Training Multidisciplinary Leaders for Health Promotion in Developing Countries: Lessons Learned

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Abstract

The global picture of maternal mortality and morbidity has changed very little over the past 20 years despite isolated (and often medically based) efforts to improve the situation. A multidisciplinary approach to this very complicated social and cultural problem has been recommended. This article describes the approach taken by the Save the Mothers program in Uganda (Master of Public Health Leadership) and its focus on training national, primarily nonmedical, advocates to bring about the political and cultural change needed to improve maternal health. Emphasis is placed on attracting the right students (through targeted advertising and interviews of candidates), delivering the appropriate package of information to these multidisciplinary students (through problem-based learning and experiential opportunities in the community), and fostering networks among students and graduates to keep the issue of maternal mortality high on their personal and political agendas. Students benefit from a flexible program that allows them to continue to work and study simultaneously while ensuring a high-quality program with faculty who are experts in their area of teaching. Students require practical assistance in their research endeavors and are encouraged to focus their topic on a field related to their place of employment.

Keywords: *safe motherhood; Uganda; educational model*

The failure to reduce maternal mortality and morbidity over the past 20 years has been the fatal frustration of midwives and obstetricians world-wide. Yet the very focus on primarily a medical model for the improvement of maternal health has been a major stumbling block in improving maternal and newborn health (Shiffman, 2007).

BACKGROUND

In recent years, there has been a call for disciplinary diversity within public health (including safe motherhood), but there is a major obstacle to people being trained in public health from other disciplines (Behague, Tawiah, Rosato, Some, & Morrison, 2009). More specifically, most Master in Public Health

(MPH) programs in developing countries attract and accept primarily health workers (e.g., physicians and nurses).

In addition to the challenges of insufficient donor resources, lack of consensus on effective interventions and weak health systems, Shiffman (2007) also suggests that obstacles in the generation of national political support for safe motherhood may be a very important factor in realizing safe motherhood in low resource countries. The costs of saving mothers and their young babies have been deemed affordable, but the key identified gap is leadership and effective implementation at every level of the health system, including national and local accountability for service provision (Chopra, Daviaud, Pattinson, Fonn, & Lawn, 2009). There is a real need for national political and social champions to promote and ensure that safe motherhood is a reality for all women.

The notion of evidence-based policy making, which infers that policies be based on scientific evidence (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996), can be seen as a luxury for countries where policy makers have the background to understand and determine best policies based on literature they have read and understood. This calls for policy makers with a diversified background and in the case of maternal health, one who is fluent in public health principles and literature.

With this background and in this context we started the Save the Mothers program—an advocacy training program in Uganda that targets primarily nonmedical professionals to become engaged in safe motherhood and to become those very champions who can bring about culturally sensitive and sustainable changes for safe motherhood (Chamberlain, Watt, et al. 2008). The purpose of this article is to inform educators and advocates about the challenges of training multidisciplinary professionals in developing countries to promote health issues and especially that of safe motherhood.

STRATEGIES

Based on lessons learned through the Save the Mothers (STM) program, we have valuable principles and guidelines to assist other institutions/organizations who may wish to start/improve programs of a multidisciplinary in the context of developing countries. This article deals with the two major aspects of the STM program:

1. The champions (or students)—who they are and how to attract them to the advocacy program
2. Program issues—the format and logistics of running a multidisciplinary program

Student Issues

Several important issues that relate to the students in the STM program are foundational to its effectiveness and sustainability. These include the recruitment of the right student for the program, the delivery of the program so that it is right for the students and finally ensuring that the students connect and stay connected with each other and the issue of maternal mortality over the long term.

Recruitment of the right students. Since the inception of STM in October 2005, there have been 427 prospective students or champions who have applied to the program (with a mean of 116 students applying per year for the past two academic years). Students range from a variety of backgrounds, including business, marketing, education, health services, politics, and faith communities. Many recruits work for nongovernmental organizations that have small maternal health programs as part of their mandate but do not have a manager with the skills/ competence to manage safe motherhood interventions. Both the students' employers and the students themselves view this educational experience as an opportunity for the student to gain and hone these advocacy skills.

