MOMENTUM

Private Healthcare Delivery

Pharmacy in Madagascar | Photo Credit: PSI

Technical brief

REVIEW OF INTEGRATED COMMUNITY CASE MANAGEMENT/FAMILY PLANNING/REPRODUCTIVE HEALTH TRAINING CURRICULA FOR PHARMACISTS AND DRUG SHOP OWNERS

THE MOMENTUM SUITE OF AWARDS works with USAID's Office of Population and Reproductive Health and Office of Maternal and Child Health and Nutrition to accelerate reductions in maternal, newborn and child health morbidity and mortality in high-burden USAID priority countries. Within the suite, the MOMENTUM Private Healthcare Delivery Project works to strengthen private sector healthcare contributions to these goals.

1. BACKGROUND

Through MOMENTUM Private Healthcare Delivery's core workplan, consortium members PSI, FHI 360, and Jhpiego will support scale up of evidence-based approaches to improve the quality of integrated community case management (iCCM) and voluntary family planning (FP) offered through private pharmacies and drug shop vendors. This will include developing a training curriculum and tools for this cadre of providers that are often left out of formal health system support. This resource will be utilized by MOMENTUM and made available as a global good for use by other stakeholders. As a first step in this process, the project undertook the following review of existing iCCM and FP/Reproductive Health (RH) curricula for lower level providers, with a view to assessing and utilizing the highest quality components of existing training resources. This report provides an overview of the process and findings of this exercise and is intended to be used alongside the Curricula Review Matrix that provides a further level of detail for each curriculum.

PHARMACIES: retail facilities, overseen by licensed pharmacists, that sell both over-the-counter and registered prescription-based medicines.

DRUG SHOPS: lower-tier retail outlets, with no pharmacist on staff, that sell over-the-counter drugs, chemical products, and household remedies. Drug shop vendors may or may not have any formal training.

RILEY ET AL, 2017[3]

2. INTRODUCTION

Demographic and Health Survey studies and recent evidence[1] show that the private sector—and in particular, pharmacies and drug shops (see text box)—is a significant source for those seeking care for sick children and those in need of FP products and services. These providers are often the first line of health care, especially in areas that lack public or private health facilities.[2] Despite the important role pharmacies and drug shops play in meeting health care needs across urban and rural settings, these providers are not systematically included in formal health system structures or routinely monitored for quality of care.

At the same time, it is increasingly clear that with appropriate training and support, pharmacists and drug shop staff can effectively manage some common childhood illnesses. For example, an iCCM intervention for drug sellers in Uganda, which included training, supply chain management, and monthly supportive supervision, resulted in increases in the appropriate treatment of uncomplicated malaria, pneumonia symptoms, and non-bloody diarrhea by 80%, 65%, and 31%, respectively.[4] Similarly, the Enhancing Quality iCCM through Proprietary and Patent Medical Vendors (PPMV) and Partnerships (EQuiPP) Approach implemented under the USAID-funded Maternal and Child Survival Program showed promising results such as a 75% average increase in proportion of children with fever who were appropriately tested for malaria amongst trained PPMV providers.[5]

For FP services, USAID has recognized pharmacy and drug shop provision of FP as a promising High Impact Practice (HIP) that can expand contraceptive choice and access. The World Health

Organization (WHO) similarly recognizes in its summary brief Task Sharing to Improve Access to Family Planning/Contraception that retail outlets like pharmacies and drug shops are important points of FP service provision. Evidence shows that with training and support, pharmacies and drug shops can safely provide contraceptive services. Studies cited in the HIP brief show that in contexts as diverse as Bangladesh, Tanzania, Nigeria, Uganda and Nepal, pharmacy and drug shop staff have safely and effectively provided a wide range of FP information and methods, including injectables.[3,6] For youth, in particular, pharmacies and drug shops are typically an important source of FP products and services. In one study cited in the HIP, youth constituted one-third of all pharmacy and drug shop clients in countries with a modern contraceptive prevalence rate lower than 20%.[3]

Given this emerging evidence base, program implementers increasingly recognize the potential of using task sharing with these cadres for selected iCCM and FP services. Considering the varied range of skill sets among pharmacy staff and drug shop vendors, enabling this cadre to safely and effectively provide certain iCCM and FP services also requires ensuring that relevant policy changes and support structures are established, such as guideline and protocol updates, regulatory oversight and supervisory requirements, and monitoring and evaluation systems.[22] Another important step in implementing a task-sharing initiative with a new cadre is to conduct training. Usually, implementers develop or seek and adapt individual nationally—or globally—approved curricula for each health area, rather than developing an integrated curriculum that may offer greater efficiency and cost-effectiveness. These trainings are often classroom- or workshop-based, last multiple days, and are not necessarily tailored to pharmacy and drug shop providers, who operate in faster-paced retail environments serving a high volume of health and non-health clients.

Based on promising results from other pharmacy and drug shop training initiatives for iCCM and FP/RH services,[3-7] MOMENTUM, funded by USAID, is building and testing an integrated iCCM/FP training and supervision approach that incorporates gender responsive and youth inclusive content. The curriculum will be tailored to the training needs of pharmacy and drug shop providers, will adhere to global best practices and recommendations, and will rely on effective, evidence-based training methodologies. To better understand what curricula have been used for this purpose previously and to see if they might be adapted/adopted for this project, technical experts from MOMENTUM Private Healthcare Delivery consortium members PSI, FHI 360, and Jhpiego identified and reviewed available child health and FP/RH curricula for pharmacy and drug shop providers.

The purpose of this review is to provide details on the structure, methodology, and technical content of existing training materials and curricula so that MOMENTUM and others may leverage and adapt these resources in their own work. It is not intended to be an evaluation or appraisal of each curriculum. For child-health-related curricula, technical content has been reviewed against the World Health Organization (WHO) 2014 training materials, including the Facilitator Notes for caring for the sick child in the community and the Chart Booklet: Caring for the sick child in the community. For FP/RH curricula, technical content has been reviewed against the 2018 Global FP Handbook.

3. CURRICULA SEARCH PROCESS

3.1 DEFINING TRAINING CURRICULUM

Ideally, a training curriculum should include the following components (Figure 1).[8, 9]

- Essential technical information the learners are expected to acquire and tasks they are expected to perform after they complete the training.
- A "road map" for transferring technical information and skills to learners; this is usually done through an instructional document where the objectives, content, and flow of the sessions are clearly outlined.
- A skills-building component integrated into the curriculum through activities, exercises, case studies, role plays—anything that provides learners with opportunities to put their newly acquired knowledge and skills into practice.

> THE CURRICULUM REPRESENTS A SET OF DESIRED GOALS OR VALUES THAT ARE ACTIVATED THROUGH A DEVELOPMENT PROCESS AND CULMINATE IN SUCCESSFUL LEARNING EXPERIENCE FOR STUDENTS.
>
> WILES J AND BONDI J (2007)[8]

Additionally, visuals, usually in the form of slides, are desirable, although not required, to facilitate knowledge transfer.[10]

Figure 1. What constitutes an effective training curriculum?

