Training Clinic Sisters

Lessons learnt based on experience of the National STI Initiative
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Introduction

The National STI Initiative is a collaborative project between the Reproductive Health Research Unit (RHRU), the Health Systems Trust (HST), the National Department of Health and Provincial Departments of Health in four provinces. The Initiative is funded by the Henry J Kaiser Family Foundation. It was set up in 1999 to develop “model” district-based STI control programmes in response to some of the recommendations from the National HIV/AIDS Review and a national consultation meeting on strengthening STI control, both of which took place in 1997.

Initially four health districts were selected as intervention sites for the Initiative: Kopano (Free State), IPU (KwaZuluNatal), Tonga (Mpumulanga) and Hillbrow (Gauteng).

Establishing Key Principles of Training

A workshop was held at the start of the Initiative. This aimed to design the approach and content for STI training that would address identified limitations in existing training practice.

The following recommendations were made about the principles that should guide the training:

❖ Link training as much as possible to real work situations
❖ Use appropriate adult participatory methods of learning
❖ Base content on assessments of training needs and current quality of care
❖ Include appropriate district and sub-district level managers and clinic supervisors – not only frontline clinicians
❖ Aim to provide a better understanding of the rationale of syndromic management
❖ Include generic issues and skills such as gender, attitudes and communication
❖ Include a practical/clinical component
❖ Include ways of monitoring and evaluating quality of care and use of data for decision making
❖ Link training to a process of follow-up and feedback
Baseline Evaluation

Before training commenced, a baseline assessment of quality of care was established through the use of the District STI Quality of Care Assessment (DISCA) – a tool designed to measure key input, output and process indicators of quality of STI care – such as:

- Accessibility
- Availability of resources for proper examination and treatment
- Availability of drugs
- Correct drug prescriptions

In addition, a number of discussions were held with clinical staff in order to gain an even better understanding of the problems and constraints around improving the quality of STI care.

Some of the points that emerged from this initial evaluation included:

- Little was being done to evaluate the quality of STI care in clinics. Most clinicians felt the level of management was good until they examined the situation more effectively through the use of a quality of care assessment tool.

- Vaginal examinations were not perceived as being an important part of diagnosis for syndromic management.

- Clinicians mostly diagnosed STIs in clients who actively reported symptoms or signs. They were not proactive in looking for STIs among other clients who might be at risk.

- The knowledge and prescription of treatments often fell short of the standard, resulting in many clients being incorrectly treated.

- Insufficient supplies of drugs, condoms, treatment protocols and equipment also impacted on quality of care.

- Clients with STIs were often characterized unfairly, typically in terms of being difficult, unco-operative, blameworthy and even immoral.
Development of a Training Plan

Based on key findings, a 3 part modular approach to training was proposed.

❖ **First module:** This covered comprehensive STI management (including diagnosis, treatment and counseling) as well as generic training skills.

   (The key resource for this module was the National Trainers’ Manual for the Management of a Person with a Sexually Transmitted Infection)

❖ **Second module:** This covered supervision skills required to sustain and monitor syndromic management, the use of the DISCA tool and programmatic planning.

❖ **Third module:** This involved practical clinical training in the real setting of an STI clinic.

In all modules considerable emphasis was placed on the effect of negative attitudes on clients, the difficulties of behaviour change, the importance of interactive health education and ways of overcoming missed opportunities for identifying and treating people with STIs. These dimensions have often been overlooked in training courses on STI management.

The training included practical exercises designed to help participants move beyond theoretical knowledge into a deeper awareness of the issues involved in effective STI management, thus developing a more comprehensive approach.

Lessons Learnt

Based on the experience of conducting training in the four districts, together with regular assessments using the DISCA tool a number of recommendations are given to guide training interventions.

These recommendations relate to the following issues:

❖ Who should be trained?
❖ What should training include?
❖ How should training be structured?
❖ How can motivation be built and sustained?
❖ How do we know if training has been effective?
❖ What is the role of supervision?
1. Is training in syndromic management still necessary?

Training in STI clinical case management is still essential – many nurses are making incorrect diagnoses, wrong treatment is given, there is limited screening for STIs among family planning and antenatal clients. Nurses are confused about what is actually being treated in syndromic management, what complications are linked to specific STIs and correct referral procedures. Efforts to ensure that every primary level clinical provider knows and understands the syndromic case management protocols needs to continue.

