Training trainers in reproductive health

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The cascade training model has brought clinical training closer to the areas in DRC most in need of skilled staff to serve conflict-affected women experiencing complications in pregnancy and childbirth.


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Although maternal deaths have decreased globally by 35% since 1980, maternal deaths in DRC have decreased by only 3% since 1990, the onset of the recent phase of conflict in DRC. Extended conflict has played a significant role in the destruction of a national health-care system already in an advanced state of disrepair, resulting in poor-quality care offered to communities, lack of well-trained health workers and, due to government disinvestment, unmotivated health-care personnel.

An estimated 15,000 women – one Congolese woman in 13 – die from causes related to pregnancy and childbirth in DRC each year, mainly from treatable or preventable complications. Yet despite the stark need evinced by these numbers, the Congolese government continues to spend only limited resources to improve public health. In 2001, African countries, including DRC, met in Abuja, Nigeria, and committed to allocating 15% of their governments' budgets to health care; nine years later, however, the Congolese government still only allocates about 5%.[1] Serious investments in good-quality emergency obstetric and neonatal care (EmONC) could save thousands of Congolese women and newborns each year.

Training essentials

An assessment in 2007 of seven hospitals in South Kivu, Orientale, Kasai Occidentale and Kinshasa provinces showed that none of the hospitals assessed offered good-quality EmONC.[2] The majority did not have family planning (FP) services or sufficient personnel qualified to handle obstetrical complications. Respect of infection prevention standards was poor. Moreover, all hospitals had shortages and stockouts of medication and supplies, and the data collection system for EmONC was almost non-existent. Finally, the use of newer, safer medicines and procedures was limited due to a lack of continuing education for health workers.

To fill this gap, the International Rescue Committee (IRC), in collaboration with the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative, aimed to improve the essential RH skills of health staff in supported health zones. Providing equipment and other supplies is necessary but not sufficient to improve the quality of care; it is also essential to train and supervise medical staff in the requisite clinical skills.[3] Yet many training programmes are undermined by a lack of follow-up supervision of the participants. To address this concern, RAISE and IRC are using existing supervision structures to ensure post-training follow up.

Phase 1: Training trainers and creating local training centres

In the first stage of the project, a training team from the African Institute of Reproductive Health (IASAR) and Souro Sanou University Hospital in Bobo-Dioulasso, Burkina Faso, trained 48 providers in EmONC and 18 providers in FP. EmONC training was organised for three clinicians from each hospital (one doctor, one nurse-midwife, one nurse-anaesthetist), as well as one doctor and one nurse from each health zone supervisory team (who also provide clinical care at the hospital). To ensure Ministry of Health (MoH) support, one provincial MoH staff member in each of the four provinces and two from the national MoH participated in the first week of training.

Several months later, the trainers visited participants in their health facilities to reinforce their new skills, recommend improvements and identify individuals to be trained as trainers. The final decisions on the selection of trainers were made in collaboration with provincial health management agencies and the National Programme for Reproductive Health (PNSR).

One hospital in each province was identified as a training centre for health workers from MoH hospitals and health centres supported by IRC. In each, a training room was constructed and equipped with instructional materials and anatomical models, and IRC ensured that the delivery rooms and operating theatres at these practical training sites adhered to best practice standards. 21 people were then trained as 'novice trainers', including in facilitative supervision techniques.

Phase 2: Training health workers from surrounding health facilities

Following the training of trainers, the IASAR trainers observed and mentored the new trainers during their first EmONC training session. From May 2009 to March 2010, the novice trainers at the new training centres conducted seven EmONC trainings for 151 health workers, and seven FP trainings for 159 health workers. As many of the trainers are also the MoH supervisory staff for the health zone, each time they conduct a routine supervision visit, they can review skills from previous trainings,

discuss problems and ensure that recommendations from the previous visit have been implemented.

Challenges and lessons learned

A number of challenges were encountered in the implementation of this training project, from which lessons for best practice can be drawn.

