplies, and commodities) had already been collected as part of the facility selection criteria. The facilities were found to be enthusiastic about having been selected to be CEAPs and were ready for the internships. Several questions were found to be unresolved at the baseline, such as when facility renovations would start, when and by whom anatomical models and other teaching equipment would be provided, and whether or not the facilities would receive contraceptive commodities and additional supplies to provide free of cost to clients.

Activity 7: Provision of Additional Equipment and Anatomical Models: Pathfinder provided clinical equipment for implant insertion and removal, as well as IUD insertion kits. Pathfinder loaned their anatomical models for temporary use. There were inadequate and had to be shared among the CEAPs for the duration of the internships (and some facilities never had anatomic models beyond the first two days of orientation). This required coaches to demonstrate procedures directly on clients and students to practice on clients with minimal prior simulated practice. New anatomical models were not procured for the facilities due to budget constraints. In the qualitative interviews, facility staff called for permanent availability of anatomical models for practice prior to performing the skills on clients, as well as to facilitate continuous learning.

Activity 8: Development of Monitoring Tools: Pathfinder developed a package of tools to track student learning and achievement of practicum objectives. These included pre/post knowledge assessment questionnaires, summary tools, and guidelines on how to orient students to the internship and report on training activities. ENSP also has standard tools that they give students to document their internship experience and to facility providers to track student attainment of objectives. The tools developed by Pathfinder that were being used for the first time were revised and refined throughout the pilot process, particularly for the first rounds of students.

Activity 9: Launch the Student Internships: In groups of 5 students per facility, 45 students from ENSP-Bobo-Dioulasso were assigned to the three CEAPs for four weeks each. The first group of students started in April 2018 and the final group completed their internships in June 2018. In groups of 5 per facility, 30 students from ENSP-Ouagadougou were assigned to three CEAPs, with the first group starting in May 2018 and the final group completing their internships in June 2018. ENSP-Ouagadougou started later as the students had not completed their classroom work and were therefore not ready for the internship. All students had to complete the internship by the end of June in order to take vacation time and be ready to return to ENSP for their final semester in July.

The students were oriented to the internship by Pathfinder and the facility managers. (ENSP-Bobo-Dioulasso also participated in the orientation of the first group of students.) Each facility allocated trained coaches/*encadreurs* for student teaching differently. For example, some facilities assigned two coaches to be responsible for the five students, whereas in other facilities, each coach/*encadreur* was responsible for one student and the student called the coach/*encadreur* when she/he had a client. This was mainly because coaches/*encadreurs* (who were all midwives) needed to perform other duties such as provision of MNCH services beyond FP/RH.

The skills building activities were conducted sequentially according to the process described in the strategy as follows:

1. **Pre-training assessment and learning on anatomical models:** Students underwent a pre-training knowledge and skills assessment on anatomical models on the first or second day of the internship. Then, coaches/*encadreurs* demonstrated tasks on anatomical models and students practiced as many times as necessary until they reached an acceptable level of performance, at which point students were permitted to provide services to clients. As mentioned above, due to the shortage of anatomical models, some of the procedures were demonstrated directly on clients and students conducted return demonstration on clients under close guidance.
2. **Guided skills acquisition:** The coaches/*encadreurs* provided guided skills acquisition on both the anatomical models and actual clients. They used skills assessment checklists to offer guidance to students and as the basis for giving feedback. The attainment of practicum objectives by each student was tracked using standard forms provided by Pathfinder and ENSP.
3. **Post-training knowledge and skills assessment:** During the final week of the internship, each student was assessed with the same tools used during the pre-training assessment. Students' performance scores were submitted to ENSP and Pathfinder.

Activity 10: Joint Supportive Supervision: The CEAP strategy specified that a joint team from ENSP, Pathfinder, and the DRS or district health management team would be present at the CEAP to receive each group of students on the first day of the internship and orient them on the mentorship system, clarify expectations, and define the roles and responsibilities of students, coaches/*encadreurs*, and facility staff. Each site was then to receive supervisory visits per round of students from a joint team of Pathfinder, district health management team and ENSP. The first round of students in Bobo-Dioulasso received joint supervision and orientation and one round of supervision during the internship. The later groups were supervised as well as the two rounds of internships in Ouagadougou received orientation and supervision from Pathfinder only.

Activity 11: Mid-implementation Assessment: In May 2018, E2A's documentation point person conducted one focus group discussion with the second cohort of 15 students in Bobo-Dioulasso and 13 key informant interviews with ENSP, MoH, regional and district personnel, Pathfinder Burkina Faso staff, facility in-charges, coaches/*encadreurs*, and other service providers at the CEAPs.

Following the above assessment activities, one-day meetings were held in Bobo-Dioulasso and Ouagadougou (close to the end of each region's second round of internships) to share findings and review CEAP implementation progress against targets. In Bobo-Dioulasso, 29 participants attended and in Ouagadougou, 27 participants attended. Participants were from Pathfinder, ENSP, regional- and district-level MoH, facility managers, coaches/*encadreurs*, and other health facility staff. Pathfinder presented the CEAP strategy and E2A presented the findings of the focus group discussions and key informant interviews. To encourage peer support, the meeting included presentations by each CEAP on the successes and challenges they had experienced. The meeting provided an opportunity for all stakeholders to review the stakeholder roles and responsibilities stated in the strategy, highlight unfulfilled expectations, and discuss challenges to the success and scalability of the innovation. The conversations revealed that health facilities had made some adjustments to their spaces to accommodate students and create more room for student learning. Facility staff worked long hours to deliver proper coaching and help trainees achieve their goals. The meeting participants also generated recommendations for successful implementation and scalability and assigned responsibilities for who would address each recommendation. These included:

- Ensure all coaches/*encadreurs* have the skills and feel confident to perform all procedures (e.g., interval IUD and postpartum IUD [PPIUD] insertion).
- Implement some of the missing elements of the innovation, such as provision of equipment and anatomical models (Pathfinder), address the issues of Implanon stockouts (DRS and district managers), and demand generation (in-charge of the CEAPs).
- Pay coaches/*encadreurs* to compensate for the additional workload and responsibilities associated with the CEAP (ENSP and Pathfinder).
- Standardize and reduce the number of tools for tracking student learning between those provided by ENSP and Pathfinder (ENSP and Pathfinder).
- Continue with supportive supervision and increase involvement of ENSP.
- In the long term, additional staff are needed at the facilities to adequately coach students, perform other duties, and reduce the long hours that coaches/*encadreurs* had to work in order to meet learners' needs.
- Improve infrastructure to accommodate CEAP activities.

Activity 12: Endline Assessment: For the endline assessment, several methods were used.

- **Document review:** A review was conducted of documents including: the drafts of the strategy, terms of references, reports of all meetings conducted, service delivery data, completed pre/post knowledge and skills assessment scores for each student, and documentation of attainment of practicum objectives.
- **Focus group discussions:** A total of four focus group discussions were conducted with the first and third groups of students in Bobo-Dioulasso (27 students) and the two groups (29 students) in Ouagadougou. The focus group discussions were conducted before the internships were completed (but close to the end), as it would have been a challenge to assemble the students for focus group discussions following the internship.
- **Key informant interviews:** Interviews were conducted with 35 respondents as indicated in table below.
- **Data analysis:** Interviews and focus group discussions were conducted in French and were recorded (with respondents' consent) and then transcribed. The initial data analysis was conducted manually, and data was categorized into themes that addressed each learning question, the 12 questions of BWEIM, and the CORRECT attributes to assess scalability. The initial draft report from this analysis was very limited because the transcripts were of poor quality. The transcripts were then analyzed for a second time using NVivo software, which helped to better organize the information under common themes and generally improved the analysis, ultimately providing useful information that had previously not been included. During the preparation of this report some of the transcripts were re-analyzed manually to validate the data, particularly to cross-check accuracy of the French to English translations.