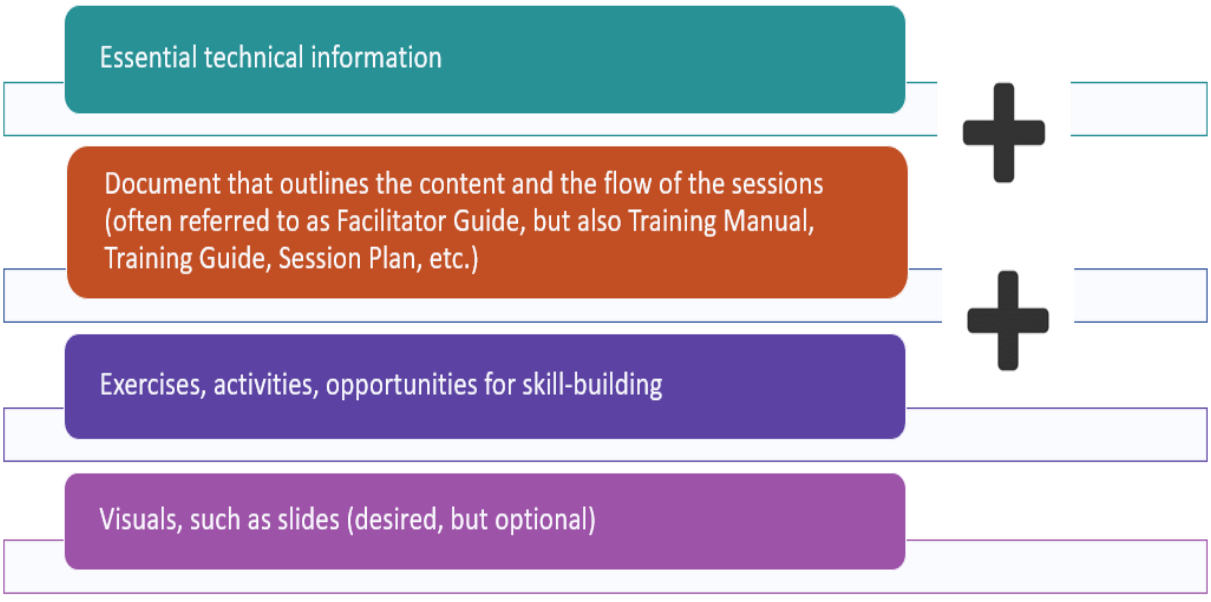


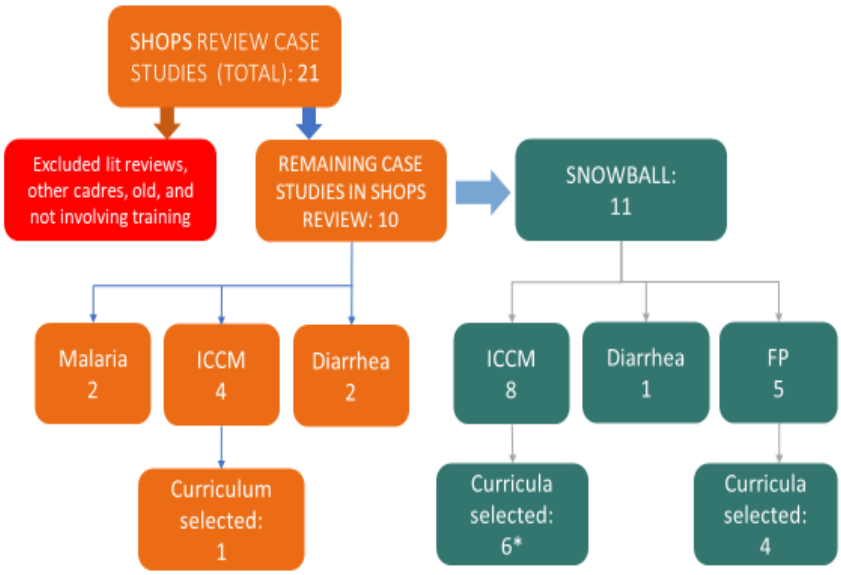
Figure developed from Wiles, J et al (2007)[8] and Intrahealth (2007)[9]

3.2 SEARCH STRATEGY

For the iCCM section of the review, we started our search with programs involving training of pharmacists and/or drug sellers that were identified in the SHOPS Plus review Case Management of Childhood Illnesses in the Private Health Sector.[11] We contacted programs and individuals listed in the SHOPS Plus report to request original curricula materials and then used a snowball approach to follow up these leads and links to other training programs. We supplemented these efforts with an online search for other training materials related to iCCM for this cadre of private providers.

For the FP section of the review, we followed a similar snowball approach by searching the Training Resource Package for Family Planning website for materials tailored to pharmacy and drug shop providers and following up with identified programs and individuals. Additionally, we reached out to colleagues and contacts in countries that approved task sharing of injectable contraceptive provision with pharmacy and drug shops providers to source any original training materials that were developed for this cadre. As with the iCCM component, we carried out a supplementary online search for other training materials related to FP/RH for this cadre.

Figure 2. Curricula search results



*Two iCCM curricula also included a session on family planning.

The process and results of this search are summarized in Figure 2. Curricula selected for the review had—at minimum—two of the first three components in Figure 1. The exception was the FP/RH curriculum from Nigeria (developed by Federal Ministry of Health for training community health workers and used without adaptation by the EQuiPP Approach to train pharmacists/drug shop vendors). In this case, we obtained only one of the three components. However, given the importance of this cadre in accessing FP in Nigeria, and considering the limited number of FP/RH curricula available, we elected to include it in our review. All reviewed curricula are listed in Table 1.

Table 1. iCCM and FP/RH curricula identified for review

Country	Curriculum
iCCM	
Tanzania	Accredited Drug Dispensing Outlet Training
Nigeria	Integrated Community Case Management (iCCM): Caring for Newborns and Children in the Community
Uganda	iCCM Private Provider Training
Zambia	Health Shops Dispensers' Training
Uganda	Training for Accredited Drug Shop Sellers
Kenya	Community Health Volunteers Training: Integrated Community Case Management
Uganda	Caring for Newborns and Children in the Community
Family Planning	
Uganda	Family Planning Training for Drug Shop Operators (DSOs)
Global resource	Emergency Contraceptive Pills (ECPs) Training for Pharmacists
Kenya	Expanding Access and Choice to Family Planning Services in Kenya: Pharmacists & Pharmaceutical Technologists' Training Package for Provision of Quality, Integrated Family Planning Services
Nigeria	Family Planning Training Manual for Tier 2 Patent Proprietary Medicine Vendors (PPMVs)—Participant's Guide

4. CURRICULA REVIEW CRITERIA

To standardize the review, we identified four review categories[9] and developed a set of criteria for each of these categories in consultation with USAID. Review categories and examples of criteria for each category are listed below (Table 2). **Annex 1** contains a complete list of review criteria.

Table 2. Review categories[9] and example criteria

CATEGORIES	CRITERIA
CURRICULUM DEVELOPMENT PROCESS	• Developed or updated within the past 10 years • Target audience clearly defined • Selection criteria for trainees specified
CURRICULUM DESIGN	• Has clear goals and objectives • Has a clear, structured training plan/methodology for each session (i.e., facilitator guide) • Includes strong skills-building component • Has a mechanism for assessing change in knowledge and skills
TRAINING METHODOLOGY	• Includes multiple methods of teaching and learning • Job aids used during training
TECHNICAL CONTENT	• Content is technically accurate and up to date/adheres to global guidelines for theoretical content specific to iCCM and/or FP/RH • Key competencies related to general iCCM steps, fever, diarrhea, and cough/difficulty breathing are covered • Information on pregnancy screening/medical eligibility for relevant FP methods included • Session on interpersonal communication skills included

5. LIMITATIONS

Due to the scope of the activity, we limited our search and review to training materials written in English. Identifying and obtaining training materials presented a challenge, as most of them were not available in the public domain, and many of the programs that developed or utilized these training curricula ended several years ago. In four cases, it was not feasible to obtain complete training

