Report on OPL2 Training in Mbale, Uganda

Purpose of this report

This report has been compiled by Alwyn Pugh on behalf of the University of Glamorgan at the request of Partnership Overseas Networking Trust (PONT) as partners in the Rhondda Cynon Taf Coalition Against Poverty (CAP). The report focuses on the training course delivered in Mbale in April 2007 for ***Op***erational ***L***evel (***2***) Health Workers (OPL2s). This training was funded by the CAP with a grant provided by the Welsh Assembly Government (NHS Division).

Background to the visit

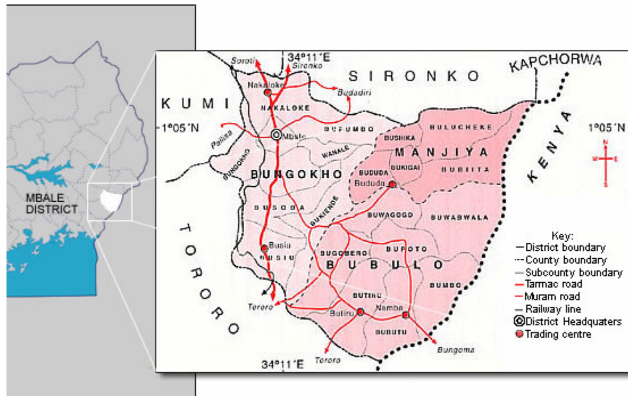
The report is based on a 7-day visit to Mbale. A full and well-planned programme was arranged by Pastor Apollo Mwenyi, Chair of the PONT Mbale CAP and Fred Chemuko, the course co-ordinator. I am indebted to PONT's field worker, Rob Rowlands, not just for the time he made available but also for his insight into the cultural and political context

About half the visit was spent observing the OPL2 training. In addition, the following meetings and field trips were arranged:

- Chairman (LC5), Chief Administrative Officer and Medical Director for Mbale Local Government
- Medical Superintendent, Mbale Regional Hospital
- Course Managers, at School of Clinical Officers, Mbale Regional Hospital
- Principal, School of Hygiene
- Busiu Health Centre
- Magale Health Centre
- FDNC Training Centre, Bubirabi

Note on reconfiguration of Mbale

The former district of Mbale was restructured in 2005 to become three districts – Mbale, and the relatively more deprived districts of Bududa and Manafwa. The activities of PONT are centred on the former district of Mbale, including Bududa and Manafwa.



Uganda is divided into 80 districts across four administrative regions. Most districts are named after their main commercial and administrative towns. Eleven new districts came into being on 1 July 2006.

Each district is further divided into sub-districts, counties, sub-counties, parishes and villages. The head elected official in a district is the Chairperson of the Local Council V.

http://en.wikipedia.org/wiki/Districts_of_Uganda (16 April 2006)

Background to the course

This was the second cohort of OPL2 health workers to be trained in Mbale: the first cohort of 20 students began in November 2006 and they are now all deployed across the district.

The duration of the course was 4 weeks and learning activities were scheduled 7 days a week, typically from 08:30 until 20:00. Accommodation and food were provided on site. It is not difficult to appreciate the burden that this training placed on the students and their families, many of whom exist at subsistence level. This course was taking place at a time when the participants would normally be planting crops for the coming season.

Recruitment to this cohort

The students were not drawn evenly from the former district of Mbale. The decision was made by the NGOs involved that the management, evaluation and monitoring of the initiative would be best served by focusing recruitment on selected sub-counties.

Half the 40 students came from Bubutu, 7 from Bungokho, 3 from Busiu, 2 each from Busoba and Bugabero. There was one student from each of Buwabwala, Buyobo, Buwagogo, Namanyongi, Bumwoni and Sibanga. This represents 11 of the former Mbale's 31 sub-counties and draws from only 2 of the 3 sub-districts of the former Mbale, to the exclusion of Manjiya.

Profile of students

The sex distribution of the cohort was about 50:50. The students were drawn from 3 NGOs; 20 from SAO (*Share an Opportunity Uganda*), 11 from FDNC (*Foundation for Development of Needy Communities*) and 9 from UWCM (*Uganda Womens Concern Ministries*). The ages of the students ranged from 19 to 66 years.

All the students I spoke to were already actively involved in their communities, through their respective NGOs. Their contributions and commitment to their communities might best be represented by profiling a few individuals:

Damascus is a 34-year-old primary school teacher in the village of Busimaolya II. He is married with two young daughters, a gently spoken, sociable man who was elected Chairman of the group by his peers. Not content with his role as a teacher, Damascus had already received training in public health through SAO and told me this had enabled him to have a major impact in his village by promoting the use of treated mosquito nets and advising his neighbours about issues like siting of latrines and not keeping livestock in their homes. Damascus approached me on my first day with the students and was eager to express his appreciation of the work PONT; "Thank you for staying with us!"

Robert, 32 has been working for FDNC in several local villages. He is a trainer in organic farming and took the opportunity to tell me that he needs funds for seeds to enable more people to become self-sufficient in healthy foods. He also provides health education, with particular reference to HIV/AIDS in Kakugulu High School, along with 2 schoolgirls he has trained. He is running a number of other projects to keep local youths usefully occupied but needs funding to continue this work. Robert is particularly pleased that he has managed to gain access to a local Jewish community and has encouraged 67 members to be tested for HIV. They were awaiting their results when I spoke to him.

Jessica is a lively 65-year-old who retired from her work as a primary school teacher to concentrate on her community work. She has worked for a number of local and international charities and, with her son, founded FDNC. Much of her work has been focused on empowering women. She co-founded and is Chair of the micro-finance bank in her own village. When I asked Jessica what she hoped to gain from the OPL2 course, she explained that she recently opened a school for children with physical and learning disabilities. It is attended by 25 children, 15 on a daily basis: she has found a teacher but believes that the OPL2 training will be helpful for this as well as other initiatives.

Curriculum sources, aims and content

The curriculum was derived from training programmes developed by the Uganda Health Ministry and adapted to fit the specific activities expected of the OPL2s. Mindful that differences can arise between an approved curriculum and the actual learning and teaching activities delivered for a specific course, this report is based on the timetable produced for this cohort and the learning activities that were observed.

The stated objectives of the training are extensive and ambitious. These "are geared towards empowering participants with knowledge and skills to enable them carry out the following in their communities:

- Manage target diseases
- Provide immunization
- Give health advice and counselling
- Collect analyse and compile data
- To identify and manage common nutritional problems.
- Manage equipment and supplies
- Manage essential drugs
- Provide family planning services
- Integrate services and support inter-sectoral collaboration
- Initiate and support community participation for health promotion
- Follow up patients /clients
- Evaluate health services
- Initiate growth monitoring, oral rehydration, breast feeding and immunization (GDB1) in the community.
- Support all primary health care strategies within their catchment areas and beyond.
- Manage Aid posts and refer patients accordingly.
- Provide support and supervision to community health promoters."

The intensive timetable covered a wide but appropriate range of topics, including primary health care, environmental health, accidents and first aid, health information systems, health services, management of medicines, family planning, breast feeding, nutrition, growth monitoring, immunization, major and common conditions, including HIV/AIDS and malaria, clinical problem solving, leadership and interpersonal skills, community entry and engagement.

Course delivery

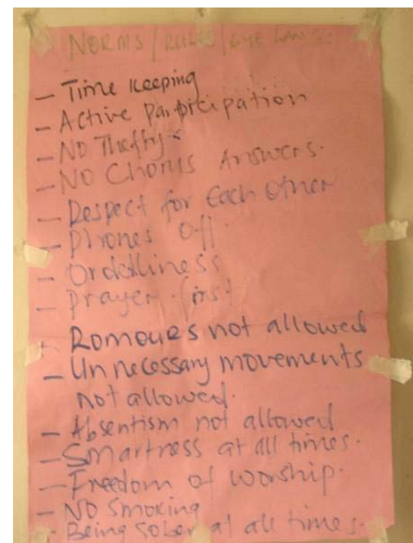
The teachers/facilitators I was able to observe demonstrated skill, enthusiasm and commitment as teachers and had relevant expertise. As practitioners or senior officials in their field, they were often able to season their presentations with local details and anecdotes. From a UK higher education perspective, most of the teaching methods I observed were quite traditional and the resources were below what we would consider basic.

Typically, the teaching I observed could be characterised as the teacher transferring the required information onto A1 flipchart paper and the students transferring this information into their ledgers. However, this characterisation would be to overlook the exchange of questions in both directions and the transmission of values and attitudes. I did observe some group work and was assured that student-centred activities were used more widely than was apparent from the sample I observed.

Assessment strategy and outcomes

The course was continuously assessed. The facilitators' assessment of student participation, together with 3 periodic written tests made up 75% of the assessment load. The remaining 25% was contributed by a 2½ hour synoptic paper. I am informed that the marking process involved several of the facilitators in cross marking.

All of this cohort passed the final examination and the course, about 15 gaining distinctions.



Learning climate

Some idea of the commitment of the students can be appreciated from the fact that they were giving up four weeks of their time to train for an unpaid, voluntary role.

The climate within the group was collaborative, supportive, playful and inclusive but purposeful and conducive to challenge. The students were appreciative of the teachers and hungry for information and practical skills.

Suitability of the course

It was apparent that the course was designed and delivered by practitioners and officials who are well positioned to identify the knowledge and skills required to have and impact upon the health of the population. It was also apparent to the observer that the students valued the expertise of the teachers/facilitators.

Every student I spoke to told me that the training they were receiving was highly relevant and useful. The 20 graduates of the first cohort evaluated the course as excellent. The only qualification I could elicit was that they needed more knowledge, more skills (and more resources) to meet the needs of their communities.

Effects of the deployment of OPL2s in Mbale

Discussions with the Mbale regional administration, hospital administrators and medical practitioners gave a consistent account that the actual and potential contribution of the OPL2s is highly valued. I was assured that data is being collected to ascertain their effectiveness but was not provided with this before my departure.

I was able to meet some of the OPL2s who graduated from the November 2006 course. They were able to provide me with a collage of personal anecdotes, self-reported data and programmes of work which gave a richer and more complete picture of their achievements. Some highlights are:

- A massive increase in deliveries at the Health centre, under the supervision of a midwife (and accompanied by the traditional birth attendants) from 26 in 2006, to over 80 in the first 2 months of their deployment.
- Virtually 100% penetration with immunization programmes.
- Large numbers of families taking up family planning advice.
- Progress with the construction of latrines.
- Much reduced incidence of fevers in children using the treated mosquito nets provided.

Trained OPL2s at their local Health Centre, Busiu, Mbale

Recommendations for consideration

The author is acutely aware of the pitfalls of judging practices within an unfamiliar culture. These recommendations are offered for consideration by the course co-ordinator in a spirit of collegial collaboration and with recognition of the excellent work already done.

1. The success of this initiative depends upon how well it integrates with existing provision. The measures already taken to promote dialogue and co-operation between the several agencies involved in health and social care should be supported and continued.
2. This first aim may be promoted by developing a number of multi-disciplinary protocols for the management of common conditions and problems by the OPL2s. These should be brief and simply worded, be based on current local concepts of good practice and specifically address the circumstances under which referral should be considered.
3. An additional benefit of the protocols is that they may provide a framework to guide refinement of curriculum content. The existing content seems to be influenced by a traditional medical model, which may not be the most appropriate framework for the knowledge and skills required by OPL2s.
4. The delivery of the course over an intensive four-week period must place a considerable burden on the students and their dependents. Division of the course into 2 periods of 2 weeks may alleviate this burden. It would also permit some transfer of learning from the classroom to the students' respective communities and allow the students to advance their understanding of the problems therein. A further possible advantage of this division is to capitalise on this review of local problems as a focus for more student-centred, problem-based activities in the second half of the course. Appropriate forward planning of future courses can accommodate this but this, in turn, requires a more constant and predictable funding stream.
5. The work of the OPL2s is demanding and not without risk. In addition they are deployed in geographically remote locations. It is important that the networks formed during the training course are supported and helped to develop. Periodic conferences and workshops, as planned by PONT, will provide opportunities for peer support, problem solving and ongoing learning. It is to be hoped that the support for this initiative voiced by all parties translates into tangible recognition of the OPL2s, perhaps in the form of help with subsistence and costs.

Summary

The OPL2 course has substantial merit and benefits greatly from the exceptional commitment shown by students and organisers alike. Review of its fitness for purpose at this point will ensure a dynamic curriculum tailored to the needs of these key health workers. While the quality of data obtained so far is less than robust, there is persuasive evidence that the OPL2s are already having an impact on the health of the people of Mbale.