Evaluation of BRIDGE-IPC Training Programme (IPC Skills Training in Routine Immunization for Frontline Workers)

Final Presentation

IPE GLOBAL
Expanding Horizons. Enriching Lives.

unicef
for every child

Structure of the Presentation

IPE GLOBAL
Expanding Horizons. Enriching Lives.

- Background of BRIDGE-IPC Programme
- Purpose, Objectives and Scope of Evaluation
- Evaluation Methodology
- Topline findings
- Conclusion and Recommendations
- Study Limitations

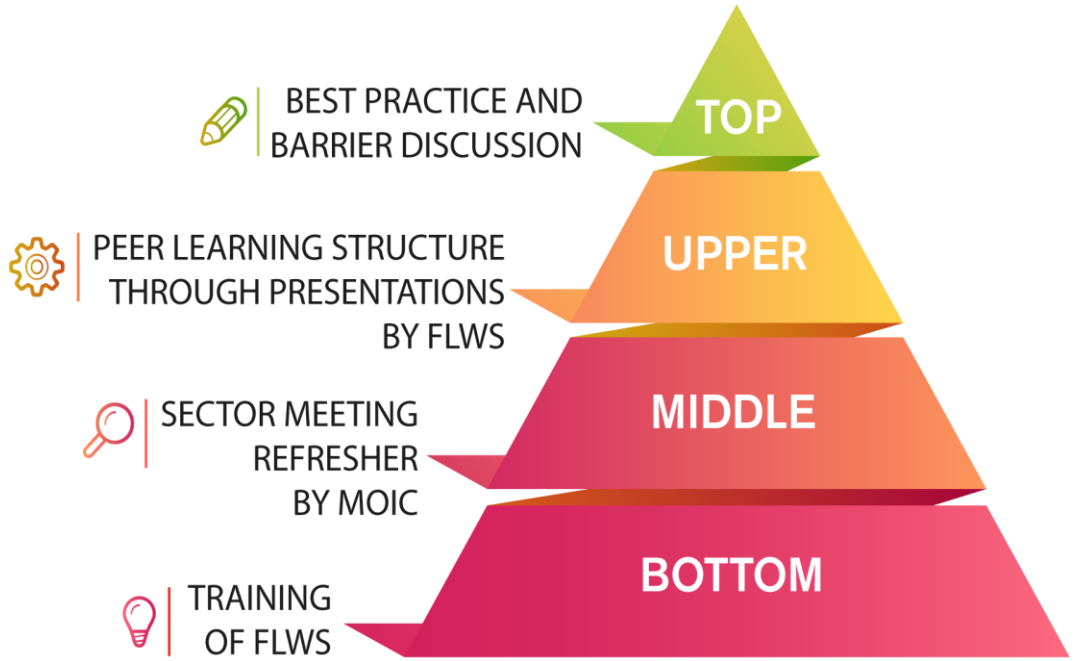
BRIDGE-IPC Training Programme

IPE GLOBAL
Expanding Horizons. Enriching Lives.

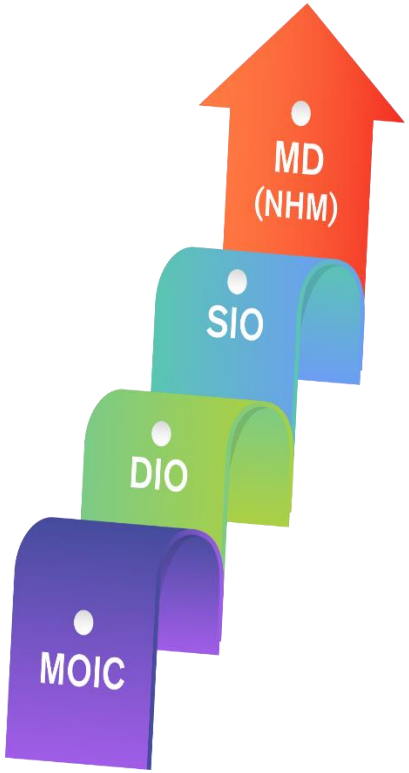
Cascading model of the BRIDGE IPC skills training

- NATIONAL LEVEL- LEAD TRAINERS
- STATE TOT- DISTRICT TRAINERS
- BLOCK FLW TRAININGS
- POST TRAINING REFRESHERS AND HANDHOLDING
- 0.01% FIELD OBSERVATION

Post-training follow-up with FLWs

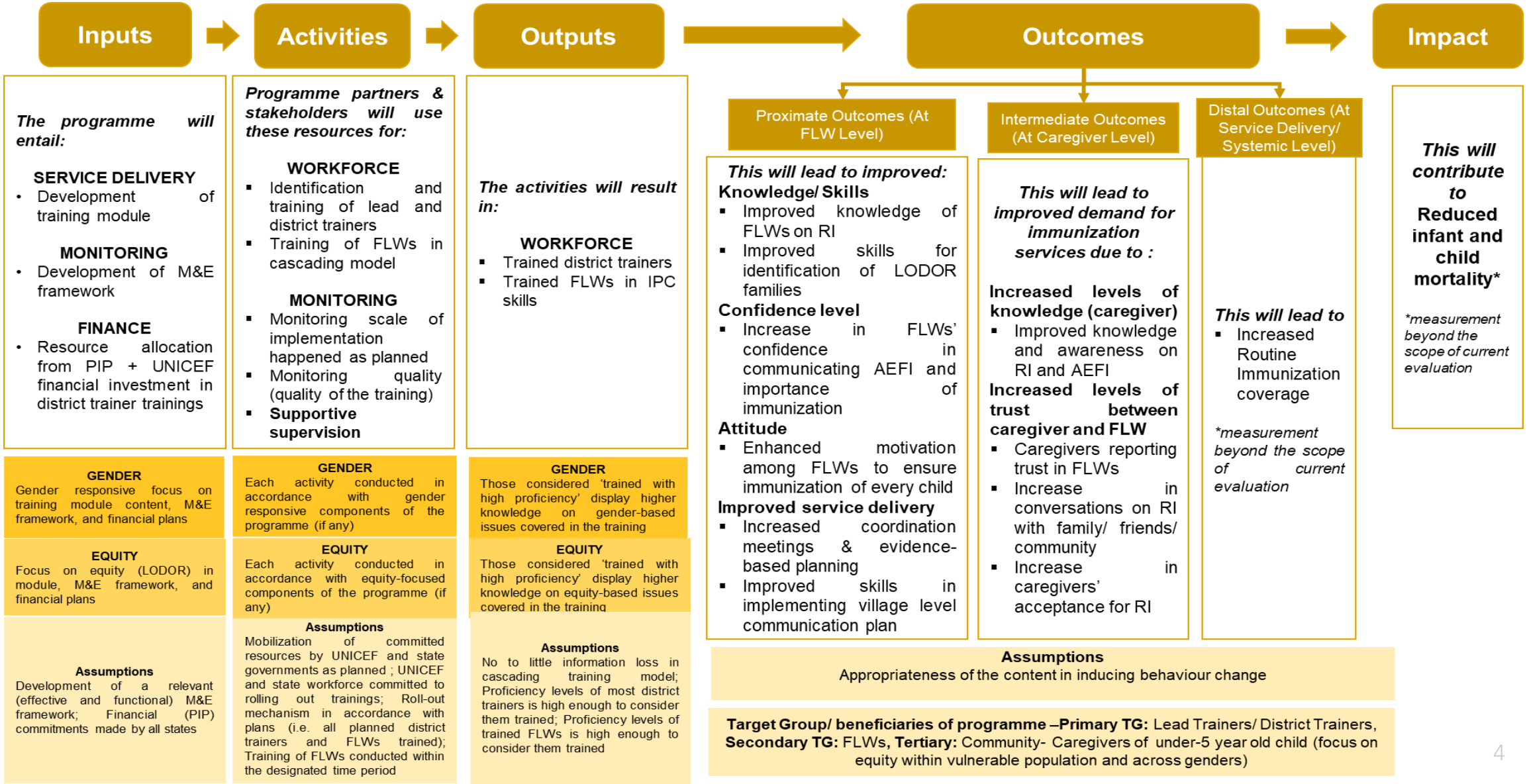


Assessment Reporting Process



This evaluation assessed planning and implementation process (what worked and what didn't work) to address the gaps related to Inter-Personal Communication Skills of FLWs (that include ASHAs & ANMs) to improve RI coverage

Theory of Change



Purpose and Scope of Evaluation

Purpose

- To gauge the level of relevance, effectiveness, efficiency and sustainability of the BRIDGE IPC skills training programme in:
- *Improving FLWs interpersonal communication (IPC) skills*
- *Improving the quality of sub-centre level demand generation and social mobilisation plans for routine immunization*

Scope

- The evaluation has assessed the programme from the development of the training module and commencement of ToTs (national lead trainers; district trainers) by UNICEF in 2017 till the date of commencement of this evaluation (November 2019)
- At this point, the evaluation is being conducted to suggest course correction to increase the effectiveness of training as they are still on-going
- *The evaluation is not assessing the impact of the training as the cascading training of FLWs is still on-going*
- **Geographical coverage:** 5 states selected for the evaluation were: **Uttar Pradesh, Rajasthan, Karnataka, Odisha and Assam**

Objectives of Evaluation

IPE GLOBAL
Expanding Horizons. Enriching Lives.

