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Nguyen Toan Tran [a,b] Kristen Harker,[b] Wambi Maurice E. Yameogo,[c] Seni Kouanda,[d,e] Tieba Millogo,[f] Emebet Dlasso Menna,[g,h] Jeevan Raj Lohani,[i] Om Maharjan [j] Sake Jemelia Beda,[k] Elizabeth Akinyi Odinga,[l] Adama Ouattara,[m] Charlemagne Ouedraogo,[n] Alison Greer,[o] Sandra Krause[p]

a Adjunct Professor, Australian Centre for Public and Population Health Research, Faculty of Health, University of Technology, Sydney, NSW, Australia

b Independent Consultant, Women's Refugee Commission, New York, NY, USA

c Assistant Lecturer, Institut Africain de Santé Publique, Ouagadougou, Burkina Faso

d Professor of Epidemiology, Deputy Director at Institut Africain de Sante Publique, Ouagadougou, Burkina Faso

e Director of Research, Head of Public Health Department, l'Institut de Recherche en Sciences de la Santé (IRSS), Ouagadougou, Burkina Faso

f Research Assistant, Institut Africain de Santé Publique, Ouagadougou, Burkina Faso

g Former Monitoring and Evaluation Coordinator, International Medical Corps, Juba, South Sudan

h Currently Grants, Monitoring, Evaluation, Accountability and Learning (MEAL) Coordinator, International Medical Corps, Amman, Jordan

i Chief Technical Advisor, Nepal Evaluation and Assessment Team, Kathmandu, Nepal

j Medical Manager, Family Planning Association of Nepal (FPAN), Lalitpur, Nepal

k Midwifery Tutor, Juba College of Nursing and Midwifery (JCONAM), Juba Teaching and Referral Hospital, Juba, South Sudan

l Program Manager, Juba College of Nursing and Midwifery (JCONAM), Juba, South Sudan

m Assistant Professor, Université de Ouagadougou, Ouagadougou, Burkina Faso

n Associate Professor, Université de Ouagadougou, Ouagadougou, Burkina Faso

o Program Manager, Inter-agency Working Group on Reproductive Health in Crises/Women's Refugee Commission, New York, NY 10018, USA. *Correspondence:* alisong@wrcommission.org

p Sexual and Reproductive Health Program Director, Women's Refugee Commission, New York, NY, USA

Abstract: *During the early humanitarian response to a crisis, there is limited time to train health providers in the life-saving clinical services of the Minimum Initial Services Package (MISP) for Reproductive Health. The Training Partnership Initiative of the Inter-agency Working Group on Reproductive Health in Crises developed the S-CORT model (Sexual and reproductive health Clinical Outreach Refresher Training) for service providers operating in acute humanitarian settings and needing to rapidly refresh their knowledge and skills. Through qualitative research, this study aimed to determine the operational enablers and barriers related to the implementation of two S-CORT modules: clinical management of sexual violence survivors (CMoSVS) and manual vacuum aspiration (MVA). Across three participating countries (Burkina Faso, Nepal, and South Sudan), 135 health staff attended the CMoSVS refresher training and 94 the MVA refresher training. Results from the focus group discussions and in-depth interviews suggest that the S-CORT approach is respectful of human rights and quality of care principles. Furthermore, it is potentially effective in enhancing the knowledge and skills of existing trained service providers, strengthening their capacity, and changing their attitudes towards abortion-related services, for example. The S-CORT is a promising model for implementation in the acute phase of an emergency upon stabilisation of the security situation. The model can also be integrated into broader post-crisis capacity development efforts. Future operational research*

Introduction

The Inter-agency Working Group on Reproductive Health in Crises (IAWG) was established to ensure that crisis-affected populations have access to life-saving sexual and reproductive health (SRH) services. The IAWG Training Partnership Initiative (IAWG-TPI) promotes this objective by developing the capacity of SRH stakeholders from crisis-affected countries and regions, including health staff and service providers.[1] Within a framework of local and international partnerships, local ownership, and involvement of local SRH stakeholders, the IAWG-TPI aims to strengthen access to and the quality of SRH services in humanitarian settings by: (i) coordinating, strengthening, and maintaining capacity building partnerships between IAWG members and training institutions in countries impacted by crises; (ii) rolling out clinical refresher trainings on life-saving SRH interventions based on sound evidence and international standards; and (iii) building the body of evidence on capacity development for SRH in humanitarian settings.