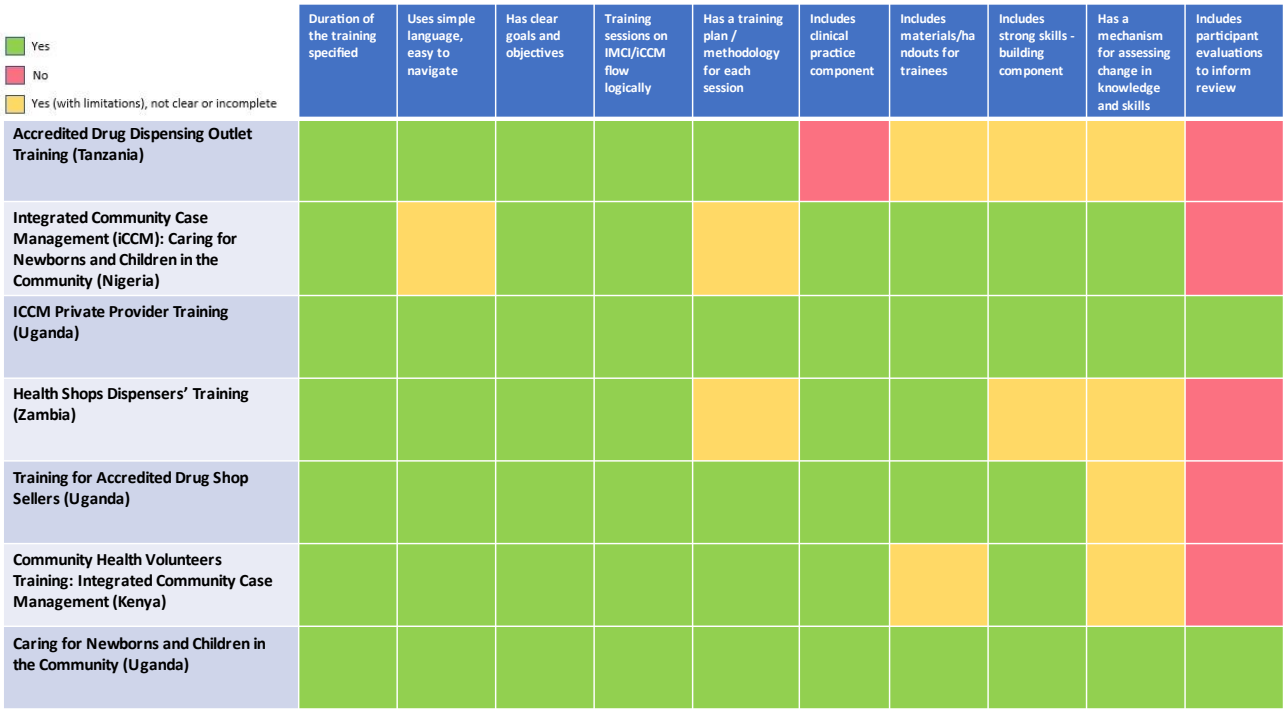
packages, and some of the inaccurate or inadequate information or features noted in our review may have been remedied by other training materials (i.e., those that were part of the training curricula but not available to us). Throughout our review, we noted where we believed this was the case. It is also possible that other training curricula exist but were not accessible through the channels we used in our search. Last, given the relative complexity of treating iCCM conditions, the review criteria for this area are more detailed than for FP/RH.

6. SUMMARY OF THE REVIEW RESULTS FOR ICCM CURRICULA

6.1 CURRICULUM DEVELOPMENT/DESIGN

The development of all but one curriculum that we obtained for this review was either led by or created in collaboration with the Ministry of Health (MOH). Regulatory bodies and/or professional societies, such as the Food and Drugs Authority (Tanzania), Medicines Regulatory Authority and Pharmaceutical Society (Zambia), and National Drug Authority (Uganda), were involved in the development of three out of seven curricula. All curricula clearly define their target audience, but only four of seven specify selection criteria for trainees. All seven curricula
are clearly written and start their sessions with specific, measurable, realistic objectives. All but one curriculum is easy to navigate. Training sessions on iCCM are arranged in a logical manner in all seven curricula. Remaining curricula design criteria and their incorporation in materials are summarized in Figure 3. More detailed information is available in the Curricula Review Matrix.

Figure 3. Curricula incorporating individual curricula design criteria



6.2 TRAINING METHODOLOGY

Because we know adults learn best when trainers use a variety of teaching methods to accommodate different learning styles,[12] we assessed the degree to which different curricula employ multiple methods of teaching and learning, including those methods that facilitate skills-building. We also looked at the use of job aids during training. Having job aids available can facilitate learning and ensure that learners are equipped with tools to support them in performing key tasks after training is completed.

Among the curricula we reviewed, five used participatory methodology that included (in various combinations) brainstorming sessions, discussions, small group work, role plays, case studies, video exercises, games, interactive presentations, and clinical practice. Of the remaining two curricula, one included multiple activities but lacked instructions for the facilitator on how to conduct or process these activities; it also did not include all the required information the facilitator needed to convey to the participants, leaving it to the facilitator to fill the gaps. Another curriculum stated in the introduction that it was designed to include role plays, discussions, group work, and individual exercises, but these were not incorporated into the training materials available for review. In this case, we were able to obtain what looked like a complete package, including the training manual, the training curriculum, and PowerPoint presentations.

Figure 4. Curricula incorporating training methodology criteria

Yes
No
Yes (with limitations), not clear or incomplete

	Includes multiple methods of teaching and learning	Job aids used during training
Accredited Drug Dispensing Outlet Training (Tanzania)	Yes	No
Integrated Community Case Management (iCCM): Caring for Newborns and Children in the Community (Nigeria)	Yes	Yes
iCCM Private Provider Training (Uganda)	Yes	No
Health Shops Dispensers' Training (Zambia)	Yes (with limitations), not clear or incomplete	Yes
Training for Accredited Drug Shop Sellers (Uganda)	Yes	Yes (with limitations), not clear or incomplete
Community Health Volunteers Training: Integrated Community Case Management (Kenya)	Yes	Yes
Caring for Newborns and Children in the Community (Uganda)	Yes	No

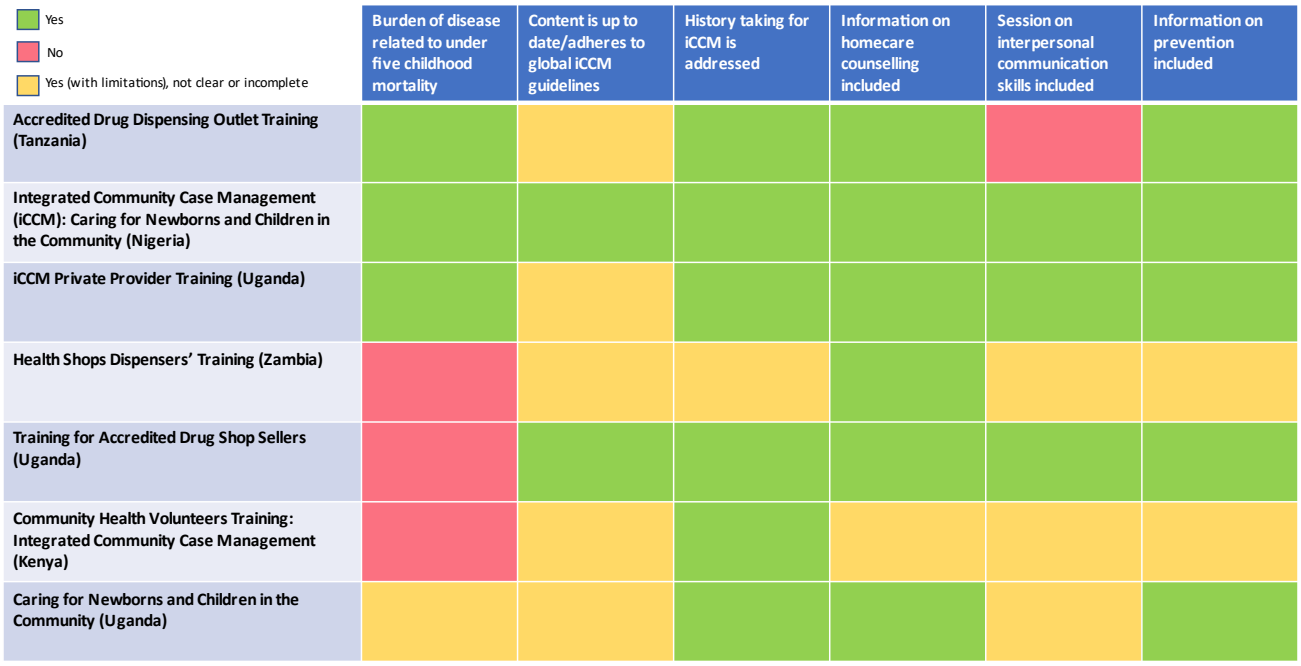
Only one curriculum did not utilize job aids. Another referred the participants to an iCCM job aid, but we were not able to obtain this, so we do not know what it covered and how the learners were expected to use it. The remaining five curricula included job aids based on the iCCM protocol and key elements. Additional job aids utilized by some curricula included instructions for conducting rapid diagnostic tests (RDTs) for malaria, good dispensing practices, good storage practices, receiving medicines, and cleaning practices. Criteria related to training methodology are summarized in Figure 4. More detailed information is available in the Curricula Review Matrix.