Objectives

1. To assess the **relevance** of the BRIDGE training, the ToTs and cascading training model in reaching its outcomes

2. To assess the **effectiveness** of the training in terms of the quality of training (ToTs and cascading model), the knowledge gained, and how knowledge from the training is being applied to change the behaviour of the community

3. To assess the **efficient** utilisation of available resources in meeting the objectives of training (ToT, cascading training)

4. To assess the **sustainability** of the outcomes of the BRIDGE training

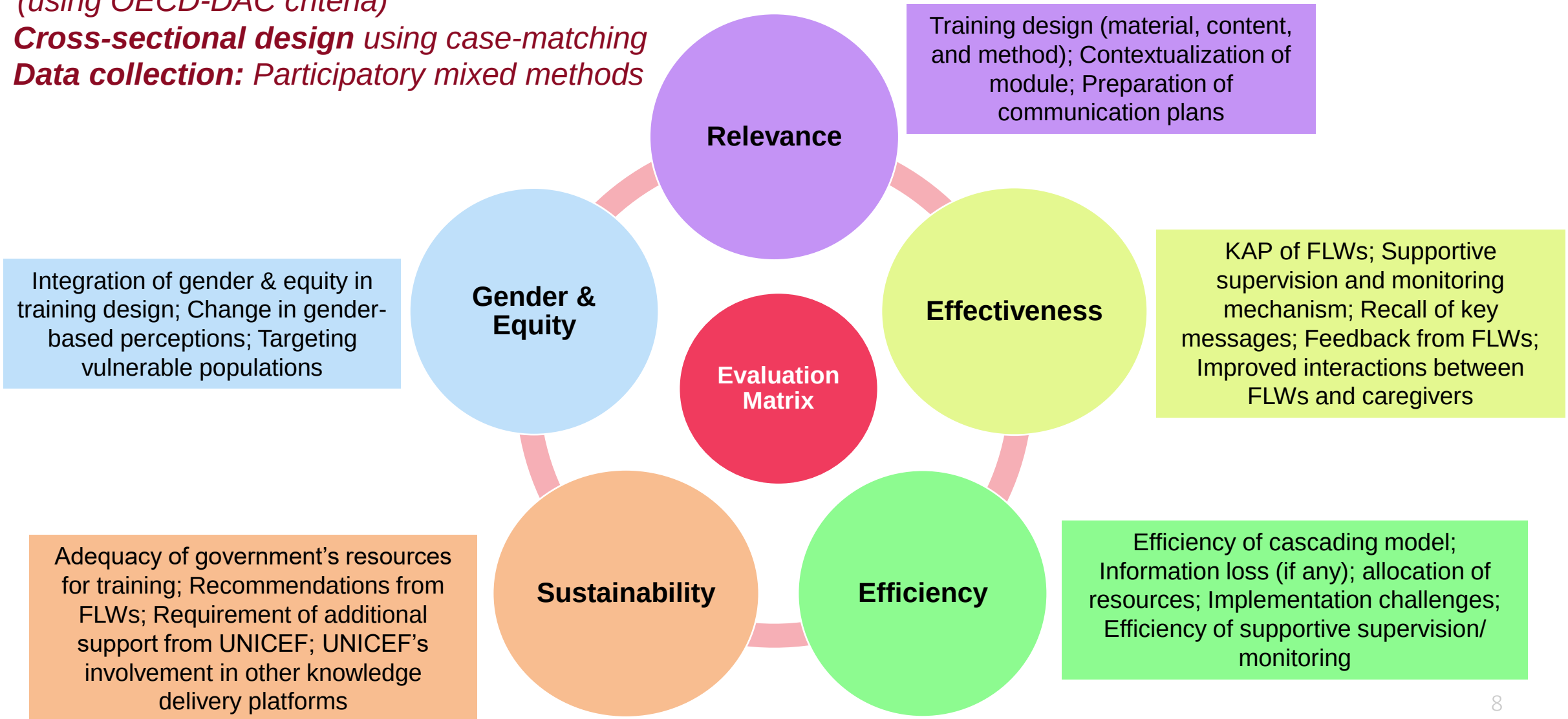
5. To understand the extent to which **gender** as an element has been incorporated in the BRIDGE programme (this is especially important since all FLWs are women)

6. To understand the extent to which **equity**) has been incorporated in the BRIDGE programme, focusing especially on the vulnerable communities

Evaluation Methodology

Evaluation Design, Areas of Enquiries & Indicators

- ***Approach:*** *Theory-based equity focussed (using OECD-DAC criteria)*
- ***Cross-sectional design*** *using case-matching*
- ***Data collection:*** *Participatory mixed methods*



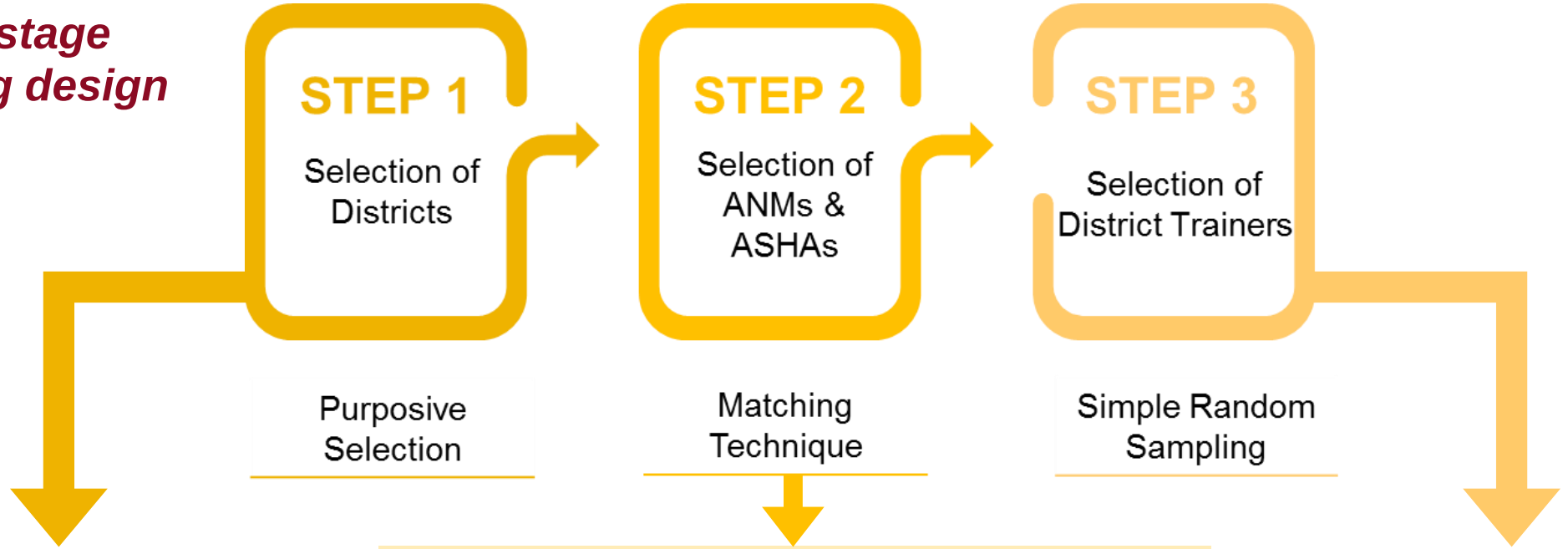
Achieved Sample Size

Particulars	Rajasthan	Odisha	Assam	Karnataka	UP	Total
No. of districts	2	2	2	2	2	10
No. of blocks (2 blocks in each district)	4	4	4	4	4	20
In-depth interview (IDIs)						
State-level						
State immunization officer	0	1	1	0	1	3
State RI Nodal Officer or State Institute of Health and Family Welfare	0	1	NA	NA	0	1
UNICEF consultant	1	1	1	1	0	4
In-depth-interviews with all lead trainers	3	3	2	2	6	16
District level						
District immunization officer	1	1	2	2	1	7
Medical officer	2	1	3	4	4	14
Block Programme Manager-NHM	2	2	4	4	4	16
Structured interviews						
District trainers - Online interview	58	146	52	144	208	608
ANMs (Auxiliary Nurse Midwife)	32	0	32	32	32	128
ASHAs (Accredited Social Health Activist)	120	152	120	120	120	632
Observations						
Observations at the immunization sites	8	8	8	8	8	40

Go to: Planned sample size

Sampling Methodology

Multi-stage sampling design



- All districts (state) were arranged in descending order of ANMs/ASHAs training coverage (%)
- 2 bottom districts selected

- Separate lists of trained and untrained ANMs/ASHAs prepared in selected districts & verified
- Verified FLWs matched using MedCalc software based on: **Age**: (+/-3 years); **Years of Education** : (+/-2 years); **Years of Experience**: (+/-2 years)
- Required no. of FLWs randomly selected from matched pairs

- List of DTs prepared in each state
- Required no. of DTs selected using a simple random sampling technique (random table)

Characteristics of FLWs: Matched Cases

IPE GLOBAL
Expanding Horizons. Enriching Lives.