At the onset of a crisis, there is limited time to train health providers to implement the clinical components of the standard of care known as the Minimum Initial Services Package (MISP) for Reproductive Health.[2] Those who are either deployed to or remain in the field should be experienced and competent in the priority life-saving clinical skills of the MISP. This may not always be the case as per findings from the 2012 to 2014 IAWG global evaluation, which identified key gaps in the field of SRH in humanitarian contexts, including the prevention of sexual violence and comprehensive management of sexual violence survivors, safe abortion and post-abortion care, and emergency obstetric and newborn care, among others.[3–5] There remains limited evidence regarding the most effective capacity development approaches to refresh service providers' knowledge and skills in these settings.[6] Well-established training models have not been evaluated and findings published, such as the two-week SRH or one-week Advanced Life Support Obstetrics (ALSO) trainings organised by and for Médecins Sans Frontières (MSF) staff only and held at a central location, such as one of the MSF Operational Centres in Europe.[7] Another example is the three-week emergency obstetrics care or post-abortion care trainings organised by Marie Stopes International/the RAISE Initiative, which are open to staff from other institutions and held at their international training centre in Kenya.[8] Shorter on-the-job training courses can be critical to refresh the knowledge and skills learned during pre-service training and ensure the continuous availability of MISP services by keeping providers at or near their clinic.

To address this need, two clinical refresher training modules on core clinical components that help manage the consequences of sexual violence and reduce maternal mortality and morbidity were developed and piloted: one on the clinical management of sexual violence survivors (CMoSVS) and one on manual vacuum aspiration (MVA). First, the IAWG-TPI's team undertook a rapid review of the literature to identify existing training curricula on CMoSVS and MVA. Based on our technical experts' in-depth knowledge of the field and of the training gaps regarding such refresher courses, a rapid review was deemed to be sufficient to produce information in a timely manner while limiting the risk of missing key publications.[9] This search did not yield any results specific to refresher trainings on SRH in humanitarian settings. Several CMoSVS and MVA curricula were identified and drawn upon to design the two refresher trainings. The CMoSVS curriculum is founded on well-established guidance from the World Health Organization/United Nations Population Fund/United Nations High Commissioner for Refugees.[10] The MVA curriculum is derived from the extensive training work of Ipas.[11]

The modules' adaptable two-day curricula are designed for service providers in humanitarian contexts, such as midwives, nurses, or doctors, who were trained on the specific clinical intervention in the past, and aim to refresh their clinical knowledge and skills. The design of the two courses was based on the following assumptions and

considerations: (i) providers have received training on the clinical intervention (during pre-service or in-service trainings), but have not used it for some time or are using outdated techniques, and therefore, require a refresher training; and (ii) to mitigate compromising the availability of providers at their work stations, curricula are limited to two days and rolled out at or close to the trainees' work setting, in a classroom or on-the-job, depending on the setting. This training model is referred to as S-CORT (Sexual and reproductive health Clinical Outreach Refresher Training). The S-CORTs were created using the latest clinical evidence and adult learning techniques (including role plays, case studies, demonstration videos, and constructive feedback) and integrate interactive PowerPoint presentations and hands-on skills practice sessions.[12,13] The modules can be freely accessed online.[14]

To inform future clinical refresher trainings, the IAWG-TPI conducted operational research (OR) on the CMoSVS and MVA modules to determine the operational enablers and barriers related to their implementation and assessed the contents of the modules from a programmatic standpoint. The hypothesis for the OR was that outreach capacity development strategies that engage training institutes in crisis-affected countries to facilitate short clinical refresher training courses are feasible and can contribute to strengthening the competencies of SRH service providers in humanitarian settings.

