Respectful Maternity Care Pilot Training Program
Juba, South Sudan

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RESPECTFUL MATERNITY CARE (RMC)

Background

Recently, maternity experts and global stakeholders have turned attention towards the presence of disrespect and abuse (D&A) by staff within health centers and hospitals as a deterrent to women seeking potentially lifesaving maternity services. Literature indicates that there is a strong correlation between how respectfully a woman is treated when receiving antenatal care and giving birth with how likely she is to utilize these services in the future. Negative experiences and perceptions of providers and health facilities also can spread across communities and deter large numbers of women from seeking care by skilled birth attendants. This is particularly alarming because the World Health Organization (WHO) recommends that a skilled attendant be present at every birth since they can prevent up to 90% of maternal deaths where they are authorized to practice their competencies and play a full role during pregnancy, childbirth and after birth.

D&A exists on a continuum ranging from shaming or neglecting women when they are at their most vulnerable to slapping and shouting at them and their families. As one physician from Juba Teaching Hospital that we interviewed stated, “Just like helping someone and being kind to them makes them want to return, when they wait for a long time in the hot sun and then are treated rudely, it is negative advertising for our hospital.”

Of particular note is the observation that women are routinely not allowed to have a family member with them during labor and delivery yet often are left alone because of understaffing. Procedures are not explained to women before they are performed, there is minimal protection of modesty, and women often have their legs forcefully separated as part of the delivery process. These behaviors can partly be attributed to the stress and burnout among staff that routinely work without the medications, supplies, and human resources they need to effectively save lives. Many also have incorrectly been taught to treat women poorly as part of their training, or because of a lack of exposure to humanized and family-centered care. Literature suggests that staff that is experiencing high stress and low job satisfaction show decreased compassion to patients.

Transforming maternity care into a welcoming and supportive experience through the systematic introduction of Respectful Maternity Care (RMC) will increase utilization of services, improve community and health system relationships, and improve staff morale and job satisfaction.

RMC is possibly one of the most significant interventions that can be introduced in order to approach the goals of Millennium Development Goal (MDG) 5. Additionally, respectful care should not be viewed as a privilege but as a human right that needs to be guaranteed for vulnerable populations such as pregnant women and their families. Addressing this problem should be a priority because if women are not willing to seek lifesaving care, then improving training, equipment, medication stocks, and financial barriers will fail to reduce the number of women dying.

Respectful Maternity Care Training Program – RMF Concepts

What makes RMF’s approach unique is that this training program is based on our concepts of “Friends helping Friends helping Friends” and “Liberating Human Potential”: Treating each other and the people we are supporting around the world with the respect and dignity you give to friends; we listen, learn and partner with the local populations, and empower local leadership. We train, educate and employ locals, producing innovative solutions and co-creating strong communities that sustain and grow (healthcare) capacity. We believe that our innate capacity to create transcends differences of ethnicity and economic standing. By empowering the people we are trying to help, we discover visionaries and partners who are best able to solve their problems. Igniting their potential will turn aid into empowerment and victims into leaders. We believe that every life deserves the chance to realize its potential. When people are liberated from their fight for survival, they begin creating a better life for themselves and their community. We believe in the human ability to transform. We are human because of our potential to change the world. When we are at our best, we are co-creators.
What this means is that the program brings a **solution-oriented** approach to the community and facilitates them to create a sustainable and independent response to challenges and not dictating a preordained set of solutions from outside the community. This mechanism of building **community resilience** is a cornerstone of RMF’s vision.