6.3 TECHNICAL CONTENT

All curricula were reviewed to determine if their technical content was up to date, adhered to global iCCM guidance, and included key components such as disease burden related to under-5 childhood mortality, history taking, home-care counseling, interpersonal communication skills, and information on prevention. We also reviewed how each curriculum covered clinical elements related to general iCCM steps, as well as management of fever, diarrhea, and cough/difficulty breathing.

It is important to note that none of the curricula reviewed included guidance for newborns (under two months), and they covered management of key health conditions in children between two months and 5 years of age only. Of the seven curricula reviewed, three included information on the burden of disease related to global and country-specific under-5 mortality. In terms of technical accuracy, only two curricula were up to date, with the remaining five missing guidance on RDT use, malnutrition screening, or both. Six of the seven curricula adequately addressed history-taking for iCCM, and six included information on home-care counseling for fever, diarrhea, and cough/difficulty breathing.

Figure 5. Curricula addressing individual technical content areas



Good interpersonal communication in iCCM is important to build trust between the caregiver and the provider. It helps the caregiver feel more comfortable explaining the child's symptoms and history, which enables the care provider to better understand, assess, and treat the child's health issue. It also results in higher client satisfaction, improved adherence to treatment, and, subsequently, improved health outcomes.[13] Furthermore, provider-patient interactions mirror the social stratification and gender norms of the society at large. The WHO conducted a review of the literature on this matter, and available evidence suggests that gender dynamics can affect what medical information the patient discloses, patients' perception of health care provided, health outcomes, as well as patient and provider abuse.[14] Hence, training in interpersonal communication, including gender sensitive

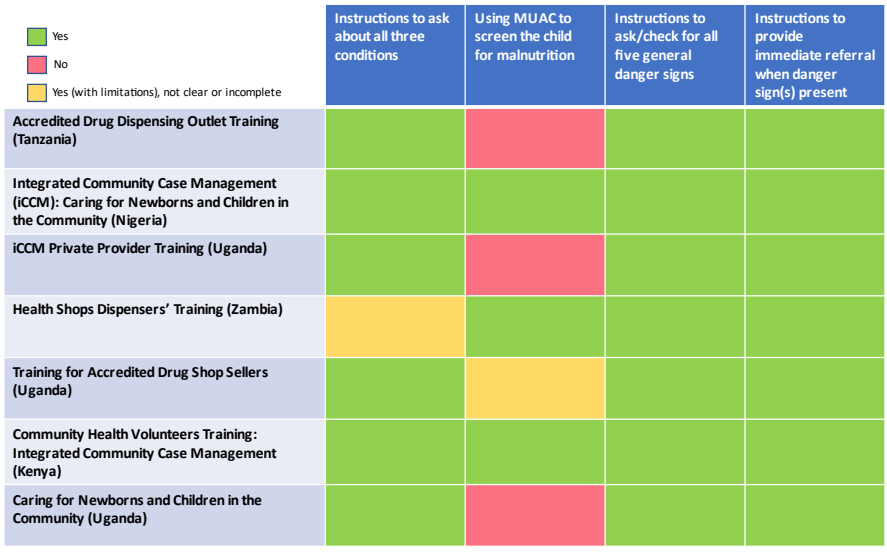
communication, is an important component of an iCCM training curriculum. In our review, we noted a varied level of focus on interpersonal communication. Three of seven curricula included a full session on good communication skills. One curriculum did not cover interpersonal communication, and the remaining three were missing a skills-building component related to communication.

While there were no stand-alone sessions on preventive measures for key iCCM conditions, five of seven curricula covered information on prevention during other sessions. Key preventive measures addressed during training were immunization, good hygiene, nutritious food, breastfeeding, feeding during illness, and sleeping under treated mosquito nets. In the two remaining curricula, information on prevention was very brief or incomplete. Criteria related to technical content and how many curricula incorporated these areas are summarized in Figure 5. More detailed information is available in the Curricula Review Matrix.

6.3.1 CONTENT RELATED TO GENERAL ICCM STEPS

As noted above, one of the seven curricula did not explain that providers should ask about all three conditions regardless of the reasons the caregiver has given for bringing the child to the provider. As part of iCCM, providers should also be screening children under 5 for malnutrition using mid-upper arm circumference (MUAC) strip. Only three of the seven curricula reviewed included content on how to use MUAC to screen children for malnutrition. Another critical element of iCCM is ensuring that providers are checking and asking about all five general danger signs (chest in-drawing, convulsions, not able to drink/breastfeed, vomits everything, lethargy/unconscious), to ensure that children with severe illness are immediately referred. All seven curricula included information about systematically checking and asking about all five danger signs as well as instructions to immediately refer a child once a danger sign has been identified. Criteria related to the general iCCM steps and how many curricula incorporated them are summarized in Figure 6. More detailed information is available in the Curricula Review Matrix.

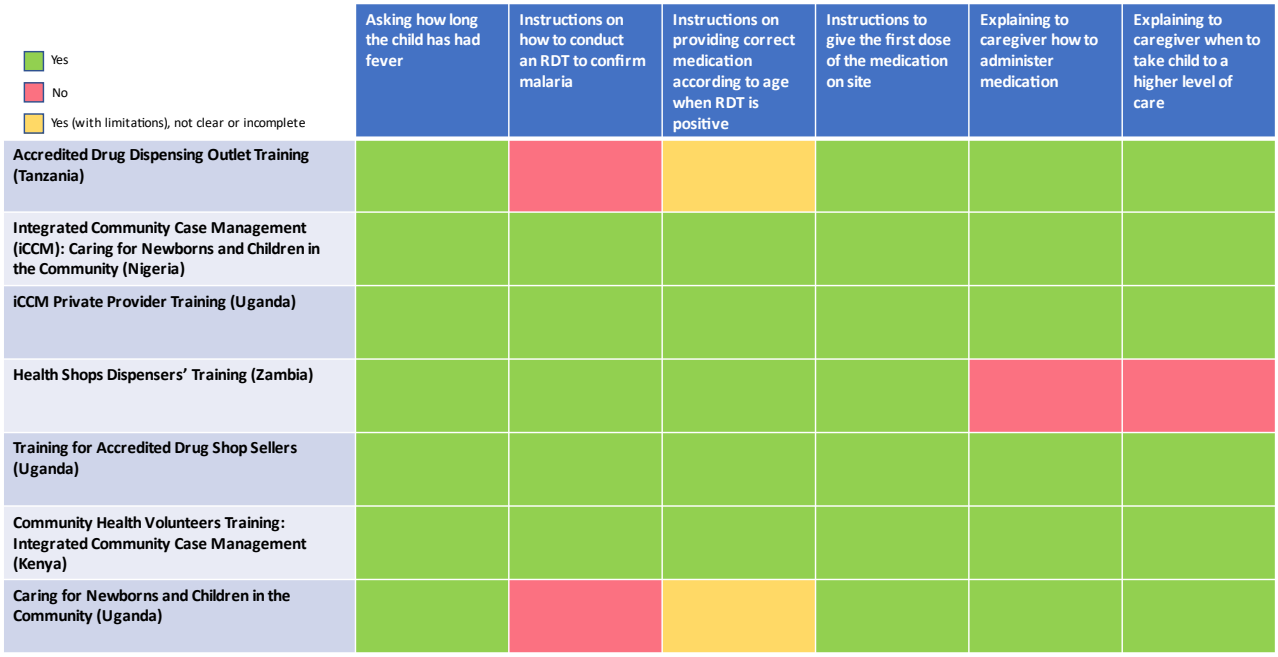
Figure 6. Curricula covering content related to general iCCM steps