Methodology

This research lies within a human resource management framework, where several factors build upon one another to strengthen human resources for health (HRH). These factors include: policy, leadership and management, financing, partnerships, and education and capacity development.[15] While all these factors are important to strengthen HRH – including in humanitarian settings – through the piloting of the S-CORT modules, this study focuses on influencing the last component, HRH education, and capacity development. The following steps were undertaken to facilitate trainings on the modules and implement the OR during field implementation.

Site selection

A call for interested institutions to partake in the OR study was launched through the IAWG listserv. Criteria for participation required that

institutions: (i) work in an acute or protracted humanitarian setting, (ii) collaborate with local implementing partners, and (iii) have experience in research or collaborate with local research institutions. Applications were submitted from six countries: Burkina Faso, Democratic Republic of the Congo, Nepal, Pakistan, South Sudan, and Sri Lanka. After reviewing the institutional capacity to facilitate the training course and implement the research protocol, the following partners were selected: Burkina Faso (Institut Africain de Santé Publique in partnership with the Ministry of Health), Nepal (the Family Planning Association of Nepal in collaboration with a research consultant), and South Sudan (the Juba College of Nursing and Midwifery supported by International Medical Corps). All three country teams committed to implementing the S-CORT modules in selected crisis-affected settings (see Table 1).

Research protocol development and ethical approval

The IAWG-TPI developed the research protocol and research instruments, which were presented and discussed with the country research partners during a regional stakeholder engagement workshop. Ethical approval was secured from the Comité d'éthique of the Ministry of Health in Burkina Faso (reference number: 2016-6-074), the Juba College of Nursing and Midwifery in South Sudan (the Ministry of Health's ethical review board approved of the research with a significant delay on 15 September 2016), and the Nepal Health Research Council in Nepal (reference number: 153/2016).

Regional stakeholder engagement

A workshop organised by the IAWG-TPI in March 2016 in Dakar, Senegal, gathered clinical trainers with experience in CMoSVS and MVA ($n = 8$; 2 female, 6 male) and researchers ($n = 3$; 1 female, 2 male) from the three country teams, as well as global IAWG-TPI partners (Jhpiego, Ipas, and the University of Papua New Guinea; $n = 5$; 2 female, 3 male). The meeting was facilitated by the IAWG-TPI coordination team ($n = 3$; 2 female, 1 male), which engaged participants to review and discuss the draft training modules (including hands-on practice) as well as the research protocol and instruments, such as the focus group discussion (FGD) and in-depth interview (IDI) guides. Seven of the clinical trainers were confirmed as master trainers at the end of workshop.

Table 1. Number of participants, location of the training, and remarks about participants and crisis settings by study country

	CMoSVS module No. of providers trained (training location)	MVA module No. of providers trained (training location)	Remarks about participants and crisis settings
Burkina Faso	25 (Sahel Region) 24 (Ouagadougou)	22 (Sahel Region)	Including providers from 2 NGO-run health posts located in two refugee camps (Goudebo and Mentao – affected by conflicts)
Nepal	38 (Dhulikhel) 18 (Gokarna)	38 (Dhulikhel) 18 (Gokarna)	Including providers from Kavre, Lalitpur, and Kathmandu districts, all of which were severely affected by the earthquake in 2015
South Sudan	30 (Maban and Juba)	16 (Maban and Juba)	Trainings included participants from crisis-affected sites across the country (including Maban, Nyal, Ganyiel, Yei, Doro and Batil – affected by conflicts)
Total	135	94	Total number of crisis settings: 11

Rolling out the S-CORT

Between April and June 2016, the master trainers facilitated the roll-out of each S-CORT in a two-day training session for service providers, including physicians, nurses, midwives, and clinical officers (approximately 2/3 of providers were female and 1/3 male). Participants received pre- and post-tests and completed a course evaluation, including a self-evaluation of their confidence to provide the interventions in which they were trained. The results of the course evaluation are summarised in country project reports and not included in this article. Providers were encouraged to apply the skills they learned in their respective health facilities. Table 1 describes the number of participants and location of the training by country.