% distribution of trained and untrained FLWs based on years of service (experience)#

Years of service (experience)	Total	Status on BRIDGE IPC training	
		Trained	Untrained
Up to 10 Years	35.0	35.5	34.7
11-15 Years	51.2	50.5	51.6
16+ Years	13.8	14.0	13.7
Total	**794**	**399**	**393**

% distribution of trained and untrained FLWs based on age#

Age	Total	Status on BRIDGE IPC training	
		Trained	Untrained
Below 35 Years	32.0	31.1	33.1
36-40 Years	24.2	24.3	24.2
41-45 Years	19.5	21.1	18.1
46 Years or more	24.3	23.6	24.7
Total	**794**	**399**	**393**

% distribution of trained and untrained FLWs based on education#

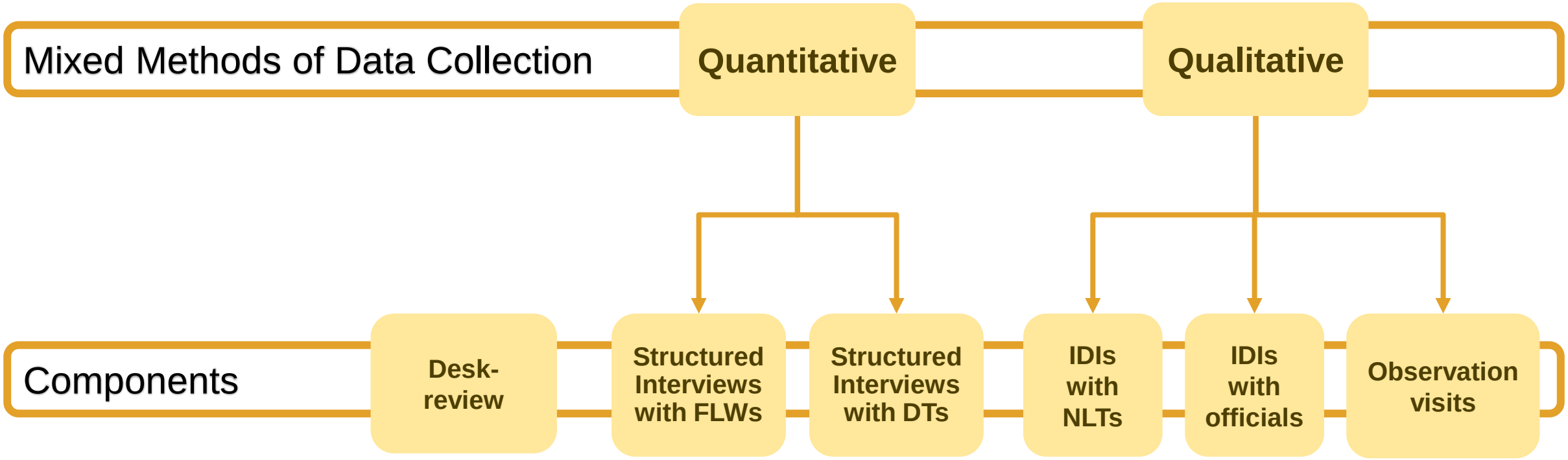
Education level	Total	Status on BRIDGE IPC training	
		Trained	Untrained
Literate with no formal education	0.3	0.3	0.3
Primary school (up to Class V)	3.8	3.8	3.8
Middle school (up to Class VIII)	28.6	24.6	32.3*
Secondary school (up to Class X)	33.6	36.3	31.0
Senior secondary school (up to Class XII)	25.4	26.3	24.7
Graduate and above	8.3	8.8	7.9
Total	**794**	**399**	**393**

Note: *Both the trained and untrained FLWs were similar in their characteristics except education level (Middle school - up to Class-VIII).*

#Percentages have been rounded off to first place

**significance tested at $p < 0.05$.*

Data Collection Methods



IDIs: *Conducted with state officials, UNICEF consultants, DIOs, MOICs and BPMs*

Observation visits at Immunization site: *Done for ANM using a checklist*

Ethical Considerations

IPE GLOBAL
Expanding Horizons. Enriching Lives.

Best practices followed:

- Assurance of no coercion for engaging the participants in the interviews
- Informed consent taken from participants
- Assurance that participation in the evaluation will not lead to any negative consequences for the participants
- Confidentiality of participants ensured
- Data stored securely

Overall, the UNEG Code of Conduct for Evaluation in the UN System was strictly followed

Team members underwent the course on Ethics- 'Introduction to Ethics in Evidence generation'

Data Analysis Methods

IPE GLOBAL
Expanding Horizons. Enriching Lives.

Review of Documents

- Documents reviewed for programme's content, planning & implementation modalities & challenges (analytical and field reports, operational guidelines, proficiency data)
- *Helped develop tools and triangulate primary findings*

Quantitative Data Analysis

- Key indicators computed & output tables generated using **STATA**
- Observation Checklists used to check processes adopted by ANMs at immunization sites
- *Helped to understand how FLWs' skills & knowledge developed through programme have translated into practice*

Qualitative Data Analysis

- Deeper understanding of stakeholders' experience/ perceptions
- **Step 1:** Transcription & translation of discussions in English
- **Step 2:** Content analysis format developed using NVivo to categorise responses
- **Step 3:** Code list generated to undertake data analysis

Triangulation of Data

- Deepening & widening the understanding of findings
- Validation of data from different sources
- Testing consistency of findings from primary data collection & literature review

Key Findings

Relevance-1

1.1. How well does training design (material/content, method) respond to the training objectives, FLW needs and expectations, and different contexts?

Training material/content & methods were consistent to address training objectives of building IPC skills of the FLWs:

- For **mobilising communities** on RI
- For **building community's confidence** in vaccination
- For **developing the village-level communication plan**
- For **tracking vulnerable children** (LODOR families)
- *Local contextualisation depicting culturally appropriate illustrations suggested in non-Hindi states*

FLW needs and expectations & different contexts

- **FLWs** found training content relevant for **building IPC skills**
- **Training relevant** to **address local issues**
- FLWs **understood content**
- **Top 3 methods liked by FLWs:** videos/films, presentations, and role-play
- Training used **participatory approach (platform for discussion)**

Illustrations and material were found relevant but require further contextualization; Out of the 89.1% of the DTs who received feedback from FLWs

1. *FLWs found the content was useful to build IPC skills (**Overall:** 80.0% DTs)*
2. *FLWs found the training material was comprehensive (**Overall:** 63.2% DTs)*
3. *FLWs found training content too technical (**Overall:** 50.7% DTs)*
4. *FLWs found content too generic (**Overall**: 26.3% DTs)*

Relevance-2

1.2. How relevant is the BRIDGE IPC training in strengthening the building blocks of health systems?

Training relevant in strengthening health workforce and service delivery

Workforce

- **Developed skills in FLWs** to reduce vaccine hesitancy, awareness gap and apprehensions for AEFI within their communities

Service delivery: Improved capacity and action for service delivery through trained FLWs in

- Development of village communication plan
- Identification of key barriers
- Preparation of list of LODOR families
- Engagement of influencers to address RI barriers

1.3. How well does the SBCC plan help in the preparation of communication plan and in addressing barriers against immunization?