Respondents	Number of Respondents
CEAP in-charge at each facility	6
Maternity in-charge at each facility	6
Coaches/encadreurs	6
Other providers at each facility	6
ENSP staff	2 (Bobo-Dioulasso only)*
DRS	0**
District Managers	1 (Bobo-Dioulasso only)*
Pathfinder staff	8 (including the 2 conducted by E2A)***
Total	35

* Key informants from ENSP-Ouagadougou and District Managers were not available for interview. **The Director General and Director of DFH were not interviewed, as there were staff changes in these positions toward the end of the student internship. ***Two of the key informants from Pathfinder (the technical lead for the CEAP strategy and technical program manager for Bobo-Dioulasso, who led the implementation in that region) were interviewed by E2A.

Activity 13: End-of-Implementation Dissemination Meeting: The meeting held in September 2018, brought together regional representatives of DRS, district health management teams, facility managers, the central DFH, E2A, WHO, UNFPA, SOGOB, ENSP, and UNESPB. Findings from the qualitative and quantitative assessments were shared and participants discussed the feasibility and scalability of the intervention. Participants generated several recommendations, which are presented in brief below and in greater detail in the Recommendations and Conclusions section. A major limitation of this meeting was that ENSP and DFH participants did not have decision-making authority, and this limited the group’s ability to decide definitively on an action plan and next steps. Nevertheless, the participants developed an action plan with suggested timelines and suggested responsible institutions. Given the absence of decision makers at the meeting, it was not clear who will make these recommendations to ENSP and MoH, so that commitments on the action plan can be secured.

Recommendations for Next set of Actions

- Strengthen system for monitoring and evaluation of student learning
Scale up the CEAP to 10 facilities in the same regions (including training of coaches/encadreurs, provision of equipment, provision of teaching models)
- Provide monthly supportive supervision to the CEAPs
- Conduct a cost analysis of the CEAP and write a concept note on costing to advocate for scale-up with policymakers at MoH
- Follow up on students trained through the CEAPs
- Ensure that coaches/encadreurs receive payment and train more coaches at each CEAP
- Improve communication mechanisms between Pathfinder, ENSP, and DFH

Findings from the Qualitative Assessment

This section presents findings from focus group discussions and key informant interviews with stakeholders about their experiences and perceptions of the process, successes, and challenges from strategy development, to implementation, to the final stakeholder meeting. The assessment also drew

out lessons learned and recommendations for scale-up. It was not possible to obtain Most Significant Change stories, as stakeholders felt that the implementation period was too short for observable significant changes.

Strategy Development

There was consensus among all stakeholder that the CEAP initiative was a good and valuable intervention for developing FP/RH competencies among students during pre-service education. The respondents affirmed that the need for the CEAP originated from ENSP-Bobo-Dioulasso.

“They could finish their entire training without having inserted a Jadelle [implant] or even an IUD—all three years, and this midwife is supposed to practice after that.”

—Pathfinder respondent

“We know that the way the activities are conducted doesn’t allow the students to acquire the expected competencies. So, when we got this approach, it was a real boon that we seized upon.”

—ENSP respondent

“Here, the person already has their competencies, and I know that trainings tend to disappear because for me, I know that from the beginning of my career in health until now, trainings have happened very rarely. If the basic education is able to instill [the competencies] in students, I think we’ll benefit even more. Because it’s a real opportunity for students to have this training. So, it’s a good thing.”

—Maternity In-Charge, Bobo-Dioulasso

“We decided to start with a pilot phase in order to make sure that it works well enough, to identify the difficulties, to find solutions so that, together with the Ministry of Health, the regional health directors, and the districts, we can have a strategy that is functional and sustainable.”

—Pathfinder respondent

Stakeholder Involvement

While Pathfinder, ENSP, and MoH were all involved in the design of the CEAP strategy, ENSP and central DFH had minimal involvement during the implementation phase, with ENSP-Ouagadougou not participating in any of the implementation activities. According to two respondents, this could be explained by the fact that the design of the strategy, drafting of the strategy, preparation of terms of references, and background documents for the meetings and facilitation of the workshops and meetings were mostly led by Pathfinder. ENSP and central MoH did not participate fully due to changes in leadership. As a result, Pathfinder and some of the respondents at ENSP felt that the CEAPs were not a priority during on-boarding of the new leadership.

User Organization and Resource Team

Multiple stakeholder meetings were held during strategy development, launch, progress review, and at the end of the internship. The strategy specifies the establishment of the User Organization and Resource Team.

User Organization: As stated in the strategy, the User Organization comprises decision makers from, MoH, DFH, DRS, District Health Managers, ENSP-Director General and Regional Director, President of

UNESPB, and Head of the School of Obstetrics/Gynecology, Unité de Formation et de Recherche en Sciences de la Santé (UFR/SDS). The role of the User Organization was to: approve strategies and workplans, ensure compliance with standards and policies, mobilize resources, conduct advocacy efforts, support the resource team, and use data for decision making for scale-up. This body was expected to meet every six months.

Resource Team: The strategy specifies that members of the resource team are: the in-charges for FP/RH at DFH, WAHO, Pathfinder, E2A, the Technical Working Group on Reproductive Health, R3M Burkina, Association of Private Health Schools, ENSP, UFR/SDS, SOGOB, UNFPA, WHO, and the Program for Reduction in Maternal Death and Morbidity. Functions of the resource team were to: provide monitoring and evaluation, report to the user organization, develop and implement strategies, select health facilities (with the User Organization), make modifications to the action plan if necessary, and ensure the dissemination of the strategy and results. The resource team was expected to meet quarterly.

Aside from the meetings to validate the strategy and disseminate the findings, these two key groups (which are necessary for strategic decision-making during strategy development and implementation to enhance scalability) were not formally convened. Meetings to launch the implementation and to review progress mid-implementation were held at different times in the regions and did not include members of the User Organization or the Resource Teams as stipulated in the strategy, except for Pathfinder and the Head of the District Medical Office.

Not formally establishing these two bodies left gaps in implementation and lack of a platform for immediate sharing of learning and problem solving. The students and facility in-charges had expectations for ENSP and Pathfinder that went beyond the roles described in the strategy. There was a general perception that this was a Pathfinder pilot study, which may have hindered ownership and resulted in very limited participation by other key stakeholders, in particular ENSP. Problems such as lack of commodities and motivation of providers at the CEAPs and non-participation of ENSP in joint supportive supervision were left unresolved. This could affect feasibility of scale-up.

Supportive Supervision

According to the strategy, Pathfinder, ENSP, and district health managers were all supposed to be present for the orientation at the beginning of each internship and to provide monthly supportive supervision thereafter. As mentioned in Activity 10 above, ENSP-Ouagadougou did not participate at all after the Director General chaired the strategy validation meeting. Ultimately, the supportive supervision was mostly provided by Pathfinder. In Bobo-Dioulasso, the joint supportive supervision—which was provided twice, once at orientation and once during the internship for the first round of students—was provided by three different teams composed of Pathfinder, the district health management team, and ENSP. Based on reports, this supervision lacked uniformity in format, intensity, and content. In Ouagadougou, the supervision was provided by Pathfinder technical staff. Respondents reported that plans for supervision visits were shared with ENSP well in advance, but this did not result in ENSP's participation. Respondents cited a lack of communication from Pathfinder with the district health managers as a possible reason for their absence. The supervision was highly appreciated by and motivating for the coaches/*encadreurs* and students. Respondents felt that ENSP, as the institution responsible for student learning, would have enhanced the internships and established communication channels between facilities and ENSP. Generally, respondents expressed that ENSP (particularly in Ouagadougou) did not have a sense of ownership of or responsibility for implementation of the strategy.

Review of the supervision reports reveals that there was no standardized supportive supervision system or tools in place. In some of the CEAPs, supervision focused on supporting the performance of coaches/*encadreurs*, whereas in others the focus was on coaching students, and, in others still, it consisted only of discussions with coaches/*encadreurs* and the facility managers on challenges and problem solving.