6.3.2 CONTENT RELATED TO FEVER

In adherence with the global iCCM guidelines, all seven curricula included content specifying that if the child has a fever, the provider should ask about the duration. Five of seven curricula included instructions on how to conduct an RDT to confirm whether a child with a fever has malaria. The remaining two curricula may not have included this because they were developed before 2011, when this guidance changed. Five of the seven curricula reviewed included instructions on providing correct medication according to the child's age in cases when the RDT is positive. The other two curricula included information on the correct medication to give to a child with malaria; however, it was not based on a positive RDT but simply the presence of a fever. All seven curricula included instructions to provide the first dose of malaria medication on-site, per the global guidelines. Six of seven curricula included information on explaining to the caregiver how to administer the malaria medication, which is critical to ensure caregivers feel comfortable correctly administering the medication to the child at home per the dosage instructions. Six of seven curricula included content on advising the caregiver when to take the child to a higher level of care (e.g., health facility). The global guidelines require this because the child needs to receive medical attention and be treated by a trained clinician if their condition persists or worsens at home. Key elements related to fever and how many curricula incorporated them are summarized in Figure 7. More detailed information is available in the Curricula Review Matrix.

Figure 7. Curricula incorporating individual elements related to fever



6.3.3 CONTENT RELATED TO DIARRHEA

Our review of technical content related to diarrhea focused on coverage of six key elements during the training: (i) how long the child had diarrhea, (ii) whether there is blood in stool, (iii) instructions to refer if there is blood in stool (based on history), (iv) providing a first dose of oral rehydration salts

(ORS) and zinc, (v) explaining to the caregiver how to administer medication, and (vi) when to take the child to a higher level of care. While six of seven curricula covered all six key elements, one curriculum covered the first five elements. This curriculum did not provide clear instructions for caregivers per the global guidelines on when to seek a higher level of care if the child's condition worsened or did not improve at home. Key elements related to diarrhea and how many curricula incorporated them are summarized in Figure 8. More detailed information is available in the Curricula Review Matrix.

Figure 8. Curricula incorporating individual elements related to diarrhea

Yes / No / Yes (with limitations), not clear or incomplete	Asking how long the child had diarrhea	Asking if there is blood in stool	Instructions to refer if blood in stool is present based on history	Instructions on providing first doses of ORS and Zinc if no blood in stool based on history	Explaining to caregiver how to administer medication	Explaining to caregiver when to take child to health center
Accredited Drug Dispensing Outlet Training (Tanzania)						
Integrated Community Case Management (iCCM): Caring for Newborns and Children in the Community (Nigeria)						
ICCM Private Provider Training (Uganda)						
Health Shops Dispensers' Training (Zambia)						
Training for Accredited Drug Shop Sellers (Uganda)						
Community Health Volunteers Training: Integrated Community Case Management (Kenya)						
Caring for Newborns and Children in the Community (Uganda)						

6.3.4 CONTENT RELATED TO COUGH/DIFFICULTY BREATHING

For technical content related to cough and fast breathing, we focused on curricula coverage of five key elements per the global guidelines: (i) asking how long the child has had cough/difficulty breathing, (ii) the cut-off points that signal fast breathing for different age ranges and instructions to measure the respiratory rate of the child for one minute, (iii) instructions to provide correct medication for the child's age in cases when fast breathing (as defined in the iCCM guidelines) is identified, (iv) instructions to give the first dose of the medication on-site, and (v) explaining to the caregiver when to take the child to a higher level of care. All seven curricula addressed the first element; the second element was addressed in all but one curriculum. The third element was covered in five curricula; the remaining two did not address the issue or simply instructed the participants to refer all children with suspected pneumonia to a health facility. While the fourth element recommends that the first dose of medication be given to the child on-site, only four curricula included this. Of the remaining curricula, one instructed learners to provide the dose only for children in need of referral, not for those who require home care. The other two did not cover this recommendation. The fifth element was addressed in five of the seven curricula. Key elements related to cough/difficulty breathing and how many curricula incorporated them are summarized in Figure 9. More detailed information is available in the Curricula Review Matrix.

Figure 9. Curricula addressing individual elements related to cough/difficulty breathing

Yes
No
Yes (with limitations), not clear or incomplete

	Asking how long the child has cough/difficulty breathing	The cutoff points that signal fast breathing for the different age and instructions to measure the respiratory rate	Instruction to provide correct medication for child's age in cases when fast breathing is identified	Instructions to give the first dose of the medication on site	Explaining to caregiver when to take child to health center
Accredited Drug Dispensing Outlet Training (Tanzania)					
Integrated Community Case Management (iCCM): Caring for Newborns and Children in the Community (Nigeria)					
iCCM Private Provider Training (Uganda)					
Health Shops Dispensers' Training (Zambia)					
Training for Accredited Drug Shop Sellers (Uganda)					
Community Health Volunteers Training: Integrated Community Case Management (Kenya)					
Caring for Newborns and Children in the Community (Uganda)					

6.3.5 CONTENT RELATED TO GENDER AND YOUTH CONSIDERATIONS

As we intend to develop content aiming to be gender responsive and youth inclusive for the integrated curriculum, we reviewed the curricula for inclusion of information on gender-related issues, such as involving partners in children's health care and/or gender imbalance when it comes to access to care and health care decisions. We also reviewed whether the content specifically addressed youth inclusion. Young mothers and caregivers may have limited decision-making power, resulting in delays in seeking care or not seeking care, and gender and social norms should especially be considered when counseling younger clients. While gender and youth barriers can affect timeliness and effectiveness of the treatment, none of the reviewed curricula included gender- or youth-related content.

Criteria related to gender and youth discussion and how many curricula incorporate them are summarized in Figure 10. More detailed information is available in the Curricula Review Matrix.