2. Who should be trained?

❖ **Frontline primary care providers.**

It is often not possible to provide training to each and every nurse who diagnoses and treats clients. Consideration therefore needs to be given to which nurses at a health service should attend training.

**Selection criteria** should include level of experience of and motivation about STI management, ability to grasp and communicate issues effectively and opportunity to communicate to colleagues what has been learned.

❖ **Supervisors/Managers**

Unless clinic supervisors and district managers are also targeted, the training of front-line clinical providers may have little or no ultimate impact. These personnel play an important leadership and motivating role. In addition, there may be many constraints to good quality of care that cannot be resolved at the facility level and require the support and intervention of staff at a management level.

3. What should training include?

❖ **Syndromic management itself**

Clear information needs to be provided on the STI syndromes, the specific infections causing these syndromes, the complications that can result and which infections are associated with which complications, how to diagnose – including awareness of differential diagnoses and what each drug is treating.
❖ **Clinical training**

There should be opportunity to observe or practise comprehensive management of STI clients including physical examination of males and females.

❖ **Attitudes and communication skills**

Clinical training also needs to address attitudes and communication skills. Although in general since the start of the Initiative, there has been an improvement in attitudes of providers towards STI clients, poor counselling and communication skills continue to act as a barrier.

4. **How should training be structured?**

   The circumstances may dictate the type of training that can be provided but the following recommendations raise issues to consider when planning training.

❖ **Modular training** has a greater impact than once-off training

   A key lesson is that one-off clinical training is less effective than a more sustained and modular approach to training. A greater proportion of the content of a training programme will be forgotten if it is concentrated in one stretch.

   In situations where the same people return for different stages of training, teamwork, motivation, skills and knowledge are more readily improved and consolidated. In addition, modular training provides an opportunity for applying what is learnt in between the modules and for identifying new issues that can be discussed at the next module. It also provides an opportunity to support the learners to do mini-research projects which will encourage their commitment and desire to identify and solve problems that affect quality of care.

❖ **Equip people to cascade training.**

   Theoretically, the model of training trainers who will then cascade their training to other primary health care providers is sound, given the large numbers of clinicians who have to be reached. However, the effectiveness of this approach depends to a large extent on the skills and motivation of those who are being trained.
It would appear that some staff are appointed as trainers because of their length of service or the fact that they have a Primary Health qualification. They are not necessarily interested in or skilled as trainers. Although there is a comprehensive Trainers’ manual for STD management, it assumes a certain level of sophistication as a trainer to be able to use it effectively. There is a need to provide a training outline with a clearer step by step guide to training for those trainers who are less skilled.

**Training that is arranged in a way where one individual from a clinic is sent on a training course and then expected to cascade the information and training to others needs to be more carefully planned.**

In addition, those expected to cascade training must be given the mandate, time, resources and teaching skills to do this cascading. Perhaps when cascading is expected, trainees should be given clear guidelines and notes on the key issues they are expected to share with their colleagues.

❖ *Look for ways to release staff for training.*

Another of the challenges of improving the quality of care is providing adequate training without leaving clinics short staffed. Many clinics struggle to send their nurses to training courses because there is no system whereby nurses attending training can be relieved by other nurses.

One approach to training that has not been used by the STI Initiative to help overcome this problem would be to provide on-site training for all staff at one particular clinic. This could be done in clinics that are able to close early for a couple of hours on a bi-weekly or monthly basis for in-service training and evaluation of the service they provide. It seems that staff at many clinics feel they are not allowed to do this. However, many companies have a regular day where normal business is suspended either at the beginning or end of the day to provide an opportunity for staff to be trained.

❖ *Build in the opportunity to see clients with STIs.*

The experience of one of the district teams whose third module of training took place at a dedicated STI clinic in Durban highlighted the value of practical clinical training. Because it was a dedicated STI clinic, it was possible to see a number of clients with different STIs in a short space of time. There were opportunities to practise speculum examinations under supervision, and for discussion of issues that arose directly out of a consultation. All the trainees felt that practical on-site training with a range of STI clients was very beneficial.
❖ **Use adult based participatory methods.**

Never tell people what they could work out for themselves. Be creative in finding methods and activities that lead to self discovery. Use a variety of approaches to hold people’s interest.

The National Trainers’ Manual has a number of examples of activities that can be used for different aspects of STI training. Trainees frequently commented about how the use of experiential exercises had given them a better insight into their own behaviour and enabled them to recognize attitudinal changes they needed to make. It was interesting to note how often trainees said “it was an eye-opener” when describing the training.