Elements of Service Delivery Strengthening Implemented

The facilities attested to their readiness to be CEAPs and were already being supported by Pathfinder in the following areas of service delivery strengthening: provider training on family planning; improving access to a wide range of contraceptive methods, including LARCs; appropriate integration of FP with PAC and postpartum care; and onsite mentorship to improve quality of services, health information systems, logistics management, and demand generation through community health workers.

Level of Fidelity to the Strategy in Implementation

All elements of the strategy were implemented, with the exception of facility renovations and provision of clinical equipment and anatomical models. Respondents expressed that there should have been demand generation activities around the CEAPs and improved supplies and commodities. Modifications were made to the following elements of the innovation:

Selection of Students: In Bobo-Dioulasso, students were selected based on merit, whereas in Ouagadougou, they were selected by lottery. There were mixed reactions to the two methods. Some felt that both were good, but some felt that the lottery selection could result in the inclusion of students who were not interested in FP and therefore not motivated to learn.

“So, I agree with those choices, because if a student hasn’t shown any interest, then I’m not sure that they’ll show any interest when they are at a Center of Excellence either.”

—Maternity In-Charge, Bobo-Dioulasso

“Because if we go looking for the best, it won’t be that obvious. There will be frustrations ... This lottery method is better ... it allows us to remove certain ambiguities in the matter. Because if we choose [the best] and later the students come to understand the benefits [of the CEAP], it will be as if we had privileged the others.”

—Trainer, Ouagadougou

The knowledge and skill levels of students in Bobo-Dioulasso was found to be low and questions were raised as to whether the classroom preparation in Bobo-Dioulasso was adequate and whether the ENSP curriculum was up to date for FP procedures. There were differences between what ENSP taught students and what the facility staff had been taught by Pathfinder.

“The level was really low because the FP knowledge wasn’t there. When we started, the theoretical knowledge—even at the practice level—was full of errors, and there were steps that they skipped. They told us that ENSP told them to do it like that, and even the instructors said that they didn’t have those [steps]. So, there wasn’t even agreement about what we were doing, so we went and sat down together and the trainers tried to retrain. Because we, the trainers, had demonstrated the techniques that Pathfinder wanted, so they redid the training and currently we’re doing evaluation of actual practice on women. (We’re doing the final evaluations and if we wait until the last day, we can’t be sure that we’ll have women [clients].) So, we already started and between the two evaluations the grades vary from 19 to 20. They are really keeping up and, well, it’s like I said, we are learning right along with them. Because if we’re inserting an IUD,

we'd do it in two moves and be done, but now with the students, we have to go step by step, so really, since the first day up to today, there's been a net change."

—Facility Manager, Bobo-Dioulasso

Unlike respondents in Bobo-Dioulasso, those in Ouagadougou spoke positively about the students' levels of competency going into the intervention. This could be indicative of students in Ouagadougou having better classroom training but could also reflect the lower expectations of ENSP since their students were generally cited as being low achievers in examinations.

"I think it's going well because we were surprised at the results of the pre-test. It was really good and we realized there were professionals among the group. At the level of the post-test, everyone passed. Before leaving, they have to have practiced all the methods. I found their level to be good."

—Maternity In-Charge, Ouagadougou

Launch Meetings: Pathfinder developed terms of reference and conducted orientation meetings with the Regional Directors of Health Services, district health managers, and facility in-charges to prepare for the orientation of facility staff and health management committee members at each facility. The meetings were not included in the strategy but proved to be important, as they ensured open communication about the CEAP and clarity around expectations and roles of each partner. The meetings enhanced ownership by DRS and district health managers, as they chaired and facilitated the meetings and made commitments to give priority to the CEAPs when distributing supplies and commodities and addressing stockouts. ENSP was involved in Bobo-Dioulasso but not in Ouagadougou.

Workload of the Coaches/Encadreurs: The workload at the facilities was said to have increased due to the CEAPs, with all staff working long hours and having to juggle their other duties and teaching students.

"The workload, yes indeed, we find the working hours long since we have to train the interns. There are so many details we have to take into consideration, so the wait time is long. But it must also be said that, if there are three of us and there's an emergency in the delivery room, we have to stop and go to it. And there are some activities, such as BBS, that we even want to do. In terms of picking children, we want to see what day we'll have a little time for them ... and there is insufficient staff."

—Facility Manager, Ouagadougou

In addition, allocating time for other tasks was found to be a challenge at most facilities, as they had to cover for staff time off and other duties and balance this with teaching students. At times, staff were either available to students on an on-call basis or came in during their time off to coach students. There was an expressed demand for additional staff.

"The problem is the rollover of shifts—we make sure that there are at least three midwives who stay to supervise the students and this is a problem because sometimes one goes out, the other shows up, and the other is on their day off. It's not easy. So you have to sacrifice yourself just for that. The management of the program is not easy and sometimes it's difficult to find someone to coach, especially the guard. The problem is that we are 8 and the midwives are 22 and while the guard is a team, we have just 8 teams and in the other teams there is no midwife. This means that if there is a delivery at night, and the woman wants a PIP, then it is the midwife who intervenes so that the student can learn. So, it's not easy."

—Maternity In-Charge, Ouagadougou

Motivation of Coaches/Encadreurs: The strategy stipulated that coaches/encadreurs would be remunerated for additional work associated with the CEAPs. However, it was not specified who would make these payments there seemed to be mixed expectations. Some expected Pathfinder to pay. Other respondents thought that ENSP would pay the coaches/encadreurs to be in alignment with private pre-service education schools. Pathfinder did not pay coaches/encadreurs, as this would have affected sustainability and scalability. This issue was raised during the orientation and progress review meetings. It was felt that remuneration was justified by the long working hours and increased workload discussed above. This issue persisted throughout implementation and was said to be a potential hindrance to feasibility and scalability of the CEAP intervention.

“So, this is to tell you about the stress it puts on the midwives; it’s not an easy thing, and there is no incentive. For starters, I would say that the complaints are starting to bubble up. If it continues like this, there are people who I personally could not force to come in during their day off, which is their right. But if people had an additional incentive, I’d say it could be a different story.”

—ICP Ouagadougou

“Now the on-call duties, in any case, there are some who aren’t staying to train the students. Being on call and then continuing at the same time—really the team has given a lot of themselves. But nowadays, they say that frankly, on-call and then being burdened with training the students, is hard. I’d say it’s because there is no incentive.”

—Maternity In-Charge, Bobo-Dioulasso

In the qualitative interviews, respondents recommended that each coach/encadreur should receive at least XOF 5,000 per student. However, it was not clear whether respondents meant that this amount should be paid per day or per internship. None of the stakeholders expressed an interest in taking on the responsibility of paying coaches/encadreurs. This additional payment may be unsustainable and not scalable in the long term for public sector health training institutions (e.g., ENSP), as the budget may not be able to accommodate a recurring expense of this magnitude, given the number of pre-service education schools and students.

Limited Clinical Equipment: The CEAPs were supposed to receive additional equipment for training and LARC service provision. Although the strategy did not specify who would provide the equipment, stakeholders assumed that Pathfinder would supply it. Pathfinder in turn assumed that MoH would provide the clinical equipment, as this responsibility would typically fall within their purview. Procurement of clinical equipment was never assigned as the responsibility of any of the stakeholders and was not included in the activity budget. Pathfinder did supply some clinical equipment for implant insertion, but this was clearly insufficient, as indicated in the responses below:

“On the second day that we made contact with the women [clients], we had at least five [clients] and by the time we got to the fifth, there were no more supplies. We had to negotiate with her to come back the next day ... And then, since it wasn’t sterilized, we couldn’t do it.”

—Focus group discussion, Ouagadougou

“With respect to the implant removals, we had only one U-shaped forceps ... Just one, for one person. Afterward, we managed to do removals with the other forceps, but with those ones it wasn’t easy. It was a little complicated.”

—Focus group discussion, Bobo-Dioulasso

Infrastructure Improvements: Minor renovations were supposed to be made at the CEAP facilities. In fact, one facility managers had assumed that being a CEAP implied that they would have a new building

constructed. During the baseline, all facilities expressed a need for facility renovations to create additional room for client consultations. Some facilities had only one room for family planning and either created alternative rooms or space (including offering services outside under the trees or in the corridors), or clients had long wait times for services, or students were asked to hurry through procedures like counseling.