Qualitative research

Four to eight weeks after the S-CORT roll-out – a flexible time period necessary to overcome logistics challenges specific to conducting research in the different settings – each of the three in-country research teams carried out qualitative research using FGDs and IDIs with participants. IDIs with master trainers were undertaken by the IAWG-TPI Secretariat at a later date due to time constraints.

Sampling

Research teams used convenience sampling for participant selection, considering the diversity of health professionals and the location of the health facilities where providers worked, which resulted in a different number of interviews conducted in each country, and a different number of participants in each FGD (see Table 2). All master trainers

Table 2. Number of FGDs and IDIs by staff type and country

	Number of FGDs (total number of providers)	Number of IDIs with coordinators	Number of IDIs with master trainers
Burkina Faso	2 (20)	3	1
South Sudan*	1 (8)	4	1
Nepal	6 (23)	5	1
Total	9 (51)	12	3

* In addition, 8 respondents provided written feedback: 6 providers, 2 master trainers.

were invited to participate in an IDI, for which the interview guide template for trainees was adapted.

Data collection

The interview guides were translated into the respective local languages (French in Burkina Faso, Nepali in Nepal), before field-testing by researchers. The main themes included (i) knowledge, attitudes, and practices (KAP) related to the MISP clinical services; (ii) perception about the effectiveness of the S-CORT; (iii) efficiency of the S-CORT; and (iv) human rights considerations and quality of care in the provision of services, including confidentiality and privacy, access and choice for clients, informed consent, and non-discrimination. Interviews were audiotaped after obtaining agreement from participants. Table 2 presents the number of FGDs and IDIs by type and country. Research assistants transcribed the interviews using Microsoft Word. FGDs gathered male and female providers and, therefore, distinction between genders was not reported in the transcription. Accuracy checks were done by comparing transcripts with audio files. For three of the six master trainers whom the IAWG-TPI secretariat could contact, IDIs were administered by Skype (one master trainer responded in writing).

Data analysis

Thematic analysis was performed by a qualitative analyst using QSR NVivo 11 software, a qualitative research management tool.[16] A basic codebook, which describes all the codes used for analysis, was established and used to code data. The four main codes reflected the themes described above. The contents of the modules were assessed by perceived changes in the KAP related to the overall MISP package of which MVA and CMoSVS are a part; perception about effectiveness (strengthening of knowledge, skills, and capacity related to MVA and CMoSVS); and the extent to which human rights and quality of care were enhanced as a result of the S-CORT. Efficiency was explored through operational barriers and enablers related to the implementation of the training model. The codebook was enriched with new codes as they emerged during the coding process.

Results

The following section presents a summary of the qualitative research findings.

MISP as a foundation

Following their training, participants appeared to be knowledgeable of the MISP and reported that the MISP is important for patients and health workers.

"During the earthquake, we were not ready to provide services related to MISP. We were not aware that there were guidance and kits for these services … MISP training was good. We learnt about the essential services we should provide. MISP services are useful for woman and children because they are the most vulnerable groups." (FGD with female and male trainees, Nepal)

However, master trainers suggested that having participants certified in the MISP distance learning module prior to the S-CORT workshop would allow everybody to start from a common ground in terms of understanding the MISP within the humanitarian context.

"They [trainees] should do and pass the MISP training module because with that in mind, then the training becomes a little bit easier, because some participants have never heard about the MISP and they are working in humanitarian crises, so it becomes a little bit challenging. And CMoSVS [and MVA] are MISP objectives, so it is important that they do the MISP online module and pass [it] before they do the refresher training." (IDI with a female master trainer, South Sudan)

Perception about effectiveness of the S-CORT

In all three countries, providers were generally satisfied with the content and delivery of the training sessions. They highlighted the professionalism of the trainers and their ability to communicate and interact. They enjoyed the material contained in the modules and thought it helped to update their knowledge as well as learn new skills.