The program usually takes in 25 to 30 students per year and their recruitment is, in many ways, different from the usual academic stream where students are looking to gain a higher education degree. Instead, the program uses a broad scope of methods to attract skilled professionals who may have never made the connection between their vocation and its possible impact on safe motherhood. The program advertises in the national paper, inviting interested individuals to attend an "information" session related to the program. These information sessions are held in a well-known place (e.g., the board room of the World Health Organization or the British Council, located in central Kampala). The sessions are offered on numerous occasions at different times to try and optimize the opportunity for potential students to learn about the program. These information sessions allow participants to "see themselves" as players in safe motherhood. In addition to information sessions, STM targets professional associations or organizations that would have potential students for the program (e.g., Federation of Women Lawyers, Rotary clubs, pastors' conferences).

When applying, students must submit a curriculum vitae (CV) that demonstrates their work/experience in health with an emphasis on maternal health. They also send in a biographical sketch that presents their vision of their participation in the program. This approach follows the example of many North American medical schools where interest significantly outpaces available educational places and where it has been demonstrated that academic achievement alone is an insufficient predictor of success. Ranking students only by their academic standing would miss many qualified prospective medical students (Ferguson, 2002; Mitchell, 1990) and medical schools are looking for individuals with a broader experience and background.

In the same way, the STM program is strategically looking for students with high motivation, good intelligence and a strong sense of social justice, especially for women and children. Interviews are then held for the 60+ students who are chosen from their CVs and autobiographical statements. A standardized marking scheme is used during the interviews with interviewers, usually being STM staff/faculty, or graduated STM students. These interviewers are quite familiar with the STM program and understand the profile of the ideal student for STM. Students are ranked according to the results of their interview and the top 30 to 35 are offered a position. There is usually a non-acceptance rate of about 15% (4-5 students). Most students who reject their admission do so because of financial or job-related issues.

Knowledge and skill delivery—making sure it is right for the students. A group of multidisciplinary professionals brings a wealth of information and experiences, but it also leads to some logistical and

important educational issues. One must expect a wide range of understanding about various topics especially in health—some may be strong in health care while others know very little about the fundamentals of health or clinical medicine— their strength may be in business or health economics. The curriculum must respond to this by allowing students, with little knowledge in a subject, to gain an understanding in the area without overwhelming them but also not boring students who are further ahead in the field. This often leads to students mentoring students. For example, the statistician in the class will hold spontaneous tutorials with students struggling with biostatistics while the journalist can give valuable assistance to his or her classmates in the "communications" course. A problem-based learning (Albanese & Mitchell, 1993) approach is taken in many of the courses, with a focus on using problems related to reproductive health and rights as the problem content. As much as possible, the program is custom designed to meet individual learning needs and build on individual strengths.

The approach taken in the STM program is consistent with the finding that collaboratively developed, collaboratively delivered, experiential, rural public health problem-based learning provides a positive learning experience for trainees in public health (Heading, Fuller, Lyle, & Madden, 2007).

The curriculum needs some flexibility so that students who miss modules or courses are able to take the required course when it is next offered. The courses are offered in six modules (of 3 weeks each) over 2 years for a total of 18 weeks in class during the program. This format allows students to be away only 3 weeks from work—a time that is manageable for most Ugandan professionals. We encourage students to get "buy in" from their employers and to ensure that their employer is seeing the benefit of their studies within the work place. This may include some sort of research done within the sphere of their work place or for the students to share the knowledge/skills that they have learned during their training with STM.

In terms of educational goals, it is important to recognize that the final objective is not to achieve a uniform outcome but rather for each student to gain the knowledge and skills that may differ from one student to another but are equally valuable to the health promotion expert. Students are evaluated through case studies, field trip reports, assignments and formal examinations. Students also evaluate the program regularly and after each module, they complete a written evaluation of the course content, delivery, and program structure. This feedback is taken seriously and, as much as possible, is incorporated into future planning/programming.