“It was said to be the FP room, but sick clients are taken there ... So then when you’re in there with a woman doing your counseling, you feel like the others want you to hurry up to free up the room. But we know that when we fly through it [counseling], often the woman isn’t adherent.”
—Focus group discussion, Ouagadougou

Supplies and Commodities: The expectation of facility managers, facility staff, and other stakeholders was that the CEAPs would receive additional supplies and that the district managers would ensure that there were no stockouts. This did not occur and became a challenge, resulting in some students and facility staff paying for supplies like gloves out of pocket. All the facilities had stockouts of contraceptive implants and IUDs during the internship, or had to borrow them from other health facilities.

“We would say even the IUDs are stocked out. Since this morning, we’ve had three women who we had to negotiate for them. They were really patient about waiting for la tantie [maternity in-charge] to run out to look for them ... we had to go all the way to the ABBF to find them.”
—Focus group discussion, Ouagadougou

Teaching Materials: The plan was that each CEAP would receive anatomical models on which to practice LARC provision, but they did not. Pathfinder loaned (temporarily) the few anatomical pelvic models and the implant insertion arms that they had in their inventory of training equipment. These were not enough for each facility and supervisors rotated the anatomical models between facilities. The inadequacy of anatomical models was said to have hindered student learning.

Training of Coaches/Encadreurs

Coaches/encadreurs reported that they highly appreciated the training they received because it reinforced some of their existing skills and developed new ones that are needed to coach students. Most facility in-charges noted that taking six midwives away from a facility that already had staff shortages put a strain on other staff and compromised service delivery during the training period. Despite this, the training was appreciated by both the coaches/encadreurs and managers. Midwives saw notable changes in the way they coached students. Generally, the role played by the coaches/encadreurs to help students learn is cited by all stakeholders as a key success of the intervention. This is attributed to the commitment of the coaches/encadreurs to helping students learn, including by working longer hours than usual and coming to work during their time off.

“When the students are there, those who are in charge of training those students are really diligent and punctual. They’re with the students for as long as they can be, or anyway, until they completely exhaust themselves—there are only so many hours in a day, you know. Whereas previously, this wasn’t the case—there were delays, tardiness, absences. But once the person was in the program, she really did respect the program.”
—Focus group discussion, Bobo-Dioulasso

“The training is good—the midwives really took their time to train us. Even if it was 2:00 pm and then a woman comes for a long-acting method, they were always there to go through it with us and support us. Anyway, I appreciate that.”
—Focus group discussion, Bobo-Dioulasso

The trainers who conducted the training of coaches/*encadreurs* had the perception that the main purpose of the FP training was to standardize procedures, as there was a general belief that (except for one person) all the providers had been previously trained in FP (including postpartum FP). Evaluation of the FP clinical competencies of coaches/*encadreurs* was therefore deemed unnecessary, despite it being included in the strategy. The trainers stated that they conducted demonstrations of all key procedures. They also found that five days for this type of training was inadequate and reported that at times the training ran over the allotted time.

“Well, for the training of the coaches, it wasn’t determined that at the end of the training, they would be evaluated, because it was an update. Because it was all trained providers who had validated their training who we had gathered for perhaps an update [or standardization of procedures?]. When we trained, I think that the time for that training was insufficient, even to do the demonstrations—that day I think we went past 6:00 pm to standardize the procedures in Amon. So, if we want to evaluate them, then the time for training the coaches would need to change. The time we allotted wasn’t enough for that. Yes, we went through it, except if we found someone saying they needed something more. If not, when we trained, we standardized the procedures. We demonstrated all the procedures one by one without evaluating, of course, because they had all been trained. It was normal standardization. But I don’t know if the coaches themselves said that they wanted additional training—that would surprise me in Ouagadougou.”

—Trainer, Pathfinder

Training Gaps: Coaches/*encadreurs* and facility managers expressed that the training should have included skills development on how to use the data collection tools developed by Pathfinder for tracking student learning. The coaches/*encadreurs* only found out about the tools at the start of the internship and, therefore, the tools were not completed for the first round of internship in Bobo-Dioulasso. All facilities’ coaches/*encadreurs* stated that there were too many tools to complete and these increased their workload. The data quality from most of the completed tools was poor, with numerous missing variables. Respondents suggested that all health workers at the CEAP should be trained in anticipation of attrition and staff absences for annual leave, days off, night duty, and other duties (e.g., provision of MNCH, HIV, and curative services). The need to plan for attrition and staff absences is evident in one of the CEAPs, which had lost 50% of its trained coaches/*encadreurs* by the end of the pilot (1 departure, 1 sick leave, 1 maternity leave).

Some respondents expressed the need to ensure that the coaches/*encadreurs* all had the necessary competencies.

“There were six of us. I believe that three had not received training [on postpartum IUD insertion].”

—Maternity In-Charge

“I only started practicing [as a midwife] less than a year ago and then at the same time I’m a coach. So, I myself need training.”

—Coach/*encadreur*, Bobo-Dioulasso

Selection of the CEAPs

One of the criteria for selection of the CEAPs was ease of access from ENSP. Distance was an issue for many of the students in Ouagadougou. Geographic distance was brought up less for the students in Bobo-Dioulasso.

Perceived Benefits and Challenges of the CEAP

The qualitative assessment gathered perceptions of the benefits and challenges associated with the CEAP initiative, with a focus on quality of services, effects on clients, impact on student learning, and scalability.

Quality of Services

The health facility managers noted positive changes in the cleanliness of health facilities, improvements in how facilities were organized, improvement in punctuality among staff, and a general positive change in attitude toward students. Facilities reported improvements in quality of services and providers reported that, due to their teaching role, they performed procedures according to high clinical standards.

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

—Maternity In-Charge, Bobo-Dioulasso

Changes in Method Choice: Students were trained in voluntary informed choice and taught to counsel on and offer all methods. The emphasis was on LARCs provision due to the complexity in provision.

“Before, with the women [clients], they were reluctant to offer the IUD. But now, the IUD even tends to overtake Jadelle and other [methods].”

—Coach/Encadreur, CEAP de Ouaga (Zagtouli)

This CEAP experienced the highest number of interval and PPIUD insertions in comparison to other sites during the student internship

Barriers to Method Choice: The cost of contraceptive methods was cited as a challenge, particularly for clients who would have liked to switch to LARCs. Additional barriers (see text box below) were related to client wait times and limited equipment to provide clients with their method of choice once the IUD kits had all been used.

“They were forced to take their old method again [refill] because they didn’t have the money to change methods.”

—Focus group discussion, Ouagadougou

Provider Behaviors and Changes in Practice: The facility managers all observed an improvement in providers’ professionalism, noting that they began wearing formal uniforms, arriving early, working longer hours, and complying with standards and policies while performing tasks. The in-charges also mentioned that the interpersonal communication between providers and clients improved. According to informants, this improved the reputation of the facilities among the communities, leading to clients coming from outside their catchment areas.

Communication about Expectations

Several facility managers expressed that there should have been better communication about the implications of being a CEAP (particularly that there would be no associated payment) at the time the invitations to apply were sent out. The possibility of receiving payment appears to have influenced some of the facilities to apply to be CEAPs.

“It’s a serious undertaking that requires reorganization and commitment, because we did not get involved knowingly ... You have to tell people if there will be financial support or not, because

when it happens like this, people are in the dark. We say ‘ah, there is money in it,’ whereas when we talk about money and we don’t see it.”

—Maternity In-Charge, Bobo-Dioulasso

Student Internship and Learning

Facility managers, heads of maternity wards, and students commended the changes in facilities’ learning environment and reception of students. The coaches/*encadreurs* and facility providers felt that the way they interacted with students had changed—they treated students more as colleagues and refrained from giving them feedback in front of clients.