Figure 10. Curricula discussing gender and youth

Yes
No
Yes (with limitations), not clear or incomplete

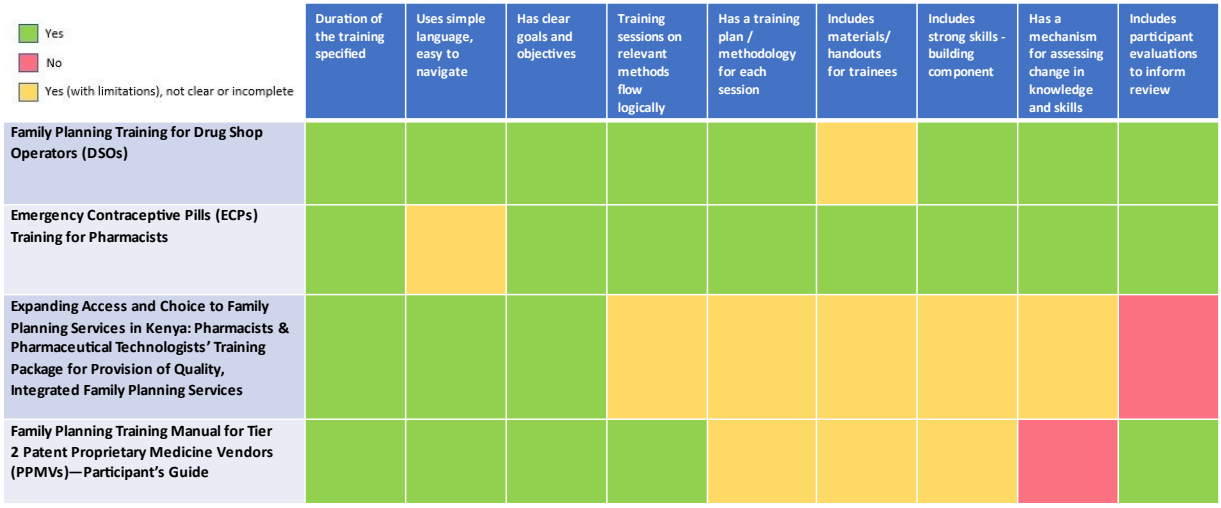
	Discussions on gender considerations are included as part of the iCCM related curriculum	Discussions on youth considerations relevant to iCCM content are included as part of the curriculum
Accredited Drug Dispensing Outlet Training (Tanzania)		
Integrated Community Case Management (iCCM): Caring for Newborns and Children in the Community (Nigeria)		
iCCM Private Provider Training (Uganda)		
Health Shops Dispensers' Training (Zambia)		
Training for Accredited Drug Shop Sellers (Uganda)		
Community Health Volunteers Training: Integrated Community Case Management (Kenya)		
Caring for Newborns and Children in the Community (Uganda)		

7. SUMMARY OF THE REVIEW RESULTS FOR FP/RH CURRICULA

7.1 CURRICULUM DEVELOPMENT/DESIGN

Three of the four FP/RH curricula obtained for the review were developed by or with the local MOH and regulatory bodies, such as national drug authorities, pharmacy associations and councils, and medical councils. The fourth, a global curriculum, was a collaboration of WHO, USAID, and the United Nations Population Fund (UNFPA). All curricula clearly defined the target audience as being pharmacy or drug shop personnel, but only two of the four specified further criteria for trainee selection. All four curricula were clearly written and started their sessions with specific, measurable, realistic objectives, though one curriculum could be difficult to navigate as content was spread across several documents. Three of the four curricula were organized in a straightforward way, while the remaining curriculum's participant's manual was inconsistently organized and contained information more appropriate to higher level cadres. Remaining curricula design criteria and how many curricula incorporated them are summarized in Figure 11. More detailed information is available in the Curricula Review Matrix.

Figure 11. FP/RH curricula incorporating individual curricula design criteria



7.2 TRAINING METHODOLOGY

Given the critical role of high quality, respectful, and nonjudgmental FP counseling in ensuring informed choice in FP provision,[15] skills-building methodologies such as case study scenarios, role playing, and practicums related to counseling were of particular importance in our review. Also, as three of the four curricula were associated with a new task-sharing policy to provide injectables through this cadre, and drug shop vendors in particular may not have had training in providing injections, we noted where curricula provided time for clinical practice during the training. As with the iCCM curricula, we looked at the use of job aids during training to ensure trainees are equipped with a reference to support them after training.

Three of the four FP/RH curricula reviewed use participatory methodologies including (in various combinations) brainstorming sessions, discussions, small group work, role plays, case studies, interactive presentations, and clinical practice. The remaining curriculum included some skills-building exercises, but they were not extensive. This was likely due to a limitation we had with this package as we obtained only the participant's version of the training manual. Two of the four curricula did not include time for clinical practicums. This was logical for one of them due to its focus on emergency contraceptive pills (ECP) provision, and again, the limitation of having only the participant's version of the training manual may explain the lack of clinical practice time indicated in the other curriculum. While the two remaining curricula provided significant time for clinical practice (nine hours and 12 hours, respectively), particularly for injection practice, only one curriculum gave instruction on what should be practiced or how to assess skills.

Two of the four curricula included job aids such as pregnancy/medical eligibility screening checklists and management of side effects. Additional job aids provided in these curricula included frequently asked questions on ECPs, contraception following ECP use, a competency- based checklist for pharmacists providing ECPs, caring for a needlestick injury, and giving intramuscular or subcutaneous injections of depot-medroxyprogesterone acetate (DMPA). The remaining two curricula referenced

handouts and job aids, but they were not included in the materials we obtained. Criteria related to training methodology are summarized in Figure 12. More detailed information is available in the Curricula Review Matrix.

Figure 12. FP/RH curricula incorporating training methodology criteria

Yes

No

Yes (with limitations), not clear or incomplete

	Includes multiple methods of teaching and learning	Job aids used during training
Family Planning Training for Drug Shop Operators (DSOs)		
Emergency Contraceptive Pills (ECPs) Training for Pharmacists		
Expanding Access and Choice to Family Planning Services in Kenya: Pharmacists & Pharmaceutical Technologists' Training Package for Provision of Quality, Integrated Family Planning Services		
Family Planning Training Manual for Tier 2 Patent Proprietary Medicine Vendors (PPMVs)—Participant's Guide		

7.3 TECHNICAL CONTENT

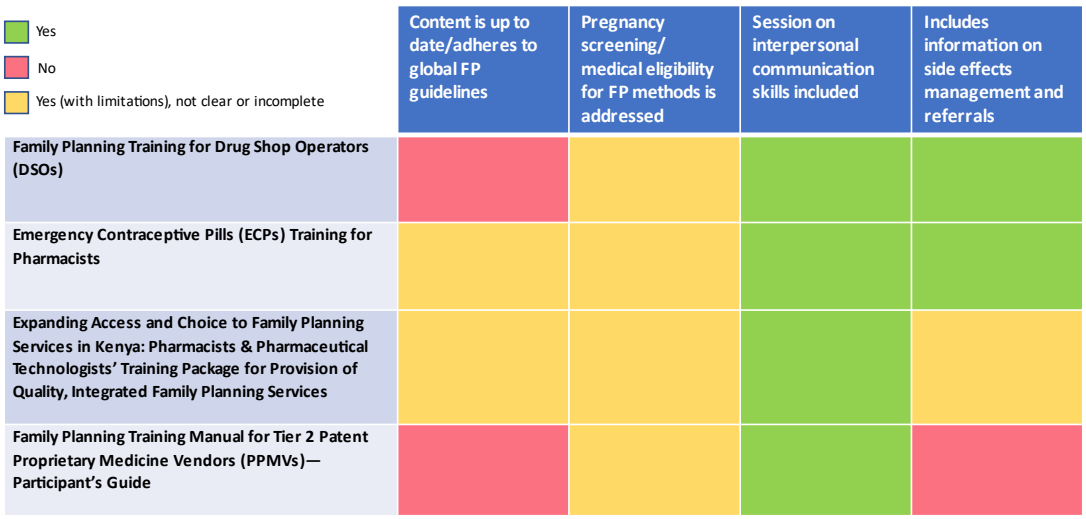
We reviewed all FP/RH curricula against the current version of the Global FP Handbook (2018) to assess the technical accuracy of the content. Additionally, we reviewed the extent to which each curriculum taught screening for pregnancy and medical eligibility, interpersonal communication skills, and information on side effects management and referrals to higher level care.

Per dates published in the training materials, three of the curricula were developed or updated in 2018 or 2019, while some components of the remaining training package were updated between 2015 and 2019. However, none of the four curricula reviewed were completely current and accurate across the entirety of their training materials. Two of the curricula had generally accurate and up-to-date information across the training package, with inconsistencies in some places. For example, one curriculum included outdated information about medical eligibility and starting progestin-only pills when breastfeeding. Presumably, it was developed before the 2018 Global FP Handbook was published as it does not include the handbook's 2018 updates. In another example, a curriculum included outdated information about when to start or restart contraception after using ECPs and about drug interactions reducing ECP effectiveness. The remaining two curricula included other inconsistencies across the training package, with one curriculum featuring clinical guidance from 2008 and 2010 despite being finalized in 2019, and the other having outdated information on management of side effects and on drug interactions with antiretroviral medications (ARVs), among others. Should a program implementer use any of the curricula in building their own training materials, the technical content should be reviewed carefully to ensure it aligns with current global guidance.