The SBCC plan helped trained FLWs in preparing social mobilisation/communication plan for identifying influencers

- 72.7% trained FLWs prepared **village level communication plan**

- **Officials: Communication plans developed by FLWs covered all high-risk areas**, helped FLWs to spread awareness about RI

Reasons quoted by FLWs who did not prepare village communication plan:

1. FLWs did not find it relevant (45.0%)

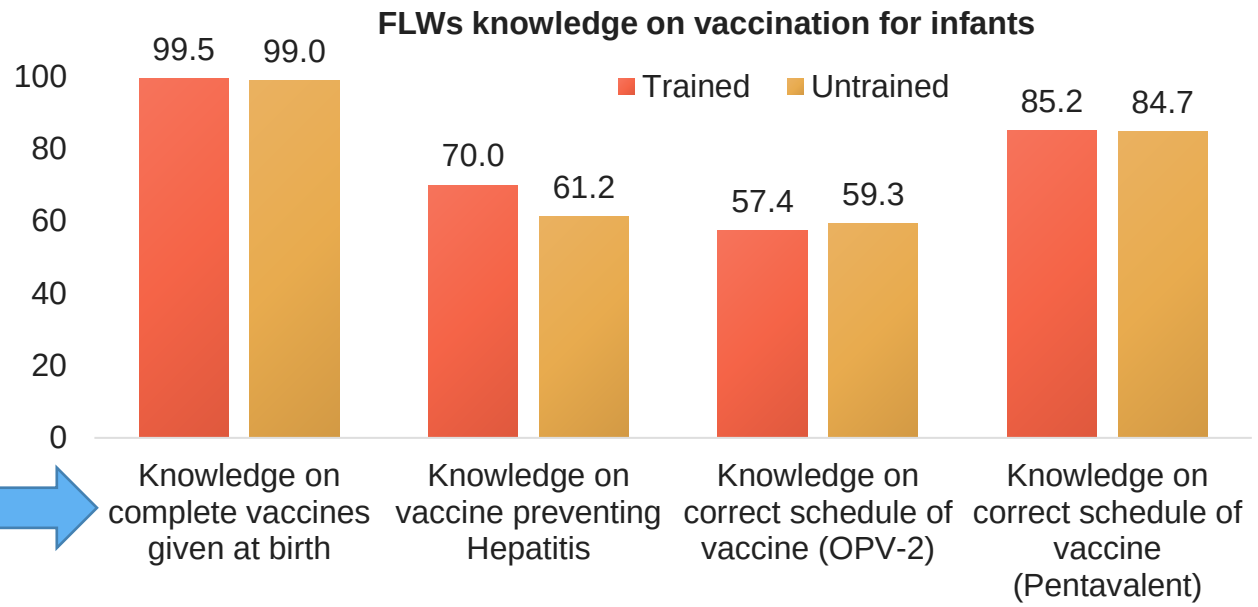
2. FLWs did not get time to prepare it (11.9%)

Effectiveness-1

2.1. How has the training been able to influence (directly/indirectly) the frontline workers' knowledge, attitude, and practices?

The training has influenced the FLWs knowledge, attitude and practices around routine immunization.

For Knowledge: Significant difference between trained (70.0%) and untrained (61.2%) FLWs' knowledge on disease prevented by Hepatitis B**



The attitudes of the FLWs on RI practices	Status on BRIDGE IPC training (%)	
	Trained	Untrained
Community members look up to ASHA/ ANMs for advice	96.5*	93.1
Building confidence of community to improve acceptance of vaccination	96.5***	90.3
Important to provide immunization to all children irrespective of caste, religion, gender	97.0***	91.1
Important to provide immunization to all children irrespective of socio-economic status	96.0**	91.3
N	**399**	**393**

Attitude: Significant differences between trained and untrained FLWs on attitudes towards RI practices

*Significance level: (p< 0.001***; 0.01**, 0.05*)*

Effectiveness-2

Practice

The majority of the FLWs felt equipped as training was effective in building new skills

- The FLWs reported positive influence of the training on **communication skills for interacting with parents and caregivers (87.0%)**
- FLWs reported enhanced knowledge (87.0%) and convincing power (69.0%)
- FLWs developed skills in evidence-based planning (**Overall:** 47.0%; 18.0% in Odisha to 98.0% in Karnataka)
- FLWs were skilled in outreach and advocacy (**Overall: 53.0%;** 12.0% in Assam to 97.0% in Karnataka)

More trained FLWs than untrained FLWs:

- **Used IPC skills** (responding to the community's concerns) for **improving community's confidence** in immunization (trained 89.8%***, untrained 80.8%)
- Discussed **about management of minor AEFI** (trained: 48.5%, untrained: 41.2%)

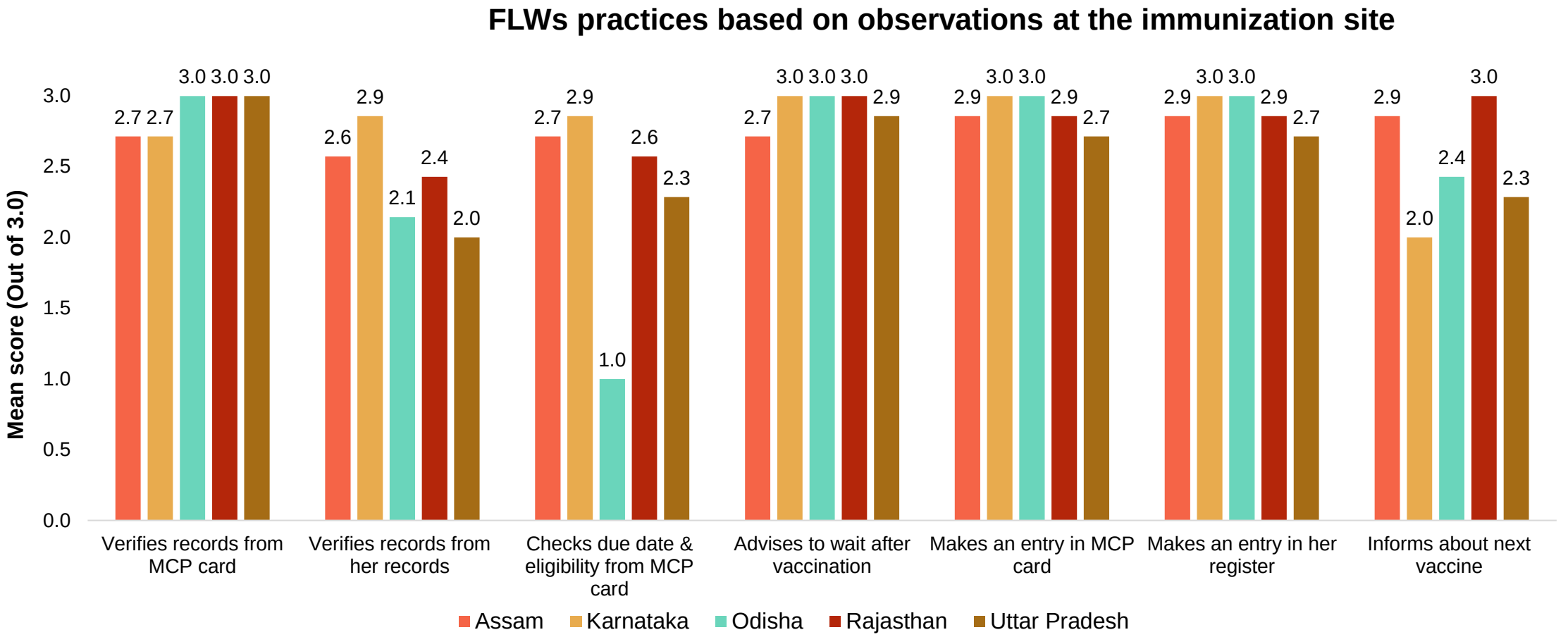
- **Top 3 influencers recognised by trained FLWs-** family elders, teachers, religious leaders
- **Trained FLWs more likely to target left out children** than untrained FLWs

Methods used by FLWs to track left out children	Status on BRIDGE IPC training (%)	
	Trained	Untrained
Prepare a LODOR list	38.3*	31.0
Home visits	84.2	79.4
Community Meetings	72.7	66.7
N	**399**	**393**

Significance level: (p< 0.001; 0.01**, 0.05*)***

1. Significant differences between trained and untrained FLWs with respect to preparing LODOR list to track left out children

Effectiveness-3



Findings through observations of immunization sites:

- **Most FLWs followed recommended steps from training** (Mean score (out of 3) of various practices)
- Mean score of **Karnataka and Odisha were higher** than other states

Effectiveness-4

2.2. Were the supportive supervision and monitoring mechanisms effectively utilised?

The supportive supervision & monitoring mechanisms were implemented for improving FLWs' performance, confidence, with wide variation across 5 states