"It [the training] reminded us about what we had forgotten in [professional] schools and made us aware of the new changes and current treatments … For post-abortion care, there was a procedure that I had forgotten but I remembered during practical exercise. Now, I know all the steps and am able to do it after the training." (FGD with female and male trainees, South Sudan)

The reported update in knowledge and skills is consistent with the improvement of pre- and post-training scores in all three countries. For

instance, in South Sudan, pre- and post-training scores for the CMoSVS module were, respectively, 48% and 67% and 55% and 74% for the MVA module (these results are available in the unpublished training reports from each country).

The use of pictograms to document injuries to body parts in the CMoSVS module was considered as a new and much appreciated practice.

"We learnt a lot about how to examine the survivor. We were taught how to draw a pictogram and try to locate the wounds, something we had never thought about. Before when we received the victims, we only looked at the genital parts, and would not try to find out whether there were wounds elsewhere." (FGD with female and male trainees, Burkina Faso)

Providers appreciated the exercise on documenting medical findings and the guidance on writing a medical certificate during the CMoSVS module. Several of them pointed out that there were many errors and missing information on the certificates they used to write before this training.

"But there are other things such as the medical certificate and how to write it. Because before we did not know how to write the certificate. We used to write certificates but they were not fully informative." (FGD with female and male trainees, Burkina Faso)

Lastly, the training had an impact on pain management during the MVA procedure in all three countries through the provision of para-cervical blocks when clinically indicated.

"I used to perform post-abortion care; there are things that I did not systematically do. But after the training I have adopted them. For example, the para-cervical block: it relieves women and it reduces pain so that we can do our work." (FGD with female and male trainees, Burkina Faso)

With regard to a change in attitudes, the training courses were perceived to contribute to enhancing providers' empathy towards patients and removing attitudinal barriers, such as judgment or blame associated with MVA procedures or during the management of sexual violence survivors.

"Training imparted awareness about the vulnerability of [sexual violence] survivors and [of patients undergoing] post-abortion. They need no further torture and discrimination. Rather, they need proper psychosocial management to give them hope again … [The training course] was very excellent in improving the technique of handling survivors in a non-stigmatizing manner and how to get information from survivors." (Written report from a trainee – unrecorded gender, South Sudan)

Additionally, the trainings generated dialogue among managers and NGOs around attitudes towards post-abortion care and highlighted the need for intentional values clarification and attitude transformation through SRH working groups at the coordination-level.

Although S-CORTs are intended as refresher courses, many participants, such as those in Burkina Faso, were never trained on CMoSVS. Therefore, this training allowed health centres to have more providers who can offer services to survivors of sexual violence, which increased the availability of services.

"We have four more people who have been trained. It helps to have more staff to care for survivors of sexual violence. I think that the practices of these people will change and then they may inspire others who were not trained." (FGD with female and male trainees, Burkina Faso)

Efficiency of the S-CORT

Regarding the training's duration, the two-day format was thought, in all three countries, to be too short to go in-depth into some subtopics and gain sufficient hands-on practice. To assess the feasibility of the S-CORT model in humanitarian settings, countries with stable humanitarian contexts were selected for pilot testing. However, some of the trainings occurred in development settings within participating countries, due to logistics constraints and security issues. Participants expressed concern that continuing to bring providers to a central location – as was done for pilot testing – would be difficult in acute crisis settings where security and staff availability can be barriers to implementation.

"If we are in a crisis, and let's say that the belligerents are back in town, people will remain at home; health workers will not come out like that to go to trainings." (FGD with female and male trainees, Burkina Faso)

These concerns can be minimised by holding the trainings at or near participants' clinical workplace, which is the recommended setting for the S-CORTS, to minimise travel and time away from clinical practice.

Human rights awareness and quality of care

As a result of the training, participants reported that they were increasingly aware of patients' rights, including confidentiality and privacy in the provision of services. They reported that good communication with patients is paramount to ensure that patients understand risks and benefits to care and can make informed decisions.

"We had less knowledge about taking consent before the training. But now we learned that we should first tell them the positive things followed by the ill effects. Then after receiving the patient consent, we take [the] signature of our client and start the procedure." (FGD with female and male trainees, Nepal)

Non-discrimination, privacy, and confidentiality were also principles that providers reported to have integrated into their clinical practice after attending the S-CORTs.