One significant example of the role of feedback from students was the initial complaint of the need for accommodation and study areas, exclusively for STM students. On-campus housing was not available at the university for modular students, so STM professionals were forced to stay in low-grade hostels off-campus. Save the Mothers International was able to garner enough funds to build a study center/accommodation facility for STM students by the fourth year of the program's existence. Students can now be housed in the STM Mirembe building where they have online access and are able to study in modern classrooms contained in the same building (Chamberlain & Watt, 2008).

Facilitating networking and leadership among students. Students benefit significantly from networking opportunities that are gained through this multidisciplinary program. The journalist works side by side

with the teacher, politician, religious leader, and medical doctor. They struggle together to grasp new concepts and to understand ideas that are challenging and sometimes disturbing (e.g., the role of female genital cutting in unsafe motherhood).

But one cannot assume that students will "network" just because they are physically in the same classroom. Opportunities for students to interact can include specially organized lunches/dinner, class outings, and joint projects. STM has hired a network coordinator who is in charge of generating an alumni/student newsletter to inform students of activities and opportunities. Organized meetings around a particular subject can be an opportunity for students/alumni to gather and share their work/ experiences and research.

The program uses experiential education—with hands-on learning through both the doing and reflection. Field trips give opportunity for students to meet traditional birth attendants first hand and to visit health facilities where that very morning a mother (or two) died from pregnancy complications because of a late arrival at the hospital or no blood in the blood bank.

Students participate in rural community outreaches where they work with community members both to understand the issues that members are facing with respect to safe motherhood as well as joining hands with these community members to carry out school outreaches where issues of adolescent pregnancy, sexually transmitted diseases, and other reproductive health issues are discussed and dramatized for the primary and secondary school students. This kind of experiential and cooperative learning gives students a unique and effective experience that facilitates a problem-based learning approach to learning and to overcoming social barriers to maternal health. In addition to these academic goals, their participation in these outreaches also contributes to the education and mobilization of rural community members in Uganda. In a place where academic institutions are essential for sustainable development of the country, it is also important for them also to be contributing to local communities in meaningful and identifiable ways.

Program Issues

Organizers of the STM program have prioritized student feedback to optimize the delivery and effectiveness of the program from the students' perspective. Three important components have been prioritized. First, the flexibility of the program; second, student research capacity and empowerment; and third, quality and diverse faculty.

Flexibility of program. The program allows students to work and study at the same time through the use of a modular curriculum structure. The amount of class time must be manageable so that the students can get the time off work and complete the program. Advanced warning of dates is necessary so that students can secure their leaves from work. If students miss a module, they need to be able to make it up within a reasonable period of time—in our program, they will graduate 1 year later but can make up the module the next time it is offered. All lectures are recorded and are available electronically. In addition, students receive a copy of the course presentations so that they can review and enhance their learning. These are also important resources and references for the students' future tasks and presentations. With increasing

internet capacity in country, the future potential for videoconferencing with faculty living abroad may soon be a reality.

Student research. Students benefit from being introduced early in the program to the concept of carrying out a research project during their studies. They must present their research in the form of a dissertation at the end of their academic tenure. Having multiple opportunities to present both the concept paper and early findings, and participate in a practice thesis defense, are helpful academic exercises for the students so that they are well prepared for their final defense. Some students lack any kind of experience with these kinds of presentations and even the use of PowerPoint and related equipment are new experiences for them. These kinds of practice opportunities for can be most helpful to increase the students' presentation skills.

The research is usually based in their own communities/ circumstances, which keeps them connected to their own roots and generates local solutions to some of the challenges evaluated through their research. By presenting the research in a number of venues (including their place of work and other locations outside of the university), the student develops an understanding of the complexity of the problem(s) he or she is studying and the intricacy of the "solutions." The student is also able to monitor his or her own development as both a researcher and health promoter. This is a basic exercise in knowledge transfer, which will be an essential part of each graduate's working life.