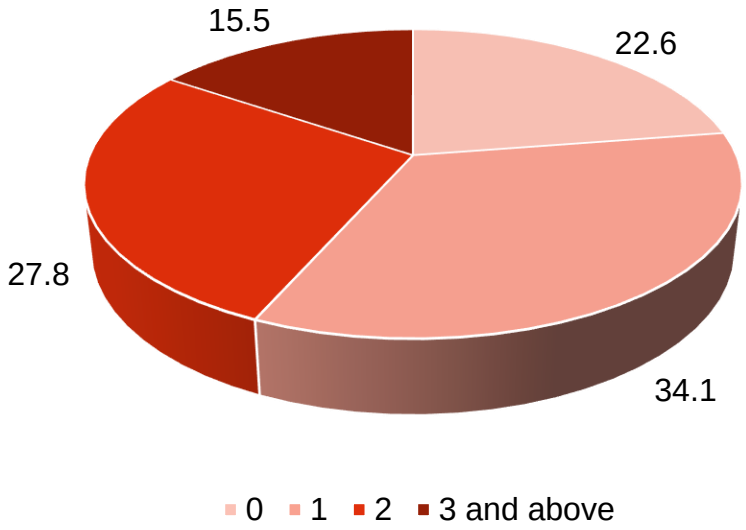
Supportive supervision:

- **Three-fourths of DTs received supportive supervision** since last training (**Assam** - 65.1%) mostly **from DIO**
- **22.6% FLWs** did not receive any handholding support in the last 6 months
- 93.0% FLWs received post-training follow-up **during monthly sector meetings**
- **Assam** – a dedicated app to implement supportive supervision

Monitoring:

- **Review meetings at district level** assessed training progress
- Local data was used to **monitor FLWs performance and resolve problems**

Frequency of handholding support received by FLWs in the last 6 months (%)

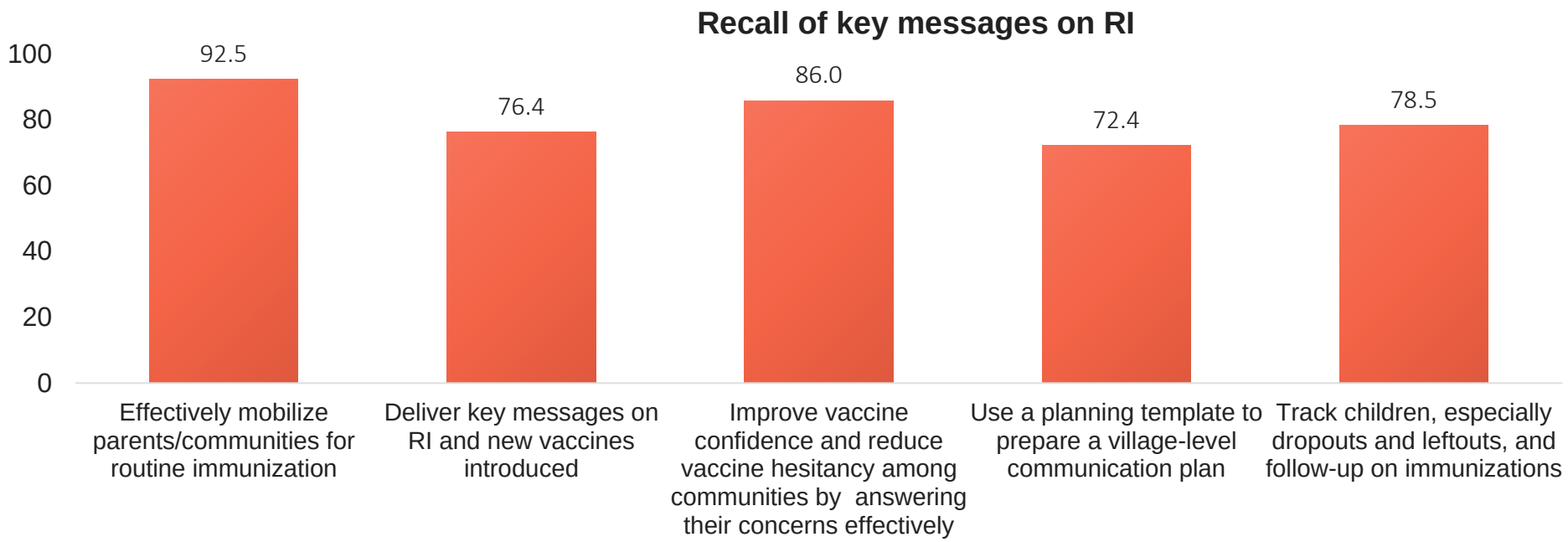


1. *Nearly one-fourth of DTs (25.7%) did not receive any guidance to improve skills as a trainer in the last training conducted (14.2% in Odisha to 34.9% in Assam)*
2. *One-fifth of the DTs (21.6%) didn't have any post-training follow-up (11.1% in Karnataka to 48.9% in Assam)*
3. *16.9% of DTs stated that there was no field monitoring support (7.5% in Odisha to 44.7% in Assam)*

2.3. Was the training effective in ensuring no information loss and in recalling key messages?

The training ensured that the FLWs were able to recall key messages. There was some information loss due to cascading model of training. Large variations were also observed across the states.

Overall, 40.1% FLWs recalled all key messages



- The cascading model was effective in **reaching out to a large number of FLWs**
- The **effectiveness** was contingent upon **quality of the DTs- proficiency level, training quality & frequency of refresher training**
- **Long gap** between training (ToTs and training of FLWs) and lack of refresher training for FLWs (**Overall- 68.0% did not receive any refresher training)** were noted

Effectiveness-6

2.4. What would the FLWs want to change/improve/revise about the training or its content?

The FLWs felt that the training content was appropriate but covered too many aspects

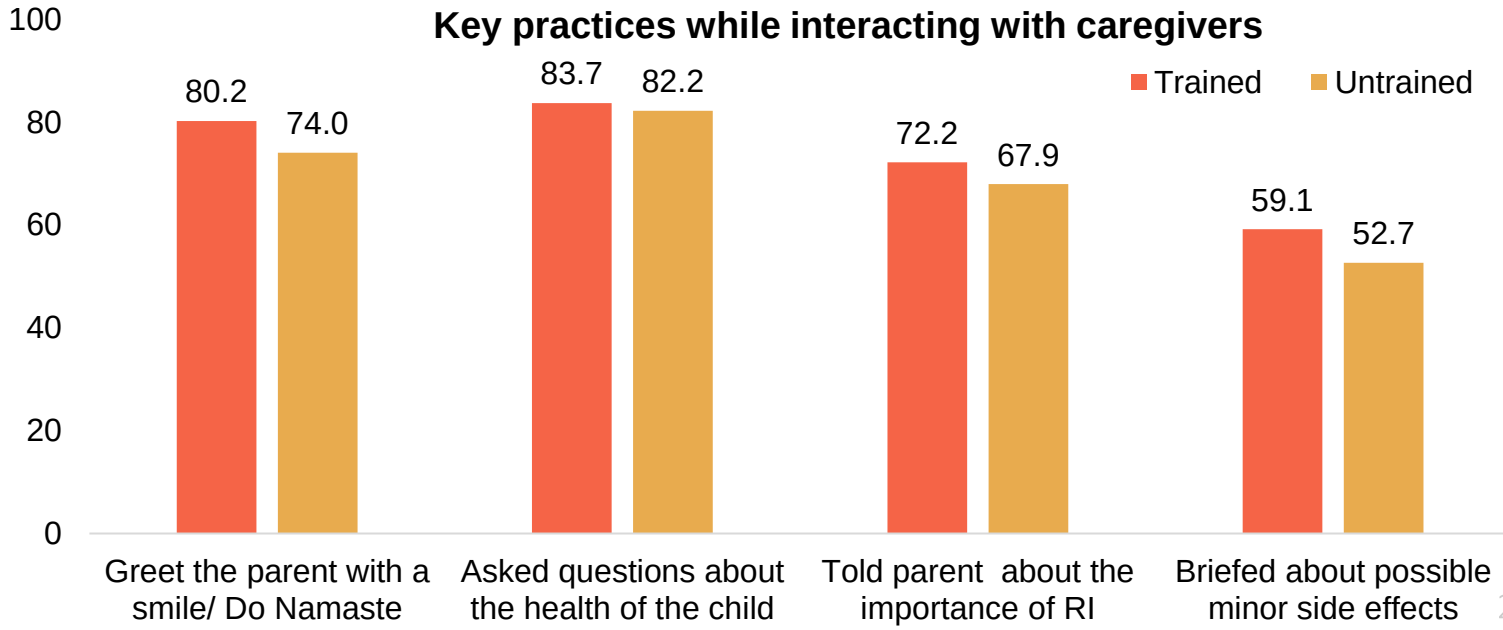
Suggestions

- Increased training duration (2 days)
- Separate training batches for ASHAs/AWWs/ANMs
- Residential training for FLWs
- Annual refresher training

2.5. How effectively do trained FLWs communicate with parents and caregivers to motivate them for immunization?

Higher proportion of trained FLWs delivered key message on RI

- **Trained FLWs** followed **GATHER approach** and avoided calls/messages/use of technical language
- Trained FLWs reported **increasing confidence in vaccines** by responding to caregivers' concerns



2.6. What were the key limitations of BRIDGE training as compared to other IPC skills training, if any?

Stakeholders mentioned that BRIDGE IPC skills training was the first training on improving FLWs' IPC skills for RI, so no limitations were reported

Distinguishing factors of BRIDGE compared to other training reported were:

- BRIDGE training included **entire FLW cadre**
- **One-day training for FLWs** as compared to one-hour of other training
- **Unique methods used** such as one-to-one interaction, videos, role-play
- **Participatory training**, not limited to classroom lectures
- **Focused on how to increase RI using different IPC methods** compared to other training discussing only immunization topics
    - ***Built capacity of FLWs to address low RI coverage*** *in community*
    - ***FLWs learnt to identify community influencers*** *to promote RI in community*

3.1. What is the overall fidelity of the cascading model in terms of timing, adequate selection, allocation and use of resources to achieve BRIDGE skill training objectives and quality?