"Providing quality care services to the survivors [means doing it] without asking where and which tribe the survivor comes from, [or without] considering age or sex because the survivor can be of any age or sex … Privacy and confidentiality in the delivery of SRH services [allows] the survivors to share their story on what happened without fear. He/she is able to explain everything in detail, [which] eases the work of the service provider." (Written feedback from a trainee – unrecorded gender, South Sudan)

Lastly, providers cited accounting for special needs groups in humanitarian contexts as another guiding principal emphasised during the refresher trainings.

"[It is important to] pay attention to groups who come for special needs. All this has been strengthened and we know that in times of crisis, there are always these features to account for." (FGD with female and male trainees, Burkina Faso)

Discussion

The S-CORT modules offer an innovative approach to strengthening the capacity of service providers to deliver life-saving SRH services in humanitarian settings. This strategy can already be implemented in the acute phase of an emergency as soon as the security situation allows. To our knowledge, the S-CORT model is the first of its kind, which focuses on the clinical services included in the MISP, targets providers who need a rapid hands-on refresher training course, and trains them close to the location where they offer these services. Mitigating the amount of time the health workforce is removed from its clinical duties is especially important in settings where conflicts or natural disasters have likely taken a toll on human capital, particularly on HRH.[17] This approach complements other well-established capacity strengthening models in SRH, which may be less suitable in the acute phase of a crisis as the trainings last over several weeks, pull trainees away from their work settings and to a centralised training location, and aim to impart a range of new skills to professionals who might not have had prior training in the topic.[7,8]

The OR from the CMoSVS and MVA pilots suggests that the S-CORT approach is respectful of human rights and quality of care principles, could be efficient for implementation in humanitarian settings, and is potentially effective in enhancing knowledge and skills, bringing changes in attitudes, and strengthening the capacity of existing providers.

Training model

The diverse and dynamic teaching methods used were reported to have worked very well. However, when feasible, SRH program managers should ensure that participants become certified in the MISP Distance Learning Module as a foundation prior to the S-CORT workshop, which will help enhance the efficiency of the model. This will also enable providers to understand how each skill is part of a minimum set of life-saving services that need to be prioritised at the time of crisis.

The S-CORT approach is meant to refresh the knowledge and skills of participants who have already been trained on a specific intervention. In all three countries, end-of-project reports from our implementing partners indicated that very few health staff had been previously trained on the CMoSVS, especially in Burkina Faso. While the CMoSVS module was perceived to be extremely helpful for participants given the need, the two-day training was seen as insufficient and it did not allow enough time for master trainers to cover all the content in the training manual. Consequently, program managers who oversee trainings for health staff should first determine if the refresher training module will meet health providers' training needs, or if a more comprehensive training is required. If providers operating in crisis settings require S-CORTs, program managers

should abide by the criteria for participation, rapidly assess learning needs, and communicate these knowledge gaps and interests to the master trainers who can modify the trainings accordingly.

In countries where there are no pre-service trainings on select life-saving SRH interventions – such as CMoSVS, MVA, or other MISP-related services – SRH working groups should advocate with policymakers and collaborate with professional schools, such as midwifery and nursing schools, to integrate the missing topics and adapt the training course into the national curricula. This is a good practice in the context of disaster risk reduction including emergency preparedness plans (DRR/EPP). The S-CORT model is not a magic bullet to fill human capital deficits in humanitarian settings. It should be implemented within the framework of strengthening inter-agency collaboration and a holistic approach based on DRR/EPP and crisis response principles and entail the establishment of effective referral systems, collaborative information dissemination, community mobilisation mechanisms, and experience sharing fora, among others, to ensure availability of life-saving SRH services.