“Before, when the interns would come, often you rushed them, you say ‘sign in and leave after!’ But now ... there was a welcome, a presentation, a tour, presentation of the services and the staff and everything. If it’s like that, the students are at ease and that allows them to learn.”

—Maternity In-Charge, Bobo-Dioulasso

“We even changed in the way that we speak to the students who we’re training now—it’s different from ... when didn’t have the training in coaching. We didn’t know that to talk to a student, you have to treat them like your colleague. We would make comments while the patient was there, but now we don’t.”

—Coach/*encadreur*, Bobo-Dioulasso

The students themselves felt that this internship was different from previous internships at the same facilities and shared positive experiences similar to the coaches/*encadreurs*:

“In any case, I had already done an internship at 24 ... So now, when we came back, it was the second time. But anyway, the reception there, it was completely different.”

—Focus group discussion, Bobo-Dioulasso

Students felt that the CEAPs were a good learning environment and expressed satisfaction with their experience and results. Despite not meeting all the practicum objectives because of low client loads, they expressed confidence in their competencies and felt ready to provide services. The facility managers and coaches/*encadreurs* across the two regions remarked that, by the end of the internship, students had acquired the necessary competencies (except in PPIUD insertion due to low client load).

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

—Focus group discussion, Bobo-Dioulasso

“I trust them because even if I’m not there, they can do the job well ... I said that they know what they can do to get me to go home. In all, since they are there, we work less, it’s even boring for us. Oh well! Yes, but we see that it is for their training, their coaching is good.”

—Coach/*encadreur*, Bobo-Dioulasso

Challenges in the Learning Experience

Despite these expressions of satisfaction with the internship, the following challenges were cited as having hindered student learning.

Reductions in time for internships:

- The late start of the internship in Ouagadougou, which reduced the internship from 20 to 18 days. (Efforts were made to make up the difference by having students come in on Saturdays.)
- Two days of national strikes, which were compensated for with a one-week extension for trainees from Bobo-Dioulasso, but not for those from Ouagadougou
- Time off due to the death of colleagues in two CEAPs in Bobo-Dioulasso (Guimbi and Sarfalao during the second round of internships)
- The internships coinciding with Ramadan, during which time there is typically low demand for FP

High number of students per facility:

- An obstacle to implementation for centers was that there were many more students assigned by the private schools and even ENSP, stretching that capacity of the coaches to manage larger group of students.
"Many, many. Because the private schools send us ... there are other ENSP interns ... we expect three students, often."
—Coach/encadreur, Ouagadougou
- In general, participants across the two regions found the number of students in each cohort acceptable.
"With the five in any case, it's reasonable because we can supervise them one-on-one, we understand the limits of each, and we can correct as needed. [But] when there's a larger number, it's not obvious. I think five here is really good."
—Coach/encadreur, Bobo-Dioulasso.

Inconsistent FP knowledge:

- The coaches/encadreurs expressed that the students were ill-prepared and that they required to update students' FP knowledge to bridge the gap between what was taught by Pathfinder and what is taught in pre-service education. They expressed that ENSP seems to teach outdated family planning content.

Quantitative Results

Student Performance

The CEAP initiative trained a total of 75 students in two cities—Bobo-Dioulasso in Haut Bassins and Ouagadougou in Central Region—on the provision of family planning services, including LARCs. This pilot program included three rounds of internships at three facilities in Bobo-Dioulasso and two rounds of internships at three facilities in Ouagadougou. With each facility hosting five students at a time, the program trained a total of 45 students in Bobo-Dioulasso and 30 students in Ouagadougou.

Pre-test of Knowledge and Skills: Prior to each internship, each student was assessed to determine their baseline knowledge and skills. Each of the 75 students took a written exam to assess their knowledge and completed a series of skills demonstrations using anatomical models to assess their ability to insert implants and IUDs. For the knowledge pre-test, the average test score for all students was 69%. The first two rounds of students had similar average knowledge pre-test scores, 73% and 76%, respectively. The average knowledge score for the third round of students (which only occurred in Bobo-Dioulasso) was substantially lower (49.4%). Additionally, the average pre-test scores were higher for students in Bobo-Dioulasso than those in Ouagadougou. Table 1, below, shows the average pre-test score for each of the six facilities that participated in the CEAP pilot intervention, as well as the averages for each region.

Table 1 Average knowledge pre-test score, by facility

Region and Facility	Average Knowledge Score
Bobo-Dioulasso	65%
CSPS Guimbi Ouattara	72%
CSPS Sarfalao	55%
CSPS Secteur 24	65%
Ouagadougou	73%
Dassagho	67%
TA 2000	76%
Zagtouli	77%
Average across Facilities	69%

Students were also required to complete a practical skills assessment on an anatomical model, which included insertion of implants, IUDs, and PPIUDs. The average composite score for all three skills was 60%. While the average scores were slightly higher in Ouagadougou than in Bobo-Dioulasso, they were similar across the three methods tested. Table 2, below, displays the average skills pre-test scores disaggregated by region and contraceptive method.

Table 2 Average anatomical model pre-test scores, by region and contraceptive method

	Bobo-Dioulasso	Ouagadougou	Total
Composite Score	57%	63%	59%
Implant	57%	68%	61%
IUD	58%	63%	60%
PPIUD	57%	57%	57%

Achievements during the CEAP Internship: Throughout the course of their internships, the students were tasked with counseling patients on contraceptive options and completing a target number of insertions and removals of IUDs (both interval and postpartum) and implants. Tables 3 and 4 (below) show the average number of methods provided per student and the percentage of students who achieved the target for each of the methods, respectively.

Table 3 Average number of services provided per student, service targets, and percent of students achieving each target

Average number of services provided per student		Service Targets	Percent of Students Achieving Service
Clients counseled	18	10 Clients counseled	49%
IUDs inserted	3	5 IUDs inserted	9%
PPIUD inserted	<1 (0.3)	1 PPIUD inserted	1%
IUDs removed	<1 (0.5)	1 IUD removed	3%
Implants inserted	7	10 Implants inserted	11%
Implants removed	2	2 implants removed	28%

As illustrated in Table 3 (above), on average, the targets were not met for any of the tasks. Furthermore, the biggest gaps in service delivery practice were for PPIUD insertion and IUD removal. Additionally, as illustrated in Table 4 (below) fewer students were able to meet the targets in Ouagadougou than in Bobo-Dioulasso.

Table 4 Percent of students achieving target, by region

Region	Clients Counseled	IUD Insertions	PPIUD Insertions	IUD Removals	Implants Inserted	Implants Removed
Bob-Dioulasso	56%	16%	0%	4%	18%	44%
Ouagadougou	40%	0%	3%	0%	0%	3%
Total	49%	9%	1%	3%	11%	28%

Post-test on Knowledge and Skills: At the end of the internship, students re-took the same written test to assess their knowledge. Data is only available for students in Ouagadougou, where the average score across the two rounds of internships and facilities was 93%. Scores were similar across all rounds of internships, with Round 1 averaging 90% and Round 2 averaging 95%. In addition, students completed a practical test using anatomical models at the completion of the internship to assess their ability to effectively insert an interval IUD, a postpartum IUD, and an implant. Skills assessment scores at the completion of the practicum were similar across the methods. The only variation between regions was on PPIUD insertion. Bobo-Dioulasso students averaged 94%, whereas Ouagadougou students averaged 87%. Table 5 (below) shows the average post-test scores, for each of these methods, disaggregated by region.