Diverse faculty. The program has been successful in generating a diverse faculty with members from various professions and backgrounds who enrich the students' experience. Faculty members are from both the academic and the applied sides of public health. Gleaning knowledge and experience from health professionals and social scientists allows students to have a broader understanding of health promotion and the challenges of providing health care on the ground. Faculty also benefit from working with students who are not necessarily trained in one particular area of expertise but rather come from a broad base of experiences and perspectives. Although faculty members are reimbursed minimally from the university for their teaching time, the compensation does not reflect the amount of time and energy that faculty members have made in teaching in the program. Their ongoing involvement in the program and regular attendance at lectures, demonstrates the personal commitment that many of them have to the concept of leadership training for maternal health within various disciplines.

CONCLUSION

The World Health Organization (2009) has made an urgent call for more political and institutional leadership with a focus on increasing visibility and resources for women's health. But this begs the following question: Where do these leaders come from? In an era where skilled young professionals are leaving developing countries for opportunities in the industrialized world, there needs to be a systematic nurturing and grooming of indigenous leaders who sit in high places of political and social power and who will become in situ champions for safe motherhood in those spheres.

Although technical solutions can lead to measurable and immediate consequences, relevant and enduring progress requires more fundamental change (World Health Organization, 2009). Developing countries need informed and competent agents of change.

The nurturing and empowering of national leaders for safe motherhood requires a training program that is sensitive to the learning needs of these leaders and the environments in which they work. The training program is best if experientially based with flexibility and relevance to the leader's life and work. Problem-based learning and team-building opportunities are essential components for the program. The program has been successful in several of these fields through selective recruitment of the right students, ensuring the program is constructed to meet the students' needs and providing networking and leadership development for individual students. Diverse and qualified faculty members ensure that the content and delivery of the program will continue to be maintained at a high standard of learning and education.

The concept and focus of the program supports the notion that development, and in this case, imp roved maternal health, must be an endogenous process of transformation that wells up within the country itself (Kühl, 2009) and is not dependent on a large influx of foreign experts.

REFERENCES

Albanese, M. A., & Mitchell, S. (1993). Problem-based learning: A review of literature on its outcomes and implementation issues. *Academic Medicine, 68*, 52-81.

Behague, D., Tawiah, C., Rosato, M., Some, T., & Morrison, J. (2009). Evidence-based policy-making: The implications of globallyapplicable research for context-specific problem-solving in developing countries. *Social Science & Medicine, 69*, 1539-1546.

Chamberlain, J., & Watt, S. (2008). Save the Mothers: Stimulating change for safe motherhood. *Leadership in Health Services, 21*, 278-289.

Chamberlain, J., & Watt, S. (2008). Education for safe motherhood: a Save the Mothers' advocacy initiative. *Leadership in Health Services*, 21(4): 278-289.

Chopra, M., Daviaud, E., Pattinson, R., Fonn, S., & Lawn, J. E. (2009). Saving the lives of South Africa's mothers, babies, and children: Can the health system deliver? *Lancet, 374*, 835-846.

Ferguson, E., James, D., & Madeley, D. (2002). Factors associated with success in medical school: systematic review of the literature. *BMJ* 324(7343): 952-957.

Heading, G. S., Fuller, J. D., Lyle, D. M., & Madden, D. L. (2007). Using problem-based learning in public health service based training. *New South Wales Public Health Bulletin, 18*, 8-13.

Kühl, S. (2009). Capacity development as the model for development aid organizations. *Development and Change, 40*, 551-577.

Mitchell, K.J. (1990). Predictors of performance in medical school. *Academic Medicine* 65(12): 149-158.

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal, 312*, 71-72.

Shiffman, J. (2007). Generating political priority for maternal mortality reduction in 5 developing countries. *American Journal of Public Health, 97*, 796-803.

World Health Organization. (2009). *Women and health: Today's evidence tomorrow's agenda*. Geneva, Switzerland: Author.