The program itself is the first to operationalize the teaching of compassion and respect to maternity workers rather than just document and define the problem of D&A in facilities. We addressed the following challenges in order to accomplish this:

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
<th>Outcome</th>
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<tr>
<td>The definition of respect varies depending on culture, community and individual experience</td>
<td>1) Surveyed and interviewed South Sudanese women in the community and local health workers to learn their preferences 2) Extensive review of published peer-reviewed literature on the concepts of respect and compassion</td>
<td>Designed a culturally competent training program</td>
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<td>Low literacy and varied educational backgrounds among participants</td>
<td>Designed learning modules to be completed using: 1) small group activities 2) simulations 3) oral story telling 4) role playing 5) visual imagery 6) multi media 7) small and large group discussions</td>
<td>Full participation by all participants with all core competency objectives met by everyone</td>
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<td>Sustainability</td>
<td>Designed the program using a ‘cascade’ model which utilizes South Sudanese Master Trainers to facilitate the training sessions and promote and ‘champion’ the program</td>
<td>Trained 3 fully competent and highly motivated Master Trainers and subsequently observed them successfully facilitating the training program</td>
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The RMC training program consists of 6 modules facilitated over a 2 full day period with the following learning objectives:

1. Analyze caring behaviors and culturally sensitive interactions in the maternity setting
2. Discuss and practice therapeutic communication skills that lead to compassionate and humanized care
3. Examine professional role expectations and standards of practice when providing care
4. Describe key features of dignity
5. Describe the methods of collaboration with other health facility staff and community members.
Learning Module Content

1. **RMF Concept of “Friends Helping Friends Helping Friends”**: welcoming patients and their families, listening to them and creating rapport and trust, concepts of body language and respectful communication, equalizing relationships between the various cadres of workers
2. **RMF Concept of “Holding the Space”**: creating a safe birth space by protecting modesty, privacy, and the wishes of the patient
3. **RMF Concept of “Gentle Voices, Giving Choices”**: open and respectful communication with women about procedures and policies, informed consent, evidence-based maternity care and confidentiality of sensitive issues
4. **RMF Concept of “Being With a Woman”**: labor support basics, the role of family members, freedom to move in labor, and delivery positions
5. **RMF Concept of “Calm Beginnings”**: skin-to-skin and non-separation bonding of the mother and baby, promotion of breastfeeding, postpartum support and education before discharge
6. **RMF Concept of “Liberating Human Potential”**: creating a positive work environment, respectful leadership, open communication with colleagues – empowering healthcare staff and allowing them to tap into their full potential as human beings and as caregivers

Participants

1) The RMC program was facilitated for **29 third year midwifery students** from the Juba College of Nursing and Midwifery (JCONAM). The students represent both males and females from a variety of ethnic groups that came to study in Juba from different states in South Sudan.

2) **4 Master Trainers** were selected by the Ministry of Health and JCONAM administration: 2 practicing physicians and 2 midwifery tutors at JCONAM.

3) The Master Trainers facilitated a 2 full day RMC training for **19 maternity staff** from Juba Teaching Hospital and two local Primary Healthcare Centers (PHCCs), Munuki and Kator. The staff was comprised of: community midwives, nurse-midwives, physicians, lab technicians, and nurses.

*Everyone sat in a circle in order to give all participants an ‘equal voice’ throughout the workshops.*
Midwifery Students role-playing how to provide informed consent for a medical procedure to patients and patient family members

Participants practicing how to introduce themselves and put the women in labor coming to the facility for care at ease during a simulation activity
Participants discussing stress and burnout reduction in small groups before presenting their ideas

Master Trainers discussing program design and sharing ideas
Viewing a film on allowing women to give birth in the position of their choice

A Community Midwife demonstrating how women outside the facility often prefer to give birth standing in order to try and convince fellow staff members that it can also be done in a maternity facility
Quantitative outcomes

Tests were administered prior to the workshop and immediately after completion. Outcome graphs show results from both training groups combined:

1. The following are ways to instill trust in a patient whom you have just met:
   a) Making direct eye contact while talking to the woman
   b) Introducing yourself by name and professional role
   c) Explaining that family members are not allowed in the maternity ward due to hospital policy
   d) A and B only
   e) All of the above

![Q 1. The following are ways to instill trust in a patient whom you have just met](image)

2. It is acceptable to discuss details of a patient’s medical condition and care plan to:
   a) Your fellow staff member who will be helping you to care for her
   b) Your sister-in-law because the patient is her cousin and she is concerned about her
   c) A nurse from the surgical ward that you are having lunch with
   d) All of the above