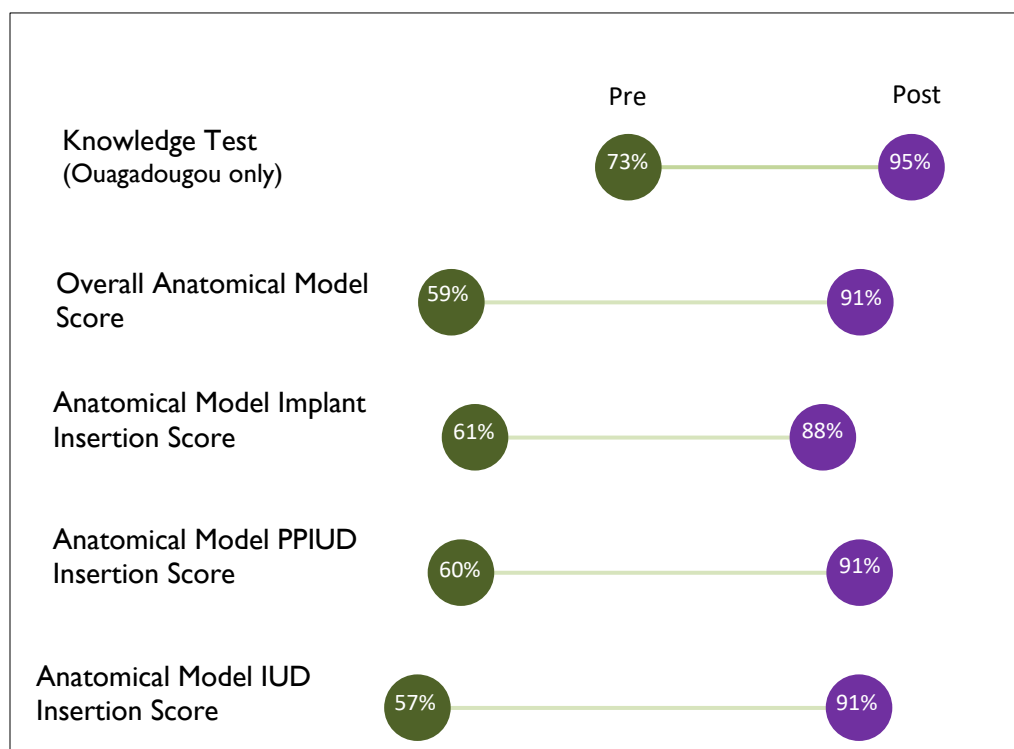
Table 5 Average anatomical model test scores at program completion, by region and skill assessed

Scores on Practical Assessment	Bobo-Dioulasso (N=30)	Ouagadougou (N=45)	Overall
Overall score	91%	91%	91%
Implant insertion	88%	88%	88%
IUD insertion	92%	90%	91%
PPIUD insertion	94%	87%	91%

Changes in Knowledge and Skills: These scores indicate that, on average, there was a 30% increase in knowledge test scores in the 3-week period of the internship; knowledge test scores were 73% at the beginning of the practicum, compared to 95% at the completion of the practicum. There was a 53% increase in the overall skills assessment on anatomical models between the pre- and post-tests. Change in practical application scores by method is illustrated by Figure 1 (below). The increase was highest for IUD insertions (60%) and lowest for implant insertions (43%).

Service Delivery at the CEAP Health Facilities

Figure 1 Changes in pre- and post-tests for practicum students for knowledge and practical skills exams



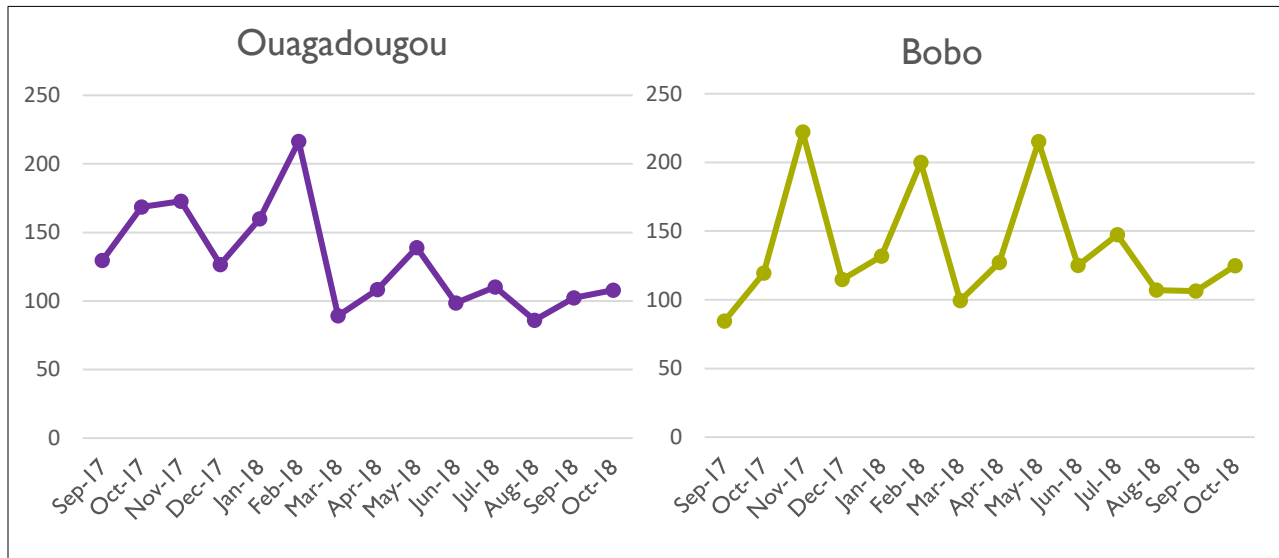
In addition to looking at the student internship data, this assessment analyzed the service utilization data for the six facilities where students were hosted in Ouagadougou and Bobo-Dioulasso for the 14 months surrounding the internship programs—from September 2017 through October 2018. During that period, there were, on average, 134 total family planning clients per facility per month. Table 6 (below) shows the average number of clients per facility per month, disaggregated by region and method.

Table 6 Average number of users per facility per month, by method and region

Region	IUD	Oral Contraceptives	Injectables	Implants	Permanent Methods
Bobo-Dioulasso	19	20	31	66	0
Ouagadougou	18	20	37	55	0
Total	19	20	34	60	0

Review of the health facility data showed no clear trends in service uptake over the course of the prior year, during, and after the conclusion of the Centers of Excellence for Practical Learning effort. Figure 2 (below) illustrates the average number of clients served per facility each month from September 2017 through October 2018 across the three health facilities in Ouagadougou and the three facilities in Bobo-Dioulasso.

Figure 2 Average number of family planning clients served, by month and region



Looking particularly at implants and IUDs (methods that were provided by the students), Figure 3 and 4 (below) highlights the pattern of average monthly clients per facility receiving implants and IUDs. For the health facilities in Ouagadougou (Figure 3), students were present during June and July. During those months there were no noticeable changes in the number of implant or IUD users. In Bobo-Dioulasso (Figure 4), students were present at the health facilities from late April to June. There was an increase in the number IUD users during the implementation phase. The use of implants did not appear to deviate from the existing use pattern, which shows an increase in users every 3 months. This trend continued throughout the implementation of the CEAP initiative.

Figure 3 Average monthly implant and IUD clients in Ouagadougou, Sept 2017–Sept 2018