The two-day model was perceived as too short to allow for sufficient hands-on practice. Some participants suggested a duration of four to five days. However, this would result in a significant disruption in the availability of health staff in participating clinics and reduce access to care for the affected populations. To help maximise the impact of the face-to-face training and when the logistics are feasible, participants should receive training materials and be encouraged to study them in advance. This inverted classroom model has been studied for advanced training in medicine and may be particularly suitable for the S-CORT model.[18] Furthermore, trainers can discuss and possibly organise a calendar of opportunities at the end of the training for trainees to practice their skills at their institution and provide additional training resources if there are opportunities to expand the length of the training by one or two days.

Integration into the broader capacity development framework

The S-CORT model offers an opportunity to boost the knowledge and skills (equivalent to a "booster immunization shot") of service providers operating in acute humanitarian settings who were already trained on these life-saving interventions during pre- or in-service trainings (which could be considered as the "first immunization shots"). This model addresses a specific gap in humanitarian settings but cannot replace a comprehensive national capacity development strategy that should be advocated for with the responsible national authorities, professionals, and regulatory bodies and implemented as soon as the situation allows.

While the S-CORT model can be considered a knowledge and skills booster, evidence indicates that such boosters should be repeated at regular intervals to improve learning outcomes and health staff performance.[19] This could be done through peer-to-peer continuous learning and practice. Regularly scheduled supportive supervision, as part of overall quality improvement efforts, is also found to be effective in reinforcing capacity development outcomes.[20] These can be challenging to implement in the acute phase of a crisis, but should be considered as soon as the situation allows, and be part of the effort to build upon the MISP and transition towards comprehensive SRH services. To encourage such an approach, the S-CORT modules should propose a calendar of continuous clinical learning through structured and ongoing practice sessions for the team of providers to practice with one another. These can include case-based learning to simulate clinical decision-making and hands-on practice of skills using checklists and job aids. Most of the exercises are already available in the existing modules but need to be repackaged into a team-administered programme of continuous clinical learning.

Limitations

Due to time constraints, the pilot testing and OR focused on the contents of the modules rather than on the feasibility assessment of the model in remote outreach settings. For OR for future S-CORT modules, emphasis should, therefore, be given to whether implementing this model in more remote outreach settings in acute or protracted humanitarian contexts is feasible, effective, and efficient.

The Nepal and Burkina Faso country teams implemented the S-CORTs in humanitarian and non-humanitarian settings, where some of the research questions were not relevant to the latter. For logistics reasons, participants from both settings attended the same workshops organised in a centralised location. Many were again invited to a centralised location for the qualitative

research and were interviewed in the same FGDs. This mix of participants is reflected in the FGDs and the results. The transcripts had to be sorted for contents that pertain solely to humanitarian settings.

Country partners reported challenges in ensuring the participation of all trainees in the qualitative research. These challenges included security concerns, inadequate staffing and workloads in certain health facilities, and staff turnover. Therefore, convenience sampling was applied and may limit the generalisability of the findings. All three in-country research partners managed nonetheless to recruit around 40% of all trainees for the qualitative research, which helped mitigate the limitations of convenience sampling.

The S-CORT model is designed for implementation in acute crises but has inherent limitations: master trainers in the country or the region must be available, the situation must be safe enough to allow them to travel to the outreach settings, and health care providers must already be trained in the topic. The last two limitations are outside the reach of the IAWG-TPI, but the first is intimately linked to its core strategy: empowering local and regional actors, such as academic and professional institutions (i.e. medical or midwifery schools) to own the S-CORT modules or other IAWG-TPI endorsed training courses, and be ready to quickly implement them upon demand.

Conclusions

The S-CORT is a promising model of global and local inter-agency collaboration to optimise human capital to deliver the life-saving clinical interventions of the MISP in humanitarian settings. Current and future modules should take into consideration and integrate the results and recommendations of this research. Further operational research is needed and should give emphasis to assessing not only the contents of new modules, but whether implementing this model in remote outreach settings in both acute and protracted humanitarian contexts is feasible, effective, and efficient.