❖ **Link training to the working situation**

Clinicians need to be able to see how the training can be implemented at their place of work. It therefore needs to take into account the limitations and opportunities within their services. It must be realistic, and while being clear about what the ideal is, it must address the realities that are there. An example of unrealistic training might be emphasising the need to do syphilis serology tests on all STI clients in a situation where roads are poor, transport is limited and laboratories are far from the clinic.

On-site training is one way of keeping training rooted in the realities of the working situation. Modular training where clinicians are given relevant practical tasks to carry out between modules will also make training more effective.

5. **How can motivation be built and sustained?**

❖ **Staff need to be motivated.** While this statement is self-evident, it cannot be over-emphasised. Many of the problems affecting the quality of care relate to staff not feeling motivated in their work. Focus group discussions with clinicians revealed that clinic nurses feel profoundly unappreciated and inadequately supported.

❖ **Training should aim to increase motivation.** Any form of clinic nurse training needs to acknowledge the generally low levels of motivation. There are however a variety of ways to complement traditional training methods with activities and approaches that will help improve motivation at the same time.
An environment of good teamwork helps provide a strong sense of motivation. If efforts to improve the quality of STI care are shared and owned by a team of mutually-supportive people, motivation is likely to increase.

Good leadership by managers and supervisors at the district and sub-district level can contribute significantly to developing and sustaining motivation levels in clinics. The features of this leadership include the ability to forge good teamwork as well as showing care, concern and appreciation for clinic nurses.

Providing staff with informal as well as public recognition is also an important way of improving motivation.

Informal recognition includes showing awareness of the pressures under which staff work and providing an opportunity during training when they can express some of their frustrations as well as the things they enjoy about their work.

An example of public recognition occurred when members of district teams who had been trained were invited to share their experiences at meetings and training events outside their district. People attending these events were impressed by what had been achieved by ‘ordinary members’ of the health services, and this strengthened the team’s motivation as well as providing an example to others of what could be done.

Empower staff with research skills. In one district, the STI team were further empowered and motivated by the encouragement given to them to conduct their own mini research projects. These included topics such as assessing the percentage of family planning clients who said they had an abnormal vaginal discharge or establishing knowledge of youth about STIs. Several of these projects were later presented by the clinicians at a National conference. This was another example of public recognition which also inspired other people with a vision of what could be undertaken by ‘ordinary clinicians’. Asking people to identify some area to investigate also means that they have to think about the context in which they work – What are the problems? What ideas do they have for trying to solve the problem? What makes a difference? When they identify some way of making a difference, no matter how small, this is in itself motivating.
6. What is the role of supervision?

❖ **Supervisors support and reinforce training**

One of the clear lessons from the training experience is that the training of front-line clinicians needs to be accompanied by supervisory and managerial support at the district and sub-district level.

Supervisors play a key role in evaluating quality of care and need to be aware of the key issues involved in effective management. Through effective support they can contribute to a sense of teamwork, thus encouraging clinicians in the challenges of busy clinics.

❖ **Supervisors can help overcome problems involving lack of resources**

Providing training when there are insufficient resources (such as specula or essential STI drugs) in the workplace to implement what is learned is demotivating. Training therefore needs to go hand in hand with management interventions to ensure that providers are enabled to implement correct treatment.

❖ **Supervisors can contribute to a sense of teamwork**

Training initiatives that **occasionally target both clinicians and managers / supervisors simultaneously** will allow supervisors / managers and clinicians to be aware of each others’ efforts and responsibilities. It will also help to develop the kind of teamwork that has already been shown to be important.

The district in which the interventions of the Initiative had the most impact was one in which there was a good standard of clinic supervision and support. This district also has a district level staff member whose sole responsibility related to STIs (including HIV). This is in contrast to another district where the district level staff member responsible for STIs was also responsible for all communicable diseases – and this in an area that was affected by the cholera epidemic and also has a high incidence of malaria. **Supervision and follow-up play a key role in sustaining the benefits of training** and it is critical that people delegated to supervise and coordinate improvements in the quality of STI care have the time and resources that are commensurate with their workload and responsibilities.
Supervisors also need supportive training

Targeting district or sub-district STI coordinators and clinic supervisors for motivational input is also important. Focus group discussions with supervisors/managers revealed that they often felt thrown in at the deep end with insufficient guidelines and training for their role. In addition they often felt pulled in several different directions and were expected to be at a range of different meetings, frequently at short notice.

When training of supervisors is planned, reasonable steps should be taken to establish that those trained will be able to implement the training. In one district, three out of the four supervisors who were trained soon afterwards left the district. This raised the issue of staff selection to key posts, as there may be no point investing training in supervisory personnel if they are about to retire or leave.

There should be clear criteria for supervisory roles

Supervisors are sometimes appointed on the basis of length of service, or availability for a post that has become vacant. There need to be clear criteria for the qualities required for supervision, as well as job descriptions to provide guidelines for responsibilities.

7. How do we know if training has been effective?

Conduct a clinic evaluation of quality of care on a regular basis

It is important that a system to monitor and evaluate the quality of STI care is built into any training activity. A useful adjunct to STI training is the regular use of the DISCA tool which is able to monitor and track change with some ‘before’ and ‘after’ measurements.

However, experience with the use of the DISCA revealed that introducing this tool to a district needs to be accompanied by training. Simply giving supervisors or trainers the DISCA tool without some orientation can result in poor quality data. In our experience, some sections of the DISCA form were not filled in, and others clearly had the wrong information.

It is important to train people before introducing the DISCA even if it might appear to be clear and self-explanatory. Documents\(^1\) are available which

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\(^1\) *A Practical Guide to using the DISCA and Evaluating Quality of STI Management at a Regional Level* are available from the Reproductive Health Research Unit (RHRU) Phone 031-304 8383. Fax 031-304 8468
clearly explain what is involved both in completing the DISCA assessment and analysing and interpreting it. Training also plays a role in obtaining commitment to the tool through discovering the benefit of using it. Where people were trained in the use of the DISCA and the interpretation of its findings, they were quickly convinced of its value.

❖ Assess the client’s knowledge and perspective

A complementary approach to DISCA evaluation is to conduct exit interviews with clients. This was done in two districts and provided information from a client perspective about his/her comfort, the attitude of the health provider and what health education they received as well as their level of knowledge about STI/HIV. A considerable number of clients who were interviewed had scanty knowledge about STIs, including HIV, and most of them said they would like more information. On exit interview some antenatal clients mentioned that they had a vaginal discharge which they had not mentioned during the consultation.

❖ Plan regular supportive supervisory visits

Supervisors can play an important role in contributing to the effectiveness of training. Supportive visits in which clinic staff can discuss queries can help clarify and reinforce aspects of training. Problems affecting quality of care can also be identified and resolved early.

8. Two key recommendations

❖ Provide a regular time for in-service training

Time needs to be provided on a regular - at least monthly - basis, when clinic staff can reflect on the quality of care being provided, discuss ways of improving the service and be updated on aspects of management. This might be done by the clinic staff on their own, or with the support of a trainer or supervisor. However, it is difficult to do this effectively unless all the staff can meet together at the same time.

Clinics could arrange to open later or close earlier once a month for this purpose. If the arranged time was advertised and kept the same every month, clients would soon come to accept it, especially if they realised that this was for their benefit to enable clinicians to provide a better service.
Explore the appropriateness of setting up one or two dedicated STI clinics in every province

This would be both a strategy for providing an effective referral centre as well as a training strategy. If a province has a dedicated STI service it would be possible for nurses from other clinics to be sent to work there on a rotational basis for one or two days. This would provide an opportunity for clinical training, especially if they worked alongside a competent and experienced clinician. The value of dedicated STI clinics for training is illustrated by the experience in several clinics where few or even no STI clients were identified during the hours that the training was being conducted at those clinics.

Conclusion

Good organisation at the district level is important

A well-organised district in which roles and responsibilities are clear and where there is a camaraderie of mutual support is always going to more effectively translate training into improved and sustained standards of care. On the other hand, in districts where staff are demotivated by organisational and managerial uncertainty and where support for clinic staff is not forthcoming, training is less effective.

Training needs to be adapted to a particular situation

Often training is provided as a pre-determined package that treats all clinics and all clinicians as though they were the same. However, a proper evaluation of the current quality of care in a given district is important so that the training can be planned and designed to meet the specific needs of that district. Generic principles of training need to take into account the specific situation of each district and be modified accordingly. Training also needs to be adapted to the skills and resources that are available. A district approach to training therefore means employing a more flexible approach.