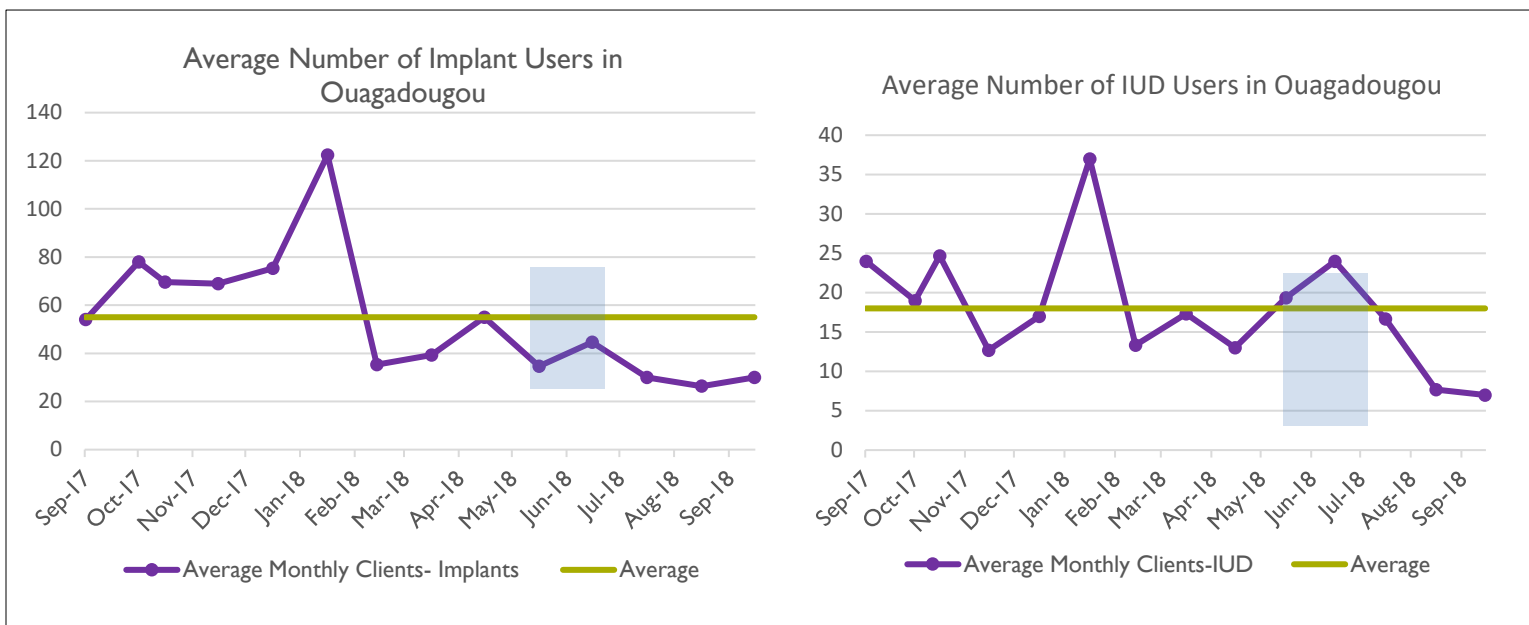
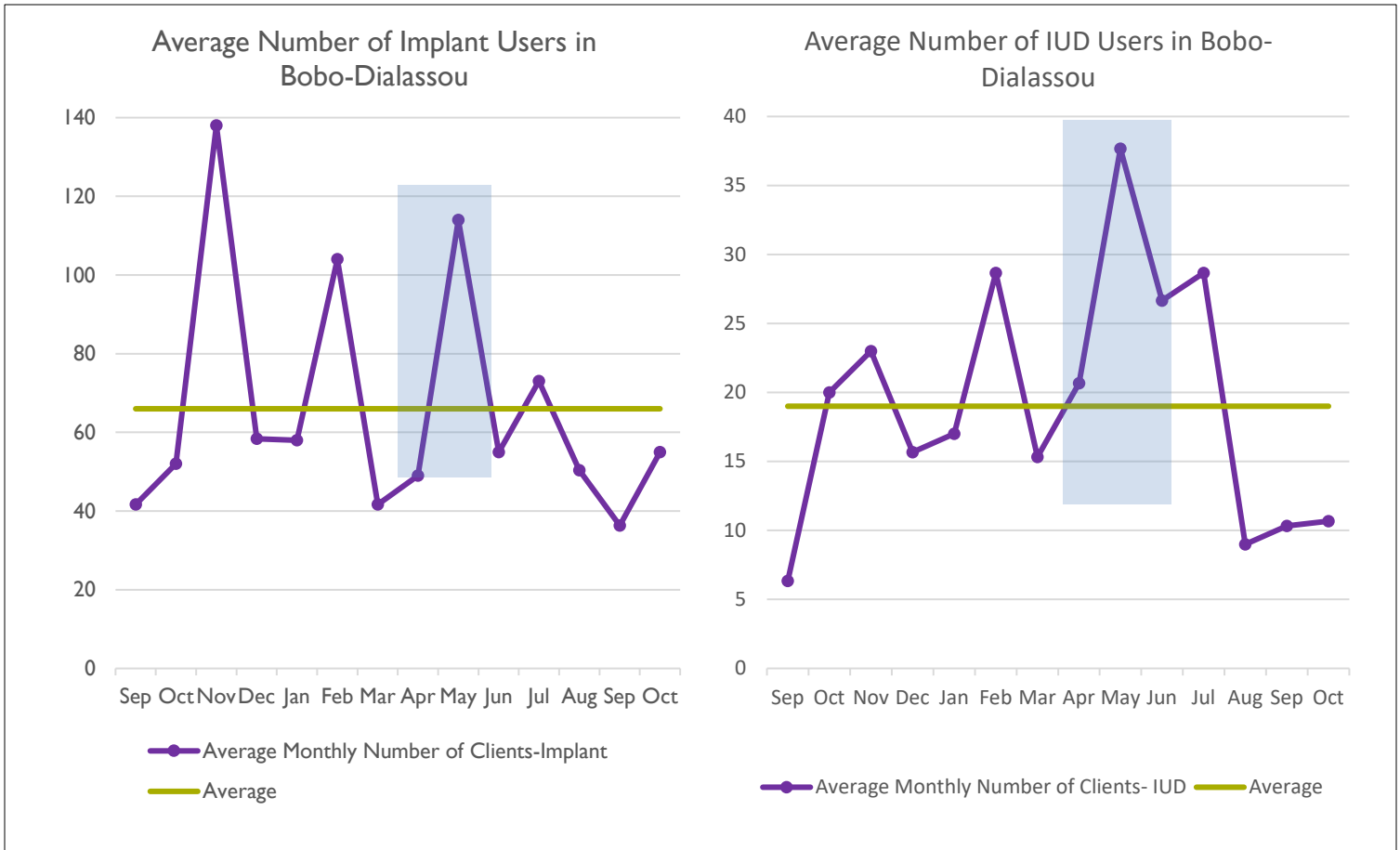


Figure 4 Average monthly implant and IUD clients in Bobo-Dioulasso, Sept 2017–Oct 2018



Assessing Scalability Using the CORRECT Attributes

This section uses the CORRECT tool alongside the qualitative and quantitative to assess the probability of scale-up for the CEAP intervention. This evidence also includes the recommendations and input from participants that were generated during the final dissemination meeting, which was intended to be an opportunity to develop the scale-up strategy. Below, the CEAP intervention is examined through the lens of the CORRECT attributes (Credibility, Observability, Relevance, Comparative Advantage, Ease of Implementation, Compatibility, and Testability).

Credibility: The results of the pilot were documented in detail, despite a few challenges with the data transcribing. However, there were mixed opinions among respondents regarding the soundness of the evidence. Several respondents felt that there should have been a control group to enable a comparison of student knowledge and skills performance, attainment of practicum objectives, and changes in client load. Some respondents also felt that students have to be follow up on after graduation to re-assess their skills before it can empirically be said that the CEAP had a lasting effect on graduates' knowledge and skills. In addition, respondents indicated that the pilot should have included rural health facilities, as experiences in Bobo-Dioulasso and Ouagadougou cannot be generalized to more remote regions, where clients loads are low, access to facilities is limited, and there are many fewer providers.

Observability: Respondents felt that, while students' learning and gains in knowledge and skills were observable, the overall benefits of using the CEAP model for student internships are not observable because there was no control group examined.

Relevance: There was unanimous agreement that the CEAP innovation was designed to address a pressing problem: lack of knowledge and skills among providers for FP service provision and limited capacity of facilities to provide quality FP internships.

Relative Advantage: The respondents rightly felt that the costs of the intervention were not tracked, but it is also unknown how other places have addressed this challenge and whether it is more cost effective than in-service training or whether it yields better results than the alternatives.