ORCID

Nguyen Toan Tran http://orcid.org/0000-0001-7134-7878
Om Maharjan http://orcid.org/0000-0003-2802-6846

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Résumé

Au début de l'intervention humanitaire en réponse à une crise, on dispose d'un temps limité pour former les prestataires de santé aux services cliniques vitaux du dispositif minimum d'urgence (DMU) pour la santé génésique. Afin de satisfaire ce besoin, l'initiative du partenariat de formation du Groupe de travail interorganisations sur la santé reproductive en situations de crise a mis au point le modèle S-CORT (cours de perfectionnement clinique avancé en santé sexuelle et génésique) pour les prestataires de services qui opèrent dans des crises humanitaires aiguës et doivent rapidement mettre à jour leurs connaissances et compétences. Avec une recherche qualitative, cette étude visait à déterminer les facteurs habilitants et les obstacles opérationnels relatifs à la mise en œuvre de deux modules d'S-CORT : gestion clinique des victimes de la violence sexuelle (GCVVS) et aspiration manuelle intra-utérine (AMIU). Dans les trois pays participants (Burkina Faso, Népal et Soudan du Sud), 135 agents de santé ont suivi le cours de perfectionnement sur la GCVVS et 94 sur l'AMIU. Les résultats des

Resumen

Durante la respuesta humanitaria temprana a una crisis, existe tiempo limitado para capacitar a prestadores de servicios de salud en los servicios clínicos que salvan vidas del Paquete de Servicios Iniciales Mínimos (MISP) para la Salud Reproductiva. Con el fin de atender esta necesidad, la Iniciativa de Alianza en Capacitación del Grupo de Trabajo Interinstitucional sobre Salud Reproductiva en Situaciones de Crisis creó el modelo S-CORT (por las siglas en inglés de Sexual and reproductive health Clinical Outreach Refresher Training, Capacitación de Actualización en Extensión Clínica en Salud Sexual y Reproductiva) para prestadores de servicios que trabajan en emergencias humanitarias agudas y necesitan actualizar sus conocimientos y habilidad rápidamente. Por medio de investigación cualitativa, este estudio tuvo como objetivo determinar los facilitadores operativos y barreras relacionados con la aplicación de dos módulos de S-CORT: manejo clínico de sobrevivientes de violencia sexual (CMoSVS) y aspiración manual endouterina (AMEU). En tres países participantes (Burkina

discussions par groupes d'intérêt et des entretiens approfondis indiquent que l'approche S-CORT respecte les principes des droits de l'homme et de la qualité des soins. De plus, elle est potentiellement efficace pour renforcer les connaissances et les compétences des prestataires de services existants, consolider leurs capacités et changer leurs attitudes, par exemple à l'égard des services relatifs à l'avortement. La formation S-CORT est un modèle prometteur à appliquer dans la phase aiguë d'une situation d'urgence, après stabilisation des conditions de sécurité. Ce modèle peut aussi être intégré dans des activités plus larges de renforcement des capacités après une crise. À l'avenir, la recherche opérationnelle devrait non seulement insister sur une évaluation des contenus de nouveaux modules, mais aussi déterminer si la mise en œuvre de ce modèle de perfectionnement dans des environnements éloignés est faisable, efficace et utile.

Faso, Nepal y Sudán del Sur), 135 integrantes del personal de salud asistieron a la capacitación de actualización en CMoSVS; 94, a la capacitación de actualización en AMEU. Los resultados de las discusiones en grupos focales y entrevistas a profundidad indican que el enfoque S-CORT es respetuoso de los derechos humanos y principios de la calidad de la atención. Más aún, es potencialmente eficaz para mejorar los conocimientos y las habilidades de los prestadores de servicios existentes, fortalecer su capacidad y cambiar sus actitudes hacia los servicios relacionados con el aborto, por ejemplo. S-CORT es un modelo prometedor cuando es aplicado en la fase aguda de una emergencia después de establilizada la situación de seguridad. El modelo también puede ser integrado en esfuerzos más amplios de desarrollo de capacidad post-crisis. Futuras investigaciones operativas deben hacer hincapié no solo en evaluar el contenido de nuevos módulos, sino en cuestionar si es factible, eficaz y eficiente aplicar este modelo de capacitación de actualización en entornos remotos.