*Results not significant for this question*

3. One reason that women may avoid or delay seeking care at a health facility is:
   a) She heard from a neighbor that the staff yells at you while you give birth
   b) When she came for prenatal care she had to wait 4 hours before she was seen
   c) She came with her sister when she gave birth and was told family members were not allowed inside the maternity ward
   d) All of the above
4. Women should be able to choose which medical procedures she does or does not want done on her when:
   a) She has discussed it with her husband first
   b) The nurse, midwife, or doctor agrees with her preference
   c) It is not in the middle of an emergency
   d) She has had some medical or nursing training
   e) She should always be allowed to choose

5. Which of the following procedures are evidence-based practices (EVP):
   a) Doing an episiotomy on all primigravidas
   b) Infusing IV fluids on all laboring women
   c) Clamping and cutting the umbilical cord on all babies as soon as possible
   d) Non-separation bonding of mother and baby
   e) None of these are EVP

Results not significant for these questions
6. Stress and burnout among maternity staff can result in:
   a) Staff members quitting their job
   b) Decreased compassion for the patients they care for
   c) Poor outcomes for patients
   d) All of the above

7. Having continuous labor support present throughout labor and birth:
   a) Reduces the rate of cesarean section by 50%
   b) Reduces the need for using pitocin by 40%
   c) Shortens the length of labor by 25%
   d) Reduces the need for forceps deliveries by 40%
   e) All of the above
Qualitative outcomes

Open-ended questions and comments were collected in writing and via interview:

“I told the group that these ideas and ways are things we can use even when not at work. We can treat our neighbors with respect, too, and then we can have a more peaceful nation.”

This was one of the most touching and amazing messages I heard throughout the training. James, one of the Master Trainers who I originally had reservations about being too shy to facilitate a training transformed before our eyes into a powerful advocate who really just took on the vision of how compassion and respect can save lives and build peace. As part of the RMF team, this was one of the highlights of completing this pilot.

“I have been treating women the wrong way at my job. I am very grateful for this training so I can go to work tomorrow and start to treat people the right way.”

The elderly traditional birth attendant who told us this said it with such conviction as if she really could not wait to use the new skills and just wake up the next day and be a happier and more empowered health worker. It was so fantastic to see that we even videotaped an interview with her on how the training made her feel.

“I think this training should be longer, maybe 5 days long. It would be good if the trainers watched us in the ward with real patients to see if we are OK with the new skills.”

We also read variations of this sentiment over 15 times in the written evaluations. They all wanted the training to be longer. They felt this style of learning was new, innovative, fun, and they could tell they were really going to remember the messages better than the lecture format they are used to.

“When I was a TBA (traditional birth attendant) I saw the women give birth squatting or standing all the time. When I came to the hospital I was told ‘No!’ you have to do it like this (lying flat on a delivery table) but now I see that the knowledge I brought with me is correct. This is very encouraging.”

Seeing some of the usual healthcare system hierarchy neutralized was a novel concept in South Sudan. The idea that a TBA could have an equal voice as a doctor and work collaboratively excited them and this was one example of how those who are usually ignored or outranked felt confident and valued as humans and colleagues.

“The thing I like the best of the training is seeing all the people from my work and we sit in a circle so we can all say the things we think. We never talk to each other like this at work.”

Seeing them talk to each other during lunch and breaks was really heart-warming. To think some have worked together for over 10 years and never socialized but RMF facilitated them to do it was phenomenal. Having the department chair come to show his support of the training and share stories with all the staff meant so much to them as well.

“In the training we saw pictures of women from other places with a family member and a midwife helping them with encouraging words and I think we can do this here as well.”

It was a true joy to see everyone come up with ideas of ways they can improve the health system which were things they could actually do themselves! I truly know they will strive to start these improvement projects because we really looked at ways to implement change that don’t take a lot of money or equipment but just human innovation and creativity.

“I did not know that it is safe to squat and give birth upright. This was very interesting to me.”
As a midwife, watching the participants come to the conclusion that the way they were taught is not necessarily the only way but that listening to the patients we take care of is key made my heart swell. To see them excited to partner with women in labor rather than ‘control’ them was amazing.