Ease of Transfer/Installation: Respondents expressed that the policies, protocols, and guidelines needed to implement the CEAP at scale could be developed, but that this pilot has many limitations and did not generate enough information to allow the development of guidelines that are feasible to implement at scale, especially in rural facilities. There is a need for training of trainers for coaches/*encadreurs* at central and regional levels and for coordination to define and coordinate the responsibilities of all stakeholders, including the User Organization and Resource Team. Major human and financial resources will be required to recruit and train every provider to coach students, ensure that there are no stockouts during internships, and ensure that facilities have enough clinical equipment and anatomical models for teaching. For example, paying six or more coaches XOF 5,000 (\$10) per student is a high recurring expense that could have implications for the MoH and ENSP budgets. In a country where salaries for health workers are already low, expecting health workers to take on substantial additional responsibilities without compensation may not be feasible. Budgetary issues could be a major barrier to scale-up by ENSP and DFH.

Compatibility: The innovation entailed a number of changes to and additional inputs into the existing systems related to supervision, logistics, health workforce recruitment and retention, provision of equipment and anatomical models, and increased duration of practicum training in pre-service education. Many of these were not compatible with the norms and current practices of the MoH and ENSP. Additional evidence will be required on the impact of changes to systems and duration of internship on

student learning and meeting accreditation requirements. Components of the innovation such as training of the coaches/*encadreurs* will need modification to include record keeping and FP/RH skills, as well as training all facility staff on coaching responsibilities. Finally, additional supervision tools and guidelines for internships will need to be developed.

Testability: Recommendations were made to: test the innovation in different areas; ensure provision of the items that were not provided (i.e., equipment, teaching models); address the problem of provider motivation; and improve the mentorship systems. With capacity building support in applying the ExpandNet systematic scale-up tools and in documentation, the User Organization could conduct another round of testing the CEAP innovation to generate more evidence prior to its adoption.

Lessons Learned

- The consensus on the relevance of the innovation among stakeholders (particularly ENSP-Bobo-Dioulasso, Pathfinder, and the health facilities) positively contributed to the design of the innovation and its pilot testing in selected facilities. Despite the many challenges, facility managers and coaches/*encadreurs* were committed to helping student interns learn.
- When the learning environment is improved and the focus is on students, students take initiative and are motivated to meet their objectives as well as mobilize clients
- The roles of and expectations for the different stakeholders were not defined and clarified, and there was lack of engagement of MoH and ENSP. While there was good consultation in the strategy development phase and selection of facilities, the resource team that would have supported implementation of the pilot and taken on a problem-solving role was never established.
- When a nongovernmental organization is leading an initiative in a setting where stakeholder expectations for compensation and material benefit/improvements are high, the roles and responsibilities of the different actors need to be clarified from the beginning and monitored throughout the process. In this case, the stakeholders were looking to Pathfinder to provide the inputs in terms of commodities, equipment, and additional compensation for implementation of the innovation. In the long run, this type of model does not lead to sustainability and makes scaling up with local resources less feasible.
- Supportive supervision by Pathfinder and the commitment of district health managers to prioritize the CEAPs for distribution of supplies and commodities contributed to the success of the learning experience for student interns. However, the repeatedly cited unaddressed components of the innovation (e.g., lack of compensation for coaches/*encadreurs*, equipment, anatomical models, and facility renovation) have a negative effect on feasibility and scalability of the innovation.

Recommendations and Conclusions

Recommendations for Scale-up

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

If the stakeholders commit to generating additional evidence, it will be important to simplify the innovation and implement it as consistently as possible. It will also be necessary to make permanent changes to factors that could hinder scale-up and successful service delivery. Some of the health system-level changes will be related to training guidelines and systems for student internships during pre-service education; management and leadership of the internship program; financing of implementation, logistics, and anatomical models and equipment; and increasing demand generation activities as part of the service delivery systems. Specific recommendations for ensuring the scalability of the CEAP initiative include:

- **Government Leadership for Strengthening and Scaling Up the CEAP Pilot:** For the CEAP model to be scalable and sustainable, meaningful buy-in and leadership from ENSP and MoH (i.e., the User Organization) is needed. Implementing partners that support this initiative should limit their role to technical assistance for capacity building of the User Organization and Resource Team, advocacy, and facilitating participatory documentation from pilot testing to generate the needed evidence to support scale-up.
- **Advocacy for Scale Up:** Advocacy for both horizontal and vertical scale up should also be directed at donors and implementing partners that are supporting reproductive health in different regions and are involved in influencing policy at the national level. Advocacy meetings led by the Director General of ENSP, as the entity responsible for pre-service education, should include capacity building for all stakeholders, facility staff, and coaches/*encadreurs* on using the ExpandNet tools for systematic scale-up and evidence of feasibility and scalability.
- **Re-Establish and Re-Define the User Organization and Resource Team:** To facilitate scale-up, there is a need to re-engage with stakeholders and, through a participatory approach, establish a clearly defined User Organization and Resource Team, agree on terms of reference, and agree on mechanisms for sharing information and problem solving. The Resource Team should be led by ENSP with sub-Resource Teams in Bobo-Dioulasso and Ouagadougou.
- **Resources:** To facilitate smooth scale-up and enhance standardization across facilities developed into CEAPs, there is a need to ensure adequate financial and human resources. Cost estimates of this pilot should be provided to ENSP and MoH for their consideration as they make decisions regarding scale-up of the CEAP initiative.
- **Roles and Responsibilities:** During the stakeholder mapping exercise that will take place in the scale-up strategy development phase, there must be a clear delineation of roles, responsibilities, and capacity building needs at all levels. Furthermore, clarity regarding financial responsibilities and expectations among all stakeholders and development partners is critical from the outset.

- **Geographic Variations:** Prior to implementation of the action plan that was developed during the final stakeholder meeting, it will be important to anticipate and plan for geographic variations and related challenges, such as smaller facilities, lower service demand and utilization, fewer trained FP providers, fewer lecturers at ENSP, transport limitations, concerns related to the personal security of health workers, and diminished accessibility of the health facilities.
- **Integration of Practicum Training Topics:** ENSP should explore alternative opportunities for students to acquire family planning skills, such as integration of practicums (e.g., FP and immunization, nutrition and community health) because extending the duration of the practicum for FP alone could reduce the duration of other areas of classroom and/or practicum training, which could affect the quality of training. All CEAPs should have the necessary equipment and anatomical models for training and service provision.
- **Integration of Service Communication with Service Delivery:** ENSP should also explore ways to engage students during their practicum to conduct information sharing and demand creation, as part of the intervention, to inform communities (women, men, leaders) about the services, strengthen students' interpersonal skills with clients, and have students and facility mentors follow up clients after service provision.
- **Sustain Quality of Care at the Health Facilities:** The CEAP should periodically spot check the performance-to-standard of facility staff and mentors/coaches during times when students are not there to ensure that improved quality is the 'new normal' that is sustained.
- **Leadership and Management:** There will be a need for capacity building for facility managers on leadership and management of a CEAP, including allocation of duties for the coaches/*encadreurs* and facility staff, logistics management, and demand generation.
- **Internship Duration:** ENSP should consider the implications of having an average of 30–45 students undergoing the internship over the course of 12 weeks, instead of the 10 hours that are currently allocated in the curriculum. ENSP would be the best institution to address the issue of increasing the duration of the internship as this may have implications for the time allocated for other clinical areas in the pre-service curriculum.

Conclusion

The Centers of Excellence for Practical Learning strategy was developed in response to a felt need and was a relevant response to the issue of a shortage of competent FP providers. The CEAP initiative explored the possibility of developing providers' FP competencies during pre-service education by making changes and improvements to the practicum component of pre-service training. While there were many challenges experienced during implementation of the CEAP strategy, there is some evidence that that pilot achieved its objective of developing practical FP competencies of students during pre-service education. Furthermore, stakeholders in Burkina Faso are coming away from this process with an awareness and greater capacity to think ahead to sustainable scale-up from the beginning of a project, and also how to use existing tools to conduct such analyses in the future. However, given the implementation challenges and lessons learned identified, there are many factors that must be addressed before considering scale-up, such as fostering local ownership and leadership, putting in place structures to promote scale-up, and better understanding of what entails the implementation of the innovation with scale-up in mind from the beginning. Addressing these crucial recommendations is a good place to begin further exploration of scaling up the CEAP strategy to improve the family planning competencies of Burkina Faso's health workforce.

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