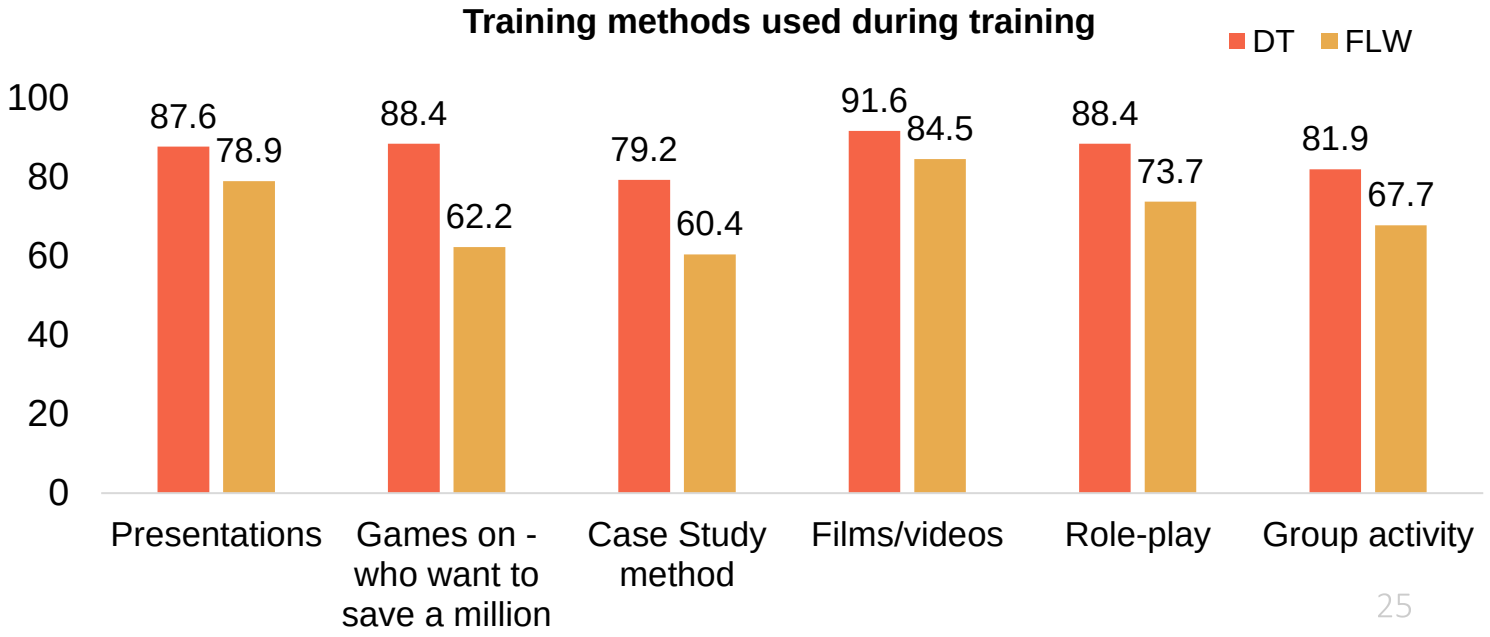
Cascading model's efficiency was contingent upon quality of trainers (with communication, health, medical background) and quality of training

Quality of DTs

- Close to **30.0% of the DTs** were still **'developing proficiency'** as rated by the NLTs post training
- **25.9% DTs knew all key messages taught during the BRIDGE IPC training**, among them 82.4% were proficient/highly proficient

"To ensure the quality of training at the district level, a state-level trainer must monitor a few initial training (this is currently being done by the nodal officer), since usually in a batch of DTs, 70-80% of people are proficient, and rest might need some hand-holding." NLT, Karnataka

1. Huge variations in training methods used for DTs and FLWs



Efficiency-2

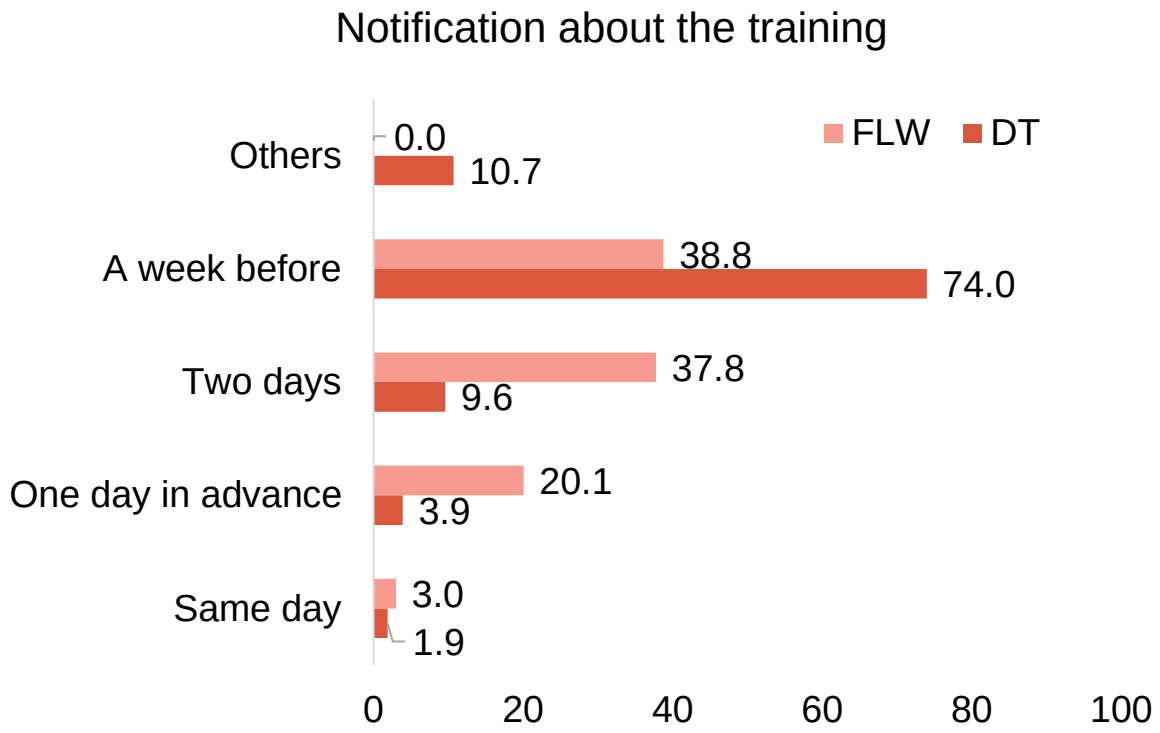
Training schedule, batch size, resources, timing

- **DTs available as per training schedules**
- **Pool of DTs maintained was sufficient**

- **Appropriate batch size maintained**
- **FLWs felt comfortable with DTs** (created a **conducive environment)**

- Most **FLWs received short notice** to attend training, compared to DTs & NLTs
- **Variation across DTs and FLWs** for provision of **transport facility, TA/DA** for training

- **Resource allocation varied at different levels of cascading model**



Challenges with logistics and availability of training material at DTs and FLWs level