“Privacy and confidentiality are the big problems here in our hospital and I am very happy we came up with ideas to improve on this so the women come to give birth where we can help them be safer.”

What was remarkable was the extent to which each participant had realized these were issues, had felt bad about them and struggled with how hard it is for patients but had never realized they could make a difference until the training. They had the solutions already within them and just needed the forum to have those ideas blossom into concrete plans and actions to improve things.
LESSONS LEARNED BY MODULE

Module 1

OVERVIEW

In this module, training participants got to know and respect each other as individuals as well as professional colleagues. We used a variety of activities to form a cohesive group that can move forward in creating a shared vision of what a true model of Respectful Maternity Care should look like. Creating a comfortable environment where everyone feels free to speak and feels valued is the first step in creating a respectful environment in which we can proceed to learn.

The group topics covered the definition of respect, why it is important in the maternity setting, and how to establish the trust and rapport needed to effectively care for maternity patients. It will introduce the main themes of RMC; RESPECT and DIGNITY that were reinforced throughout the training.

This module is based on the RMF concept to give each other and the people we are supporting the respect and dignity that you would give your friends.

METHODOLOGY

– We discussed the reasons women have stated that they avoid facility-based maternity care in South Sudan
In small groups, they created solutions to current problems that they identified in relation to the concerns of the women in the community.

We practiced introducing ourselves repeatedly by having every person turn to someone next to them with each person pretending to be the health worker and each then being the woman in labor: concepts reviewed were eye contact, body language, tone of voice, giving professional information. For example, I would look in a woman’s eyes; place my hand gently on her shoulder and say, “Hello. My name is Cindy and I am the midwife that will be taking care of you until 7 pm tonight and then I will introduce you to the night midwife coming on. By what name do you like to be called?”

We did a simulation of a woman in labor and how to make her feel at ease using the following narrative: “Sara is a 24 year old woman who comes to the facility in labor. It is her first baby and she seems very scared and in pain. She is having some bleeding as well. Her husband and her mother are with her and seem very anxious about Sara and her baby.” Each person played the role of Sara, a family member, and the health worker.

**WHAT WENT WELL**

During the simulation, the students were like Oscar-winning actors. They all enjoyed taking turns as the ‘hysterical’ woman in labor and her family versus being the health worker to calm them down; they were fantastic and made it really seem real.

The participants really started to get comfortable with the idea of sitting in a circle so they all had an equal voice and began to open up and share personal stories with each other by the end of the first module.

**WHAT NEEDS IMPROVEMENT**

Signing in, establishing mutually agreed upon ground rules, and finishing the ‘ice breaker’ activity where they introduced themselves (“Say one thing that nobody in this room may know about you”) took much longer than expected. This was a cultural issue; they had never really done these things before.

We realized that not all modules take the same amount of time.

**HOW WE ARE FINE-TUNING THE MODULE**

We decided to shift the timing of Module 1 as it covers very important content. But at the beginning of the training the participants are not yet comfortable enough with the group to speak freely.

We will streamline the sign-in process by having nametags pre-printed.
OVERVIEW

In this module, participants learned the importance of privacy and modesty for women giving birth. They also explored what “woman-centered” birth and humanized care mean and why these things are critical parts of the RMC model. By the end they were able to:

- verbalize the difference between privacy and confidentiality
- explain why privacy and confidentiality are critical parts of RMC
- define what “woman-centered care” means and its key features
- provide care using a humanized model.

METHODOLOGY

– We facilitated a large group discussion about their own beliefs regarding confidentiality, respect and compassion. This helped them to see that it is critical to consider the beliefs of others since the concepts are universal but the details vary based on culture, age, social groups, ethnicities, and other factors.

– We came to a group agreement as to what constituted creating a ‘safe haven’ for maternity patients and a range of solutions ranging from the ‘dream scenario’ we created if an unlimited amount of resources were available, moderate solutions, and intermediary ones based on the low resource setting they are currently in.
We did a large ‘game of telephone’