Involvement of health authorities at all levels is crucial. Effective training requires a politically supportive environment, a strategy, resources, appropriate guidelines and policies, job expectations, and motivation and feedback. IRC is working closely with the MoH PNSR to finalise and adopt national RH standards. At the local level, key MOH authorities' approval can facilitate the implementation and use of new skills by the trainees on their return to their facilities.

All necessary equipment, supplies and medications must be available at the trainees' health facilities so they can put their skills into practice immediately after training. Delays in procurement of supplies and equipment can delay post-training follow-up supervision visits. Sometimes these visits occurred five to six months after the initial training, which meant participants then needed extra coaching to successfully perform some of the skills learned.

An important element of competency-based training is having the time to practise skills in a real clinical setting under supervision. The low clinical caseload at some of the training sites – a frequent disadvantage of creating training sites in rural hospitals – made it difficult for trainees to practise an adequate number of cases. To address this issue, the trainings offer a strong focus on follow-up supervision and additional practice on anatomical models – and as services continue to improve, we hope that caseloads will increase.

Continued support and post-training follow-up by supervisors are key elements to successful training. Clinical supervisors must have the skills to offer post-training follow-up and coaching to develop confidence in trainees and help them make improvements at their facilities. Traditionally, supervisors did not involve supervisees in problem resolution, and problems persisted. Training health-zone supervisors in facilitative supervision improved the quality of the supervision visits, and supervisors now encourage staff to solve problems and take ownership of their work.

The departure of trained personnel to other positions left a gap in the planned training and/or mentoring teams in some sites. IRC has tried to coordinate with the MoH to ensure that new trainers remain in their positions for a minimum of two years. Another possibility would be for the MoH to send health workers from outside the health-zones to be trained so that skills can be spread beyond IRC's direct intervention areas without transferring skilled providers away from these areas.

In conflict-affected settings, clinical staff should be trained to be prepared for fluctuations in demand. In February 2009, for example, an upsurge in conflict displaced some 4,300 households in Kalehe and Itombwe health-zones; the Kalehe General Referral Hospital experienced a shortage of EmONC drugs and post-exposure prophylaxis kits as the overall utilisation rate increased, along with the number of gender-based violence cases.

Conclusions

The cascade training model has brought clinical training closer to the areas in DRC most in need of skilled staff, allowing for more staff to receive training. By using existing supervision mechanisms, it is possible to provide longer-term facilitative supervision and follow-up to ensure that skills and skilled staff are retained. Furthermore, this means that support and supervision are possible in areas where insecurity may restrict access from outside the area.

IRC has already begun to replicate this model in its programmes serving displaced populations in North Kivu. IRC and RAISE plan to evaluate this project in late 2010 to ensure that the training is resulting in improved RH service delivery. Already, observation has shown an increase in the pride the staff take in their work, especially among those trained as trainers, which should ultimately lead to better quality RH care for the many displaced in DRC.

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Training amidst turmoil

For Professor Blami Dao, Director of IASAR, the presence of a clinical workforce well-trained in RH is absolutely vital when serving refugees and internally displaced persons: "In conflict situations, reproductive health becomes even more urgent, because there is a risk of increased sexual violence, leading to pregnancy, sexually transmitted infections and problems linked to unsafe abortion, in addition to the need for contraceptives and monitoring and treating the possible complications during pregnancy."

Training alone, however, cannot address the pressing RH needs of conflict-affected populations. "To truly make progress, there must be improved working conditions for health workers, better coordination of supplies and equipment, and better coordination of policies and standards of care throughout the country. In areas affected by conflict, this is difficult," admits Professor Dao. Nevertheless, IASAR's training team is pleased with the number of trained clinicians in Africa who can trace their skills back to the Institute's work. "We must share the approach, share the tools, share the training methodology," Professor Dao says. "We hope to see a day when our work is no longer needed at all."