One set of training materials was notable for inclusion of screening for integrated services such as cervical cancer, breast cancer, dual protection related to sexually transmitted infections and HIV, and reproductive coercion and intimate partner violence. However, this curriculum did not provide instruction on how a pharmacist or drug shop vendor would conduct this screening, as many of the screening questions are personal and require privacy and established trust.

Criteria related to technical content and how many curricula incorporate them are summarized in Figure 13. More detailed information is available in the Curricula Review Matrix.

Figure 13. FP/RH curricula addressing individual technical content areas



7.3.1 PREGNANCY AND MEDICAL ELIGIBILITY SCREENING

Three of the curricula included information on pregnancy and medical eligibility screening before FP provision with some inaccuracies or inconsistencies. The remaining curriculum provided conflicting information about ECPs provision. Current global guidance dictates that no health conditions prevent use of ECPs and that no pregnancy test or other physical examination is required before using ECPs. However, this curriculum includes contradictory instructions to screen for pregnancy and for drug interactions. Primarily, the inconsistencies in the other three curricula were related to the absence of instructions on screening checklists, or of updated pregnancy screening guidance advising how and when to use the pregnancy checklist versus pregnancy tests. One curriculum included extensive discussion on use of the WHO medical eligibility criteria wheel tool, but it did not include medical eligibility screening checklists, which offer clearer and more concise instructions on screening clients for category 3 and 4 conditions prior to initiation of certain FP methods. Another curriculum included information on screening for medical eligibility and for pregnancy but uses outdated versions of the WHO and Global FP Handbook guidance.

7.3.2 INTERPERSONAL COMMUNICATION SKILLS

All four curricula offered strong discussion on fostering supportive and respectful provider-client interactions, which is critical for ensuring informed choice in FP provision. Two of the curricula referenced the Balanced Counseling Strategy or the Balanced Counseling Strategy Plus approaches to comprehensive FP counseling. A third curriculum referenced the REDI counseling approach for all methods. As noted above, one curriculum included counseling for reproductive coercion and intimate partner violence. While the remaining curriculum provided discussion on creating a respectful, supportive, private, and confidential interaction, it did not provide training on comprehensive FP/RH counseling due to its method-specific focus. Additionally, all four curricula dedicated training and discussion time to dispelling myths and misconceptions with FP clients.

7.3.3. SIDE EFFECTS MANAGEMENT AND REFERRALS

Information on side effects and when to refer was inconsistent across the four curricula. Given this cadre is not permitted to provide long-acting reversible contraception (LARCs) or permanent methods, information on how to assess FP needs and when to refer for these methods is important. Two of the curricula provided extensive information on LARC and permanent methods and pointed out these methods required referral to a higher level of service. One of these curricula included a space in the participant's manual for a provider to list their chosen referral sites for tubal ligation, vasectomy, implants, intrauterine devices (IUDs), HIV/AIDS testing and counseling, antiretroviral therapy (ART), prevention of mother-to-child transmission of HIV (PMTCT), and sexually transmitted infection services, for their own future reference. The participant's training manual we obtained provides extensive information on how to insert implants as well as information on other LARCs and permanent methods but does not clearly note that this cadre must refer to other FP providers for these methods. All four curricula provided some information on side effects, though two curricula did not include clear instructions on how to manage side effects at the client or pharmacy/drug shop level, nor did they include clear instructions on when side effects required higher level care. While a third curriculum gave information to the pharmacy or drug shop provider on how to manage minor side effects, it did not consistently provide information on when to refer to higher level care for side effects management. Due to its focus on ECPs, the fourth curriculum provided comprehensive information on expecting and mitigating side effects for this method as well as a dedicated handout as a job aid.

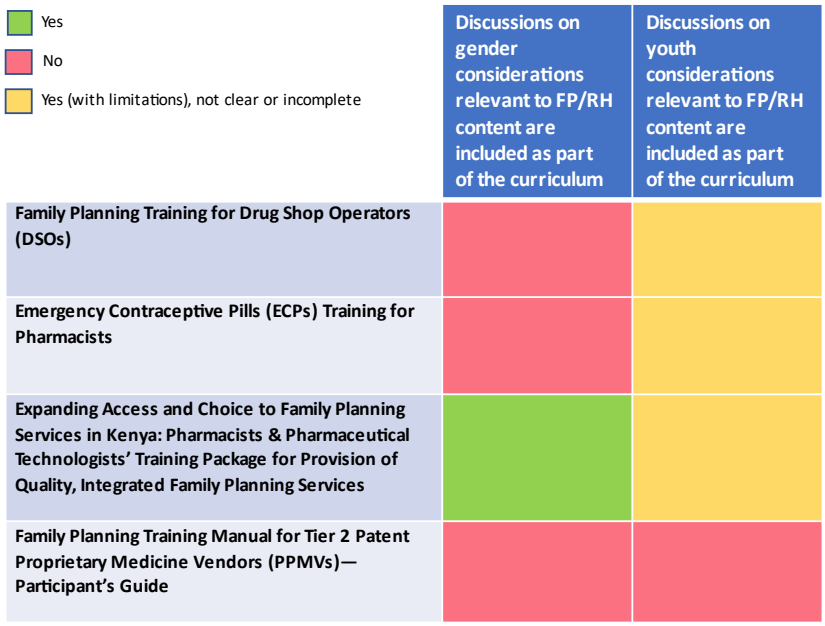
7.3.4 CONTENT RELATED TO GENDER AND YOUTH CONSIDERATIONS

We noted where curricula included discussion of gender and youth considerations, if any. Relative to men, women's weak decision-making power over her time-usage, financial resources, mobility, and her own reproductive health all greatly affect FP access, as do male gender norms that encourage fertility, favor male children, and discourage men from seeking health care. Apart from the curriculum that provided significant training time to discuss reproductive coercion and intimate partner violence, meaningful discussions related to gender were scant across the remaining curricula. Similarly, content on youth inclusion in FP provision were inconsistent across the curricula, though some case studies and scenarios during skills-building sessions featured stories of adolescents accessing FP/RH

services. Given the complexity of these topics, it could be assumed the curricula authors expected an additional and separate training would be needed to cover them in-depth. However, as pharmacies and drug shops are particularly important to FP access for younger and more vulnerable populations, taking advantage of the time spent with these trainees to render their service more gender responsive and youth-inclusive could benefit existing and future clients.

Criteria related to gender and youth discussion and how many curricula incorporate them are summarized in Figure 14. More detailed information is available in the Curricula Review Matrix.

Figure 14. FP/RH curricula discussing gender and youth



7.3.5 FP/RH CONTENT WITHIN ICCM CURRICULA

Two of the iCCM-focused curricula included sessions dedicated to FP/RH. It appears both curricula drew FP/RH content from the same or similar sources because their FP/RH sessions are practically identical. Overall, the technical FP/RH content was relatively limited, and it focused on provision of male and female condoms, combined oral contraceptives, and progestin-only pills. FP/RH supplements in both participant manuals included other methods that required referral at the time each curriculum was developed. In both curricula, the FP/RH content is not current or aligned with the 2018 Global FP Handbook. Both curricula included information on side effects for each method covered, when to seek urgent medical attention, and screening handouts for pregnancy and medical eligibility, though these handouts were not up to date. However, there was no instruction in principles of informed choice or the importance of counseling in FP, and while the sessions included role-play exercises, it is not clear if providers were instructed to interact with clients in a respectful, nonjudgmental manner.