1. Rajasthan, Uttar Pradesh, Karnataka – *implementation challenges due to funds constraints and training supplies*

2. Odisha – *re-scheduling of 10% training due to COVID-19 pandemic*

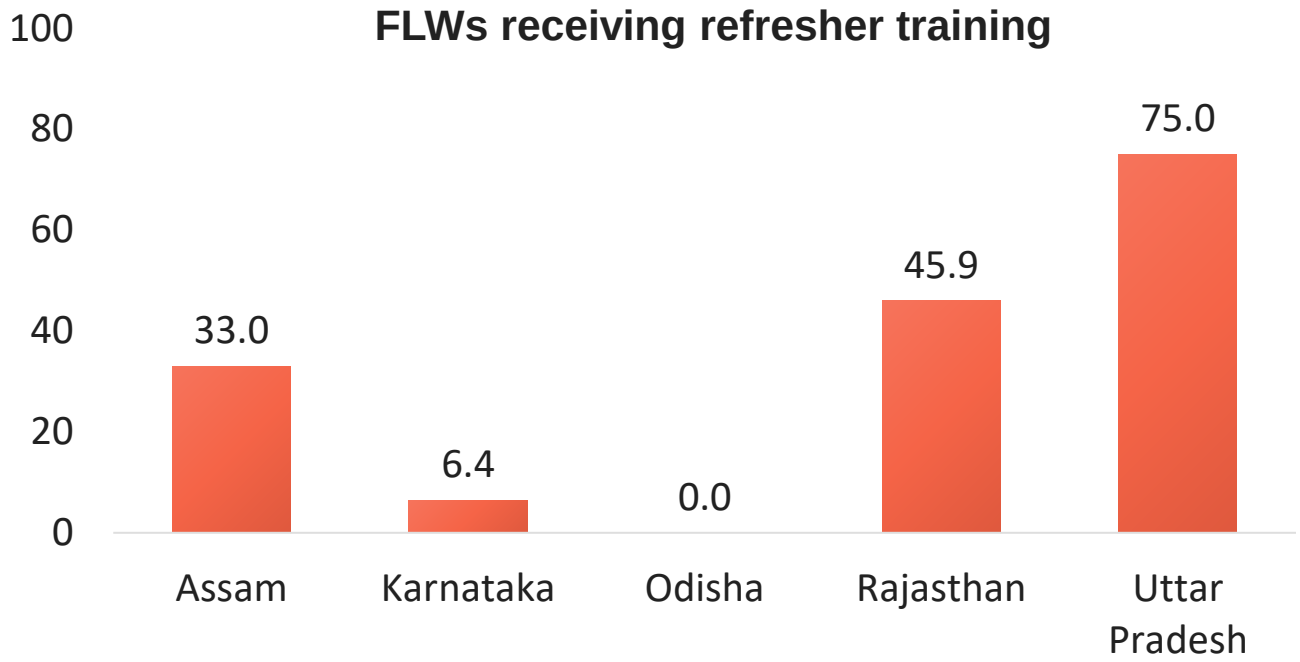
3. Assam – *needed more HR to train FLWs and implement training*

3.2. How well did the training design ensure the retention of information and avoided loss of information?

Cascading model was efficient in transferring the intended information

NLTs: the training model is most efficient when the trainers impart the training soon after receiving it, (within 10-15 days) for better retention of content

- **Compromised information transfer** due to time gap between DTs and FLWs training (few districts in Karnataka)
- **Overall: 13.2% DTs received refresher training** (Assam: 34.0%, Rajasthan: 30.6%); **one-third** (32.0%) of FLWs received refresher training
- Wide **state-wise variation in FLWs** who received refresher training
- Lack of retention of information among FLWs due to **absence of refresher training**



3.3. How well was supportive supervision, monitoring and coordination implemented (fidelity, timeliness, resources required)?

The officials from all the states reported having a coordination mechanism in place for smooth supportive supervision & monitoring of FLWs activities

- **Monitoring & supportive supervision at block level provided by different officials in each state**. E.g.:
  - **Assam:** Block Program Manager (BPM)
  - **Odisha:** Medical Officer in charge (MOIC), Public Health Officer (PHO) and District Programme Management Officer (DPMO)

- **Supportive supervision did not happen uniformly** across the states for DTs (**Overall:** 92.0%; 80.0% in Uttar Pradesh to 100.0% in Karnataka and Odisha)

- **One-fifth DTs** did not receive on-field **monitoring/handholding support** in last 6 months; similar pattern was observed across FLWs (Overall-22.6%)

- **Review meetings** conducted in states to check the performance of different districts based on action points

1. No specific meetings were conducted for IPC skills, but combined review meetings were conducted for FLWs
2. Challenge pertaining to unavailability of the officials was also noted
3. Absence of an integrated MIS system for monitoring training planning, implementation, feedback etc.

3.4. What were the implementation challenges encountered and what measures were taken to overcome these challenges?

Challenges at officials' level

- Delay in release of funds in Rajasthan, Uttar Pradesh and Karnataka
  - **Overcome:** Districts utilised other available local funds; Fund allocation & release streamlined in districts with strong leadership
- **Coordination issues** due to the busy schedule of district officials
- **Natural calamities** (floods, and COVID-19)
- **Availability of HR:** Assam: absence of multilingual human resources (Assamese, Hindi, English)

Challenges at DTs level

- **Lack of proper communication channel** to resolve issues (Mostly in Odisha)
- **High workload** due to which DTs couldn't prioritise these training (Mostly in Assam)
- Lack of required **training material**

Challenges at FLWs level

- **High workload** hindered prioritising training
- **Absence of IPC materials**
- Security concerns
- Distance between the households
- Lack of **handholding support**

Sustainability-1

4.1. How has the programme contributed to its sustainability by strengthening the health system?

The BRIDGE training programme has been designed for strengthening the health system by enhancing the FLWs IPC skills to encourage RI

- Government officials have **shown willingness** to take programme forward
- **Positive change in KAP of trained FLWs** compared to untrained FLWs
- **'GATHER approach' has been useful** for the FLWs to build their IPC skills (Govt. Officials)

4.2. What role is envisaged for UNICEF to sustain the results of BRIDGE IPC skills training in the future?

Officials: as the goal of the BRIDGE IPC training is partly achieved, UNICEF's presence still vital for BRIDGE-IPC skills training

- To conduct continuous **refresher training** at all levels
- To conduct **national and state level ToTs**
- To support training implementation across India
- To build robust **monitoring & handholding support mechanisms** at district and sub-district level

Equity and Gender-1

IPE GLOBAL
Expanding Horizons. Enriching Lives.

5.1. Did the training adequately address some of the gender-based IPC challenges that frontline workers experienced?

Training module stressed prioritising reasons for low immunization among all children

- Training **positively** influenced **gender-based perceptions** of FLWs
- **Significant differences between trained & untrained** FLWs views on importance of RI to children (irrespective of caste, religion and gender)
- **Training module did not explicitly** mention covering both boy and girl child for RI (Desk-review)

5.2. How the training addressed the development of a strong understanding of how vulnerable populations (based on caste, tribal, poverty levels) were targeted during immunization programmes?

Training module & sessions addressed the inclusion of vulnerable populations during RI discussions

- FLWs found training useful to **understand 'who' the vulnerable population is**
- Positive change in **targeting of vulnerable populations as FLWs bond with community**
- FLWs used **LODOR lists**, **identified influencers, etc.**

"This training was given to FLWs to handle the community members. We go to the field to check if FLWs are explaining RI to the community and giving proper information about vaccine importance and why one should take it. The training has resulted in enhanced FLWs skills that have led to an improved rate of immunization across the state." State official, Odisha

Conclusion-1

IPE GLOBAL
Expanding Horizons. Enriching Lives.

Training module and content

- **Standardized & appropriate** for local context
- Developed in **English & Hindi**, translated in regional languages
- **Illustrations, audio-visual resources** most liked by participants

Training approach: Cascading model

- Model designed to impart **appropriate knowledge to a large pool of FLWs** across the country
- Leverage**d DTs knowledge of local context for efficient comprehension** among the FLWs

Planning of the training

- **Training planned and organised** in advance with state level variations
- Adequate **resource allocation at NLT level**
- In some DTs and FLWs training, **organisers faced challenges, e.g.,** resources, administrative aspects and funding, etc.

Implementation of the training

- Most DTs and FLWs **were satisfied with the facilities** & arrangements at the training venues
- **Few participants faced issues** due to logistical challenges (internet connectivity, projectors); availability of training material for the participants; late notification; etc.

Quality of the training

- As per NLTs, **majority of DTs were effective** in delivering the key messages during the training
- Trainers adopted a **combination of methods** including films/videos, role-plays, participatory games and group activity
- Most of the FLWs and DTs **liked their trainers** and felt comfortable in raising their queries during the training
- **Few FLWs felt uncomfortable** in communicating and asking queries from male trainers in some instances
- **Some degree of information loss** occurred in some places due to gap between the ToTs and FLW training

Conclusion-2

Outcome of the training

- Training **augmented FLWs' IPC skills** to facilitate delivery of key messages, improving the confidence of the community on vaccination, etc.
- FLWs learned to **prepare the village-level communication plan** for tracking vulnerable children; and **identify influencers** for approaching the left-out and dropped-out children and resistant families
- FLWs gave feedback to DTs that the **training covered several aspects** in a shorter duration

Monitoring and supportive supervision

- **Operational guideline** for the training included **well-drafted** protocol for monitoring & providing supportive supervision to the DTs & FLWs
- For ensuring quality training, NLTs conducted **pre- and post-assessment of DTs** along with self-assessment done by DTs on key aspects related to training
- Monitoring of the training progress was done during the **state-level review meetings**
- Frequency of the review meetings **varied across states**
- Gaps observed in some places in **supportive supervision** of the participants (DTs and FLWs) & field-based monitoring

Sustainability

- Training has successfully created a **foundation with a well-designed training module** to equip FLWs with improved IPC skills
- There is a need to **conduct refresher training** periodically to upgrade the IPC skills of FLWs
- There is a need to **develop robust monitoring & handholding support** mechanisms to monitor the performance of FLWs

Equity and gender

- The training & the **module addressed the 'equity'** aspect and positively influenced targeting of vulnerable populations
- Trained FLWs prepared a list to **identify and cover LODOR families**
- The training material and sessions focused on how to **approach vulnerable households**
- The training module did not explicitly covered gender aspect for immunization

Lessons Learnt

Local contextualisation of training module for improving relatability and comprehension

- **Contextualisation of the module and training material** (appropriate attire/culture of people depicted in audio-visuals) is important for connecting the participants with the local issues

Systematic monitoring of implementation of training programme at all stages

- Regular supportive supervision and monitoring support for DTs and FLWs is essential for ensuring quality of the training

Proper resource allocation is a key for the smooth implementation of the training

- Timely release of funds and planning of human resources are critical for training implementation

Regular refresher training is needed to upgrade the skills and knowledge

- Regular refresher training is critical to upgrade the FLWs' IPC skills with the changing pattern of epidemics/health needs in the country

Recommendations-Immediate Priority

For UNICEF: Slide-16 (Points 1 to 4)

- There is a need to review and revise the content from the lens of last-mile users. It would be useful to include more real-life scenarios so that participants can relate better to the local issues.

For Government (Facilitation by UNICEF): Slides-26 (Points 1 to 3) & 29

- Concerned authorities at the state level should map out available resources, especially funds and human resources, and plan for training taking into consideration various logistical aspects.

For Government (UNICEF can support in building robust monitoring and handholding support mechanisms at each level by deploying personnel): Slide-21 (Points 1 to 3)

- Supportive supervision and systematic monitoring at each level during and post-training are critical for ensuring quality, consistency and success across different states. Training planners and concerned authorities need to implement standardised protocols and operating procedures for ensuring hand-holding support to trainers as well as to FLWs through supportive supervision, review meetings and field level monitoring.

Recommendations- Mid-Term Priority

For UNICEF: Slide- 16 (Points 1 to 4)

- Local contextualisation of the training content especially illustrations and videos would help in improving relatability and understanding.

For Government: Slides- 26 (Points 1 to 3) & 29

- Proper resource allocation is key for the smooth implementation of the training. Any gap in resource availability can result in compromise of the quality outcomes.

For Government: Slides- 25, 28 & 29

- Establishing accountability and ownership at all levels of training is crucial to ensure quality. Senior government officials should conduct periodic reviews at state, district, and sub-district levels to monitor progress and quality of training.

For Government: Slides- 21, 27 & 28

- Periodic refresher training is important for DTs and FLWs to upgrade their skills and knowledge. Planners and authorities must allocate resources for periodic (bi-annual) refresher training.

For Government (Facilitation by UNICEF): Slide- 19

- The BRIDGE IPC skills training could emphasise more on topics related to evidence-based planning, improving outreach and advocacy and tracking left-out and drop out children in the states with low reporting.

For UNICEF: Slide- 31

- Training content should have details of gender-inclusive strategies and more focus should be given on sensitising regarding gender inclusion during service delivery while orienting different cadres of functionaries.

Recommendations- Long-Term Priority

For Government: Slides- 25, 28 & 29

- An integrated monitoring system should be established with key performance indicators. Realistic targets must be identified to monitor the training processes and outcomes. Programme managers must use data to identify challenges to apply mid-course corrections. A dedicated supportive supervision app, like in Assam, could be developed in other states.

Study Limitations-1

Content Analysis

- The content analysis could not be conducted as personnel involved in the development of the module were transferred
- The staff was occupied in dealing with the COVID-19 pandemic situation

Coverage of FLWs

- For this evaluation, only ASHAs and ANMs were covered as prescribed in the TOR
- Evaluation was not designed to disaggregate data for different FLWs

Data related issues

- No access to the content of the feedback given by DTs for FLWs training & the attendance data for FLWs

Information on Budget

- Secondary information pertaining to financial aspects, budget allocation & expenditure for the BRIDGE training were unavailable for analysis

Study Limitations-2

Change in data collection methodology due to COVID-19

- Shift from physical data collection to remote data collection
- Protocols & mitigation plans developed to overcome the crisis
- Methodology changed for observation of immunization sites from physical-virtual-physical
- Exit Interviews/FGDs/ASHA field-level observations were dropped
- Demand-side perspectives not captured in absence of interviews/discussion with caregivers

Issues in adhering to timeline

- Revision in data collection methodology led to delay
- Face-to-face data collection undertaken where remote data collection was not possible through trained local teams

Absence of BRIDGE IPC skills training MIS Data

- Post-training data of the FLWs in the selected districts
- Post-training feedback data of DTs and FLWs in the selected districts
- On-field assessment/performance data of the FLWs
- Attendance data (Pre-post training) of the FLWs
- Proficiency level of trained FLWs

Study Limitations-3

Delays in getting details of the respondents

- Longer duration to gather information on characteristics of FLWs
- Challenges in Odisha, Rajasthan & UP in providing data on untrained FLWs
- Latest coverage data on training led to revision of districts in 3 states

Selection of DTs

- Unavailability of proficiency data of the selected DTs

Challenges in the availability of the stakeholders

- Officials were engaged in COVID-19 vaccination drive & launch of MI (ward level)
- Multiple rescheduling of state and district-level immunization officials' interviews
- Some officials involved in the BRIDGE training were transferred

Self-Reported Data

- Inferences are drawn from the DTs and FLWs & are not based on the community's perceptions; chances of social desirability bias and over-reporting may occur

Comments & Discussion

Expanding Horizons. Enriching Lives.

Annexures

Planned Sample Size

Particulars	Rajasthan	Odisha	Assam	Karnataka	UP	Total
No. of districts	2	2	2	2	2	10
In-depth interview						
State-level						
State immunization officer	1	1	1	1	1	5
State RI Nodal Officer or State Institute of Health and Family Welfare	1	1	1	1	1	5
UNICEF consultant	1	1	1	1	1	5
In-depth-interviews with all lead trainers	3	3	2	3	3	14
District level						
District immunization officer	2	2	2	2	2	10
Medical officer	4	4	4	4	4	20
Block Programme Manager-NHM	4	4	4	4	4	20
Structured interviews						
District trainers- Online interview	146	146	140	144	202	776
Frontline Health Workers						
ANMs	32	32	32	32	32	160
ASHAs	120	120	120	120	120	600
Exit Interviews with caregivers	32	32	32	32	32	160
Observations						
Observations at the immunization sites for ANMs	8	8	8	8	8	40
Observation at field level for ASHA	8	8	8	8	8	40
Focus Group Discussion						
FGDs) (in each state 6 FGDs with caregivers of immunized children and 2 FGDs with caregivers of drop out and left out children)	8	8	8	8	8	40

Go to: Actual Sample size

Acronyms

AEFI	Adverse Events Following Immunization
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BPM	Block Programme Manager
BRIDGE	Boosting Routine Immunization Demand Generation
COVID-19	Coronavirus Disease-19
DA	Dearness Allowance
DAC	Development Assistance Committee
DIO	District Immunization Officer
DPMO	District Programme Management Officer
DTs	District Trainers
ERG	Evaluation Reference Group
FGD	Focused Group Discussion
FLW	Frontline Worker
GATHER	Greet, Ask/Assessment, Tell, Help, Explain, Return
HR	Human Resource
IDI	In-depth interview
IPC	Inter-Personal Communication
KAP	Knowledge Attitude Practice
KPI	Key Performance Indicator
LODOR	Leftout, Dropout and Resistant
MCP Card	Mother and Child Protection Card
MI	Mission Indradhanush
MOIC	Medical Officer-in-Charge
M&E	Monitoring and Evaluation
NCD	Non-Communicable Disease
NHM	National Health Mission
NLT	National Lead Trainer
OECD	Organisation for Economic Co-operation and Development
OPV	Oral Polio Vaccine
PHO	Public Health Officer
PIP	Project Implementation Plan
RI	Routine Immunization
SBCC	Social and Behaviour Change Communication
SEPIO/ SIO	State Expanded-Programme-on-Immunization Officer/ State Immunization Officer
TA	Travel Allowance
ToT	Training of Trainer
UN	United Nations
UNEG	United Nations Ethical Guidelines
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh