

# Africa Grants Programme, THET 2016-2017

## Report on 2nd Training

**Sponsor:**



**Project Goal:**

Palliative care capacity building at a community level in Mauritania

**Activity:**

Training of 25 health care professionals from the interior of the country in the foundations of palliative care.

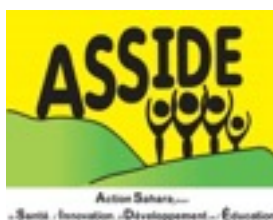
**Actors:**

Cairdeas International Palliative Care Trust

Action Sahara pour la Santé, l'Innovation, le Développement et l'Éducation

**Dates:**

5th to 9th December, 2016



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# Introduction

The second THET sponsored palliative care training took place from the 5th to the 9th of December, organised by Cairdeas Sahara, a collaboration between the Scottish Charity, Cairdeas International Palliative Care Trust and the Mauritanian association 'ASSIDE'. Twenty-two health care professionals from rural Mauritania were able to travel to the capital, where the training took place at the office of ASSIDE.

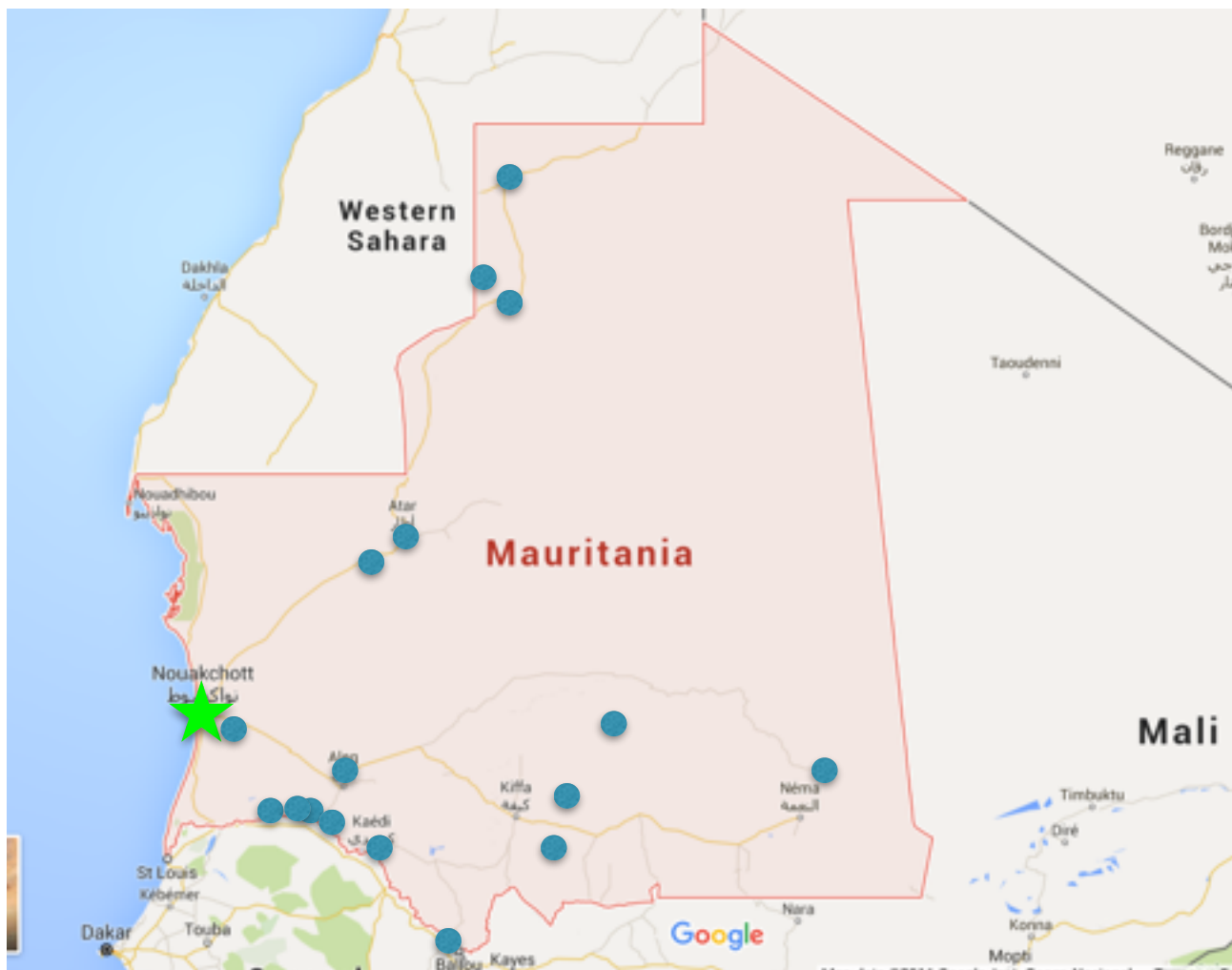


Image 1: Location of participants; the star shows the capital, Nouakchott where the training occurred

Nurses and doctors attended from all over Mauritania, the furthest away was 2,400km away from the capital., with the average distance being 1,135km (Image 1 and Appendix 3).

The training covered a wide range of topics relating to palliative care in a resource limited setting. It was based on the Palliative Care Toolkit, which was provided to each participant. The training benefited from a rich mix of trainers, both international and local (appendix 1). Multiple approaches

to teaching were incorporated in to the training; lectures, small group work, interactive activities, role playing. One activity included groups having to establish the major problem from a case history, and then decide which medications they were going to buy from a pharmacy set up in the room. This task was adjusted so that the doctors formed one group with more complex scenarios than for the nurses.

We evaluated the training employing confidence rating scales, knowledge tests and evaluation forms.

## Evaluation

Daily anonymous evaluation forms were completed, which enabled a reflective and flexible approach to comments. Examples of feedback included a request for more fresh fruit during the coffee break, which was accommodated for the following day.

Overall the training received very positive feedback, both in personal communication and in formal written anonymous feedback. **100%** of participants found the training to be relevant to their context, and **87%** marked the training as either excellent or very good.

Many participants marked all modules as being useful however several mentioned the evaluation and treatment of pain (5 participants) and cancer (3 participants) as especially useful.

## Confidence Rating Scale

Confidence rating scales were used to provide formative feedback to the participants. These facilitate a reflection on the training, rather than a measurement of the effectiveness of the training. Confidence was rated for 5 questions, marked on a scale prior to the training. These scales were returned to the participants at the end of the training and changes were recorded on the same scale. Confidence was rated from 0 (not at all confident) to 10 (fully confident). Table 1 shows a global increase in confidence across a spectrum of palliative care domains, especially relating to the holistic approach and in breaking bad news.

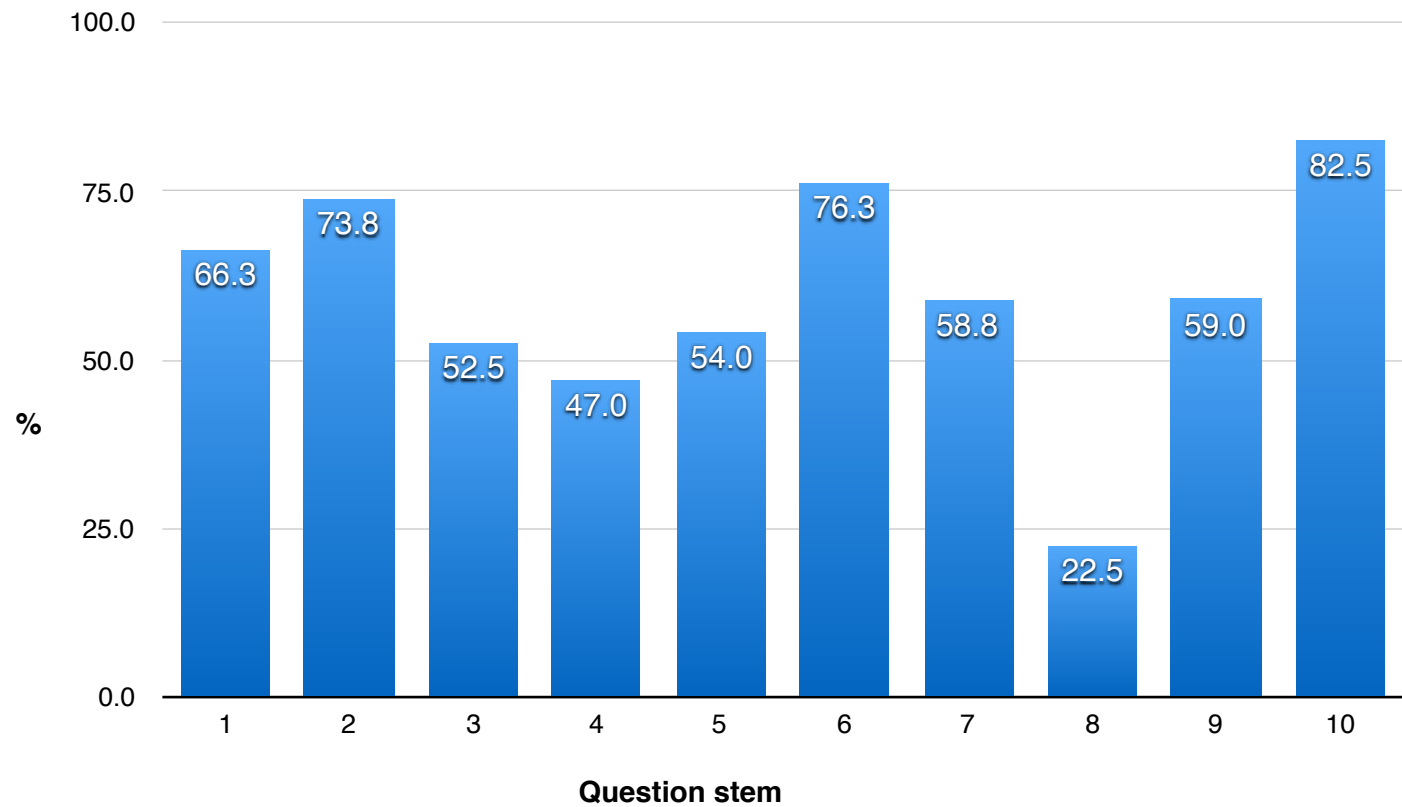
Question	Confidence rating	
	Pre-training (0 to 10)	Post-training (0 to 10)
I can evaluate the pain of a palliative patient	4.6	8.0
I understand the three step WHO pain ladder	4.8	8.8
I understand the role of palliative care for cancer patients	3.8	8.2
I understand the concept of holistic care.	3.3	8.4
I feel trained to inform patients of bad news	3.5	8.2

Table 1. Average confidence rating

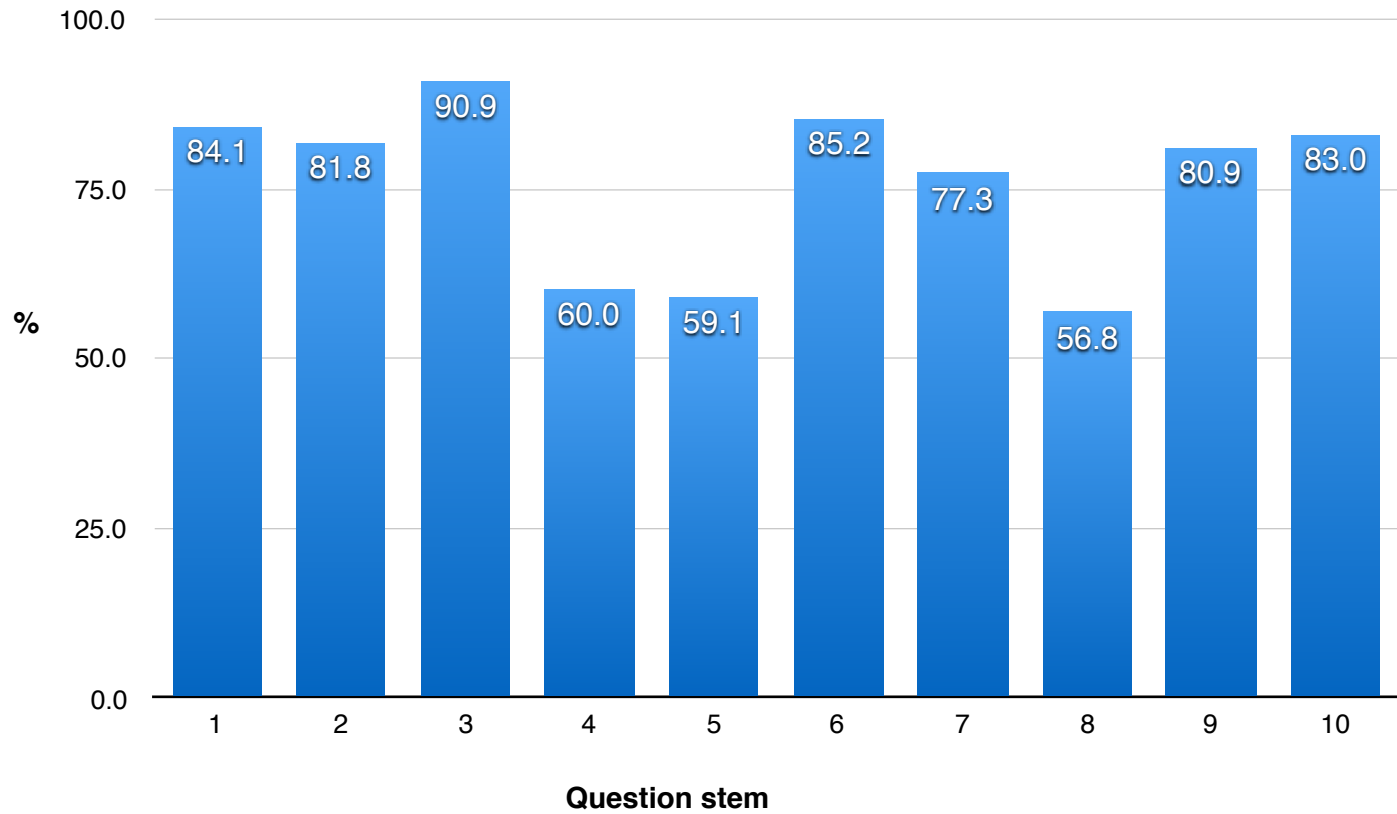
## Knowledge Tests

Knowledge related to palliative care was tested through the completion of a exam with 43 multiple choice questions, divided across 10 domains. The median score of results per domain are represented in the graphs below. The domains are; the foundations of palliative care (1), the holistic approach (2), the WHO pain ladder (3), oral morphine (4), chronic pain (5), neuropathic pain (6), emotional pain (7), end of life care (8), the control of symptoms (9), and communication (10). The two graphs below demonstrate a global improvement in knowledge of palliative care, especially in regards to the WHO pain ladder (domain 3) and end of life care (domain 8). The same questions were presented to each participant before and after the training, they had 15 minutes to complete the questions.

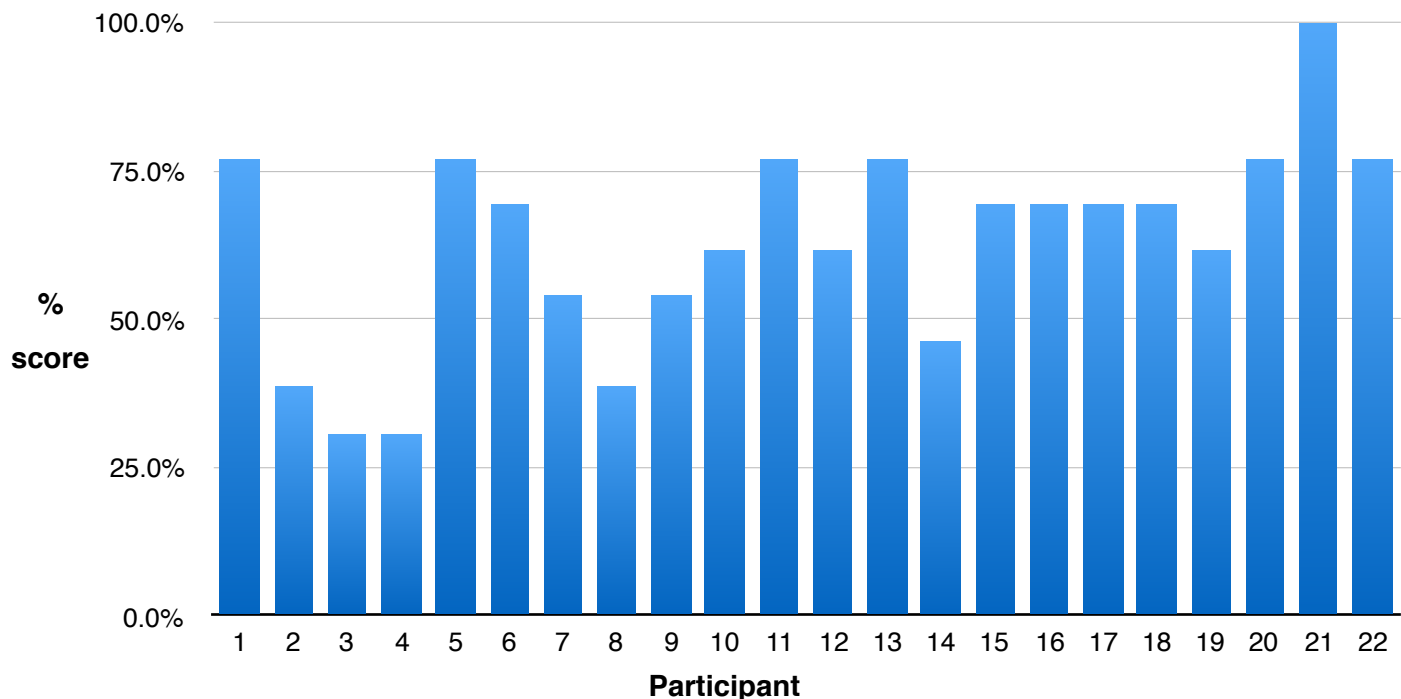
Graph 1. Knowledge testing: Pre-training



Graph 2. Knowledge testing: Post-training



In the training of partners in June 2016, partners were asked to complete an additional knowledge test on the WHO pain ladder. This activity was to shed light on the high levels of confidence self reported on this topic. This test was repeated at the end of the training for all participants of this current training. The average score was 69.2% however Graph 3 demonstrates the spread of scores, from 31% to 100%.



Graph 3: Scores for the knowledge test on the WHO pain ladder.

## Adjustments

25 participants had confirmed their presence 2 weeks prior to the start of the training, as requested in the initial invitation. Unfortunately three cancelled at the very last minute, one on the Sunday evening before the training began, one on the first day of training and a third did not turn up and we were required to phone to clarify that they were no longer going to attend. In light of the very late notice we were unable to find replacement participants. This however did not negatively influence the group dynamics. It is interesting to note that the three non-attendees were all medical doctors. It is hypothesised that medical staff have more access to training than nurses and therefore this training was less attractive to them. There is also a culture of training participants receiving relatively large 'sitting fees' to attend trainings, which we do not provide. This could therefore play a factor. Overall it was felt that the participants appreciated the training for what it was, and did not attend to earn a sitting fee.

Two participants, one nurse and one doctor, remained for two days of home visits with the team after the training. This was well appreciated and allowed a short exposure to the actual putting into practice their learning.

Several of the modules were adjusted from the first training in May. The communication module was adjusted from the first training which worked well. The insights gained from the mentoring visit were incorporated throughout the programme, specifically in the module 'palliative care in a rural context'.

## Research

Three semi-structured interviews were carried out with participants. The two participants who attended home visits were interviewed, in addition to a nurse who was previously interviewed during the mentoring trip at their health post.

## Conclusion

Overall the team of trainers was pleased with the participation and motivation of the participants. The mix of doctors and nurses worked well, enriching the debates within the group. It was encouraging to witness how the components of the THET sponsored capacity building have been built upon, creating a momentum. A nurse technician trained in May as a partner returned to help in the training. This was helpful to the team as he contributed insights from his place of work. He was also able to participate in several home visits and was interviewed as part of the creation of a short video documentary. Insights from the mentoring trip were incorporated throughout the training, for example health professionals have argued that it is not necessary to treat pain as it relieves sins according to their religion. This claim contradicts the data from the several focus groups held with imams during the mentoring trip. The following discussions were held on the subsequent trainings and the training of trainers.

## Acknowledgements

The Cairdeas Sahara collaboration would like to sincerely thank all those involved in the training, up front and behind the scenes. Special thanks goes to the visiting trainers, Dr Boubacar Sow, (Senegal) Oulimata Sow (Senegal) and Sylvie Dive (Uganda). This training provided an excellent opportunity to reinforce the international network of francophone folk passionate about palliative care.



# Appendices

## Appendix 1: Trainers

Trainers	Experience	Role
<b>Sylvie Dive</b>	Trainer and programme coordinator for Franco-phone Africa, based at Hospice Africa Uganda	Volunteer
<b>Dr Boubacar Sow</b>	Geriatrician, running a palliative care service in Senegal	Volunteer
<b>Oulimata Sow</b>	Nutritionist, running a palliative care service in Senegal	Volunteer
<b>Dr Dave Fearon</b>	General Practitioner, PhD student in palliative care	Volunteer with Cairdeas International
<b>Ndiaye Aliou</b>	Mauritanian Nurse, recently completed a five week training in palliative care in Uganda	Employed by ASSIDE
<b>Dr Ahmedou ould Toulba</b>	Mauritanian. Clinical Oncologist, Centre National d'Oncologie, Nouakchott	Friend of Cairdeas Sahara
<b>Dem Abdoulaye</b>	Mauritanian nurse, trained as partner in the first THET training in May 2016	Partner with Cairdeas Sahara
<b>Fatimata Abdoulaye</b>	Mauritanian Nurse, recently completed a five week training in palliative care in Uganda. Works in Onco-paediatrics at Centre National d'Oncologie	Friend of Cairdeas Sahara
<b>Kari Kinard</b>	Nurse Practitioner	Volunteer with Cairdeas Sahara

## Appendix 2: Programme

### Formation en Soins Palliatifs : Nouakchott

	Lundi 5/12/2016	Mardi 6/12/2016	Mercredi 7/12/2016	Jeudi 8/12/2016	Vendredi 9/12/2016
8h30-10h00	Session d'introduction	Évaluer la douleur et d'autres problèmes	Aider à soulager différents symptômes 1	Aider les enfants et leurs familles	En parler avec les autres
10h00-10h30	Pause	Pause	Pause	Pause	Pause
10h30 - 11h15	Que sont les soins palliatifs ? (Soins holistiques)	Contrôler la douleur	Aider à soulager différents symptômes 2	Expérience d'une unité mobile de SP à Dakar	Post-Tests, échelles, évaluation et clôture
11h15 - 12h15				Le deuil	
12h15 - 12h30	Pause	Pause	Pause	Pause	Fin
12h30 - 14h00	Offrir des soins palliatifs dans le milieu rurale	Traiter, soigner et prescrire	Les Soins Palliatifs et le VIH	Donner des soins de fin de vie	
14h00 - 15h00	Déjeuner	Déjeuner	Déjeuner	Déjeuner	
15h00 - 15h45	Le soutien spirituel	Améliorer vos compétences de communication	Annoncer de mauvaises nouvelles avec tact	Le Cancer	
15h45 - 16h30					

### Appendix 3: List of participants

	Occupation	Town	Distance - Return distance
<b>Mustafa ould Mohameden</b>	Doctor	Rachid	1,300
<b>Dieynaba Amadou Dia</b>	Nurse	Fonde (Bababé)	820
<b>Diko Abdoul Bâ</b>	Nurse	Kaedi	830
<b>Cheikh Tijane Yall</b>	Nurse	Tekane	600
<b>Elhousseinou Samba N'Diaye</b>	Nurse	Timbedgha	2,400
<b>Ba Khassoum</b>	Doctor	Boghé	630
<b>Thiam Mamadou Harouna</b>	Nurse	N'Goral (Boghé)	700
<b>Coumba Diop</b>	Nurse	Akjoujet	500
<b>Zeinabou Kasse</b>	Nurse	Kaedi	830
<b>Sall Yahya Souleymane</b>	Nurse	Boghé	630
<b>Oumou Aliou Diop</b>	Nurse	Selibaby	1,290
<b>Aissata Saïdy Tall</b>	Nurse	Aere Nbare	800
<b>Mohamed Ould Med Vadhel</b>	Nurse	Zouerat	1,530
<b>Ramata Salif Sall</b>	Nurse	Atar	900
<b>Safiyatou Sarr</b>	Nurse	Fderik	1,480
<b>Hamidou Mamadou Ndongo</b>	Nurse	Birmougren	2,100
<b>Dia Hamadi Mamadou</b>	Nurse	Kiffa (Lebher) 195km après Kiffa	1,600
<b>Mohameden Ould Abou</b>	Nurse	Atar	900
<b>Itawel Oumrou</b>	Doctor	Owjeft	1,000
<b>Nah Ahmedou Toulba</b>	Doctor	Ouad Naga	100
<b>Oumar Sow</b>	Doctor	[Kiffa] 250km après Kiffa	1,700
<b>Alya Mint Mohamed Bouhoubeynie</b>	Nurse	Zoueratt	1,530

## Appendix 4: Updated GANTT Chart

Definition	Symbol	Explanation
Completed task	C	
Partially completed task		The activity consists of 2 focus groups (completed) and qualitative interviews (not yet completed)
New task to be completed	X	The program and modules needs to be adapted as per evaluation, and for translation into Arabic for the third training
Task to be completed	X	

Activities	Timing of Activities											
	Months											
	M	J	J	A	S	O	N	D	J	F	M	A
	1	2	3	4	5	6	7	8	9	10	11	12
Organisation and preparation of training	C	C	C				C	C	X			
<b>Training:</b> 25 participants each training		C						C		X		
M&E: Pre and post quantitative evaluation of training		C						C		X		
M&E: Observation of training		C										
M&E: Qualitative Evaluation of training		C						C		X		
Training of trainers: 8 participants trained		C										
M&E: Transcription and Translation of interviews		C	C									
M&E: Analysis of research from first training and feedback to inform the mentoring visit			C	C	C							
<b>Mentoring Visits: 4 community health posts visited</b>						C	C			X	X	
Community workshop during visit						C	C			X	X	
M&E: Qualitative interviewing of participants and families						C	C					
M&E: Analysis of data from 1st training and 1st visit						C	C	C				
Implementation of research findings in subsequent training and visits							C	C	X	X	X	
Creation of video							C	C	X	X	X	X
M&E: Analysis of data from 2nd visit								C	X			
M&E: Most Significant Change										X	X	X
M&E: Synthesis of quantitative and qualitative data											X	X
M&E: Writing up of research for submission to academic journal											X	X

## Appendix 5: Photos of training



Day 1: Large group teaching session



Day 1: Ndiaye and Dem lead a session on Palliative care in a rural context





Day 2: Sylvie and Fatimata teaching analgesia



Day 3: Symptom and problem group activity



Day 3 'Gold fish bowl' role playing



Day 5 'Egg drop' team working activity





Day 5. Participants with their certificates