Criteria related to FP/RH elements within iCCM curricula and how many curricula incorporate them are summarized in Figure 15. More detailed information is available in the Curricula Review Matrix.

Figure 15. FP/RH elements within iCCM curricula

8. RECOMMENDATIONS

In summary, while the curricula we obtained and reviewed offer useful foundational iCCM/FP/RH content and resources appropriate for this cadre, we did not find a curriculum with an ideal, complete, or comprehensive training package that fit our purposes in either health area. Generally, most of the curricula followed a logical structure; were organized around specific, measurable, and realistic objectives; and incorporated participatory training methodologies and skills-building exercises. Many of the job aids in these curricula, along with select role-playing exercises and case study scenarios, are practical and compelling tools to adopt or adapt for our own, and other, training packages. The majority of the iCCM curricula reviewed follow most (if not all) global recommendations and utilize country-specific versions of the Sick Child Job Aid. Unfortunately, because full sets of training materials were either not obtainable or the materials contained outdated information (or were missing some information), none of the curricula we reviewed could be used without being updated. The FP/RH curricula reviewed offered strong interpersonal communication and counseling content, in particular. However, as noted above, technical accuracy was uneven across all curricula in both health areas so that any curriculum would require a close review against current global and national guidance before borrowing technical content. Also, the consistent lack of discussion on gender and youth themes was a clear gap and missed opportunity across all curricula for both ICCM and FP/RH.

We recognize that a successful service delivery program does not rely solely on provider training; it requires a multifaceted and comprehensive set of elements, including clear policies and guidelines, a strong supply chain, effective supportive supervision and quality assurance, reliable monitoring and recording/reporting systems, and functioning referral linkages.[16] However, this review focuses on training materials used with pharmacy and drug shop staff for select iCCM and FP services. Thus, the recommendations below are related to our review's focus only and do not include broader programmatic recommendations. We also recognize that expanding access to ICCM and FP services through this cadre is a promising approach but requires more evidence. Programs, in general, need a better understanding of how emerging evidence translates to practice, and what is and is not realistic within a real-world pharmacy or drug shop setting (e.g., comprehensiveness of counseling, number of services that can be integrated, provider motivations, etc.). It is important to continue sharing detailed programmatic experiences related to training and subsequent service provision by this cadre. As more programmatic experience accumulates, training materials can take these "lessons learned" into consideration. Going forward, curricula developers and program implementers may consider the following points, which will also inform the development of the MOMENTUM iCCM/FP integrated curriculum:

- Ensuring better visibility/accessibility for the training curricula they develop. Most of the curricula discussed in this review were hard to obtain, and, in most cases, full training packages were not available. Having an online space where programs and local governmental counterparts can post their training materials would allow others to build on existing materials and adapt them to their needs instead of duplicating efforts and developing training curricula from scratch.
- Tailoring information and tasks in the curricula to better suit the pharmacy/drug shop environment, where privacy and time limitations can affect how iCCM/FP tasks are delivered. Some of the curricula reviewed were originally developed for community health workers (CHWs) and then used to train pharmacists and drug sellers without adaptation. Further, the materials we reviewed that were developed specifically for this new cadre of providers contained no discussion about how the tasks they are expected to perform fit into their workflow and what they can do to ensure privacy, build trust, and manage their time more effectively.
- Tailoring information, tasks, and training intensity to a particular cadre of providers (pharmacists vs. drug shop vendors). Because drug shop vendors may have limited training or no training at all, they may not be able/allowed to provide the same range of services as pharmacists and may require more time and practice.
- Ensuring technical information is based on the latest global/national guidance and updating the curricula as new evidence/guidance emerges.
- Developing training curricula in a modular structure that allows for easy integration if new components are added.

- Designing the curriculum in a way that is suitable for digital "short-burst learning,"[1] which, overall, takes place across a longer period, but may be more acceptable to busy private sector providers than a five- or 10-day in-person workshop. With this approach, they may be able to choose their own pace for theoretical portions of the training, while still being required to complete practical or skills-building components in person.
- Designing the curriculum in a way that is suitable for (or can be easily converted to) an online format to accommodate digital learning/self-paced learning. In such cases, a mechanism for assessing knowledge and skills (including offline practice) should be considered.
- Packaging all training components in a way that is easy for the trainer/facilitator to navigate and, in cases when training components are spread over several training documents, creating clear instructions and linkages for easy access and navigation.
- Including information for facilitators on how to conduct or process individual activities rather than relying on facilitators to conduct these based on their experience alone.
- Incorporating knowledge assessments, such as pre- and post-tests, and including test questions and suggested post-test passing scores as part of the facilitator manual.
- Using USAID/HRH2030's Gender Competency Framework as a guide, develop/adapt and integrate content to encourage iCCM and FP services offered at pharmacies and drug shops to be gender responsive and youth-inclusive, given the important role of these service delivery points in health care access for certain populations. The content would include a focus on the physical, cognitive, and social barriers for women and youth to accessing FP and MCH services, reflections on services providers' gender and youth biases, and practical approaches to more gender responsive and youth- inclusive services. Several materials exist[14, 17-21] that offer content that may be adapted.

[1] Also known as "microlearning," this approach is often used in business and technology sectors, especially for eLearning/virtual training situations. It refers to knowledge being delivered in smaller segments, which has been shown to increase knowledge retention and be more effective than traditional learning and is more acceptable to those who are not able to commit to several days in the classroom.
https://www.allencomm.com/blog/2020/12/learning-bursts-support-attention/

ANNEX- METHODS COVERED IN FP/RH CURRICULA

Figure 16 shows which FP methods are covered in the reviewed FP/RH curricula. The methods chosen are those for which this cadre is most likely to counsel or provide directly (i.e., condoms, oral contraceptive pills, ECPs, injectables, lactational amenorrhea method (LAM), fertility awareness methods) as well as those for which this cadre is most likely to refer (i.e., implants, IUDs, permanent methods).

Green indicates that the method is a taught component of the curriculum. *Yellow* indicates that information about the method appears in reference materials. *Red* indicates that the method does not appear in the curriculum materials.

Figure 16. Methods covered in FP/RH curricula

	Male and female condoms	Combined oral contraceptive pills	Progestin-only pills	Emergency contraceptive pills	Progestin-only injectables	Monthly injectables (CICs)	LAM	Fertility awareness methods	Implants	Copper IUD and hormonal IUD	Permanent methods
Family Planning Training for Drug Shop Operators (DSOs)					DMPA -IM & DMPA -SC only; does not include self-injection				Referral	Copper only; Referral	Referral
Emergency Contraceptive Pills (ECPs) Training for Pharmacists	Handout 4; as follow up to ECP use	Handout 4; as follow up to ECP use	Handout 4; as follow up to ECP use		Handout 4; as follow up to ECP use			Handout 4; as follow up to ECP use	Handout 4; as follow up to ECP use	Handout 4; as follow up to ECP use	Handout 4; as follow up to ECP use
Expanding Access and Choice to Family Planning Services in Kenya: Pharmacists & Pharmaceutical Technologists' Training Package for Provision of Quality, Integrated Family Planning Services					DMPA -IM, DMPA -SC & NET-EN; includes self -injection				Referral	Referral	Referral
Family Planning Training Manual for Tier 2 Patent Proprietary Medicine Vendors (PPMVs)—Participant's Guide					DMPA -IM, DMPA -SC & NET-EN; includes self -injection						Referral
Health Shops Dispensers' Training (Zambia)					DMPA -IM only; Referral		Referral		Referral	Referral	Referral
Training for Accredited Drug Shop Sellers (Uganda)					DMPA -IM only; Referral		Referral		Referral	Referral	Referral

Resources related to the Curricula Review are available:

Curricula Review Matrix

Reviewed Curricula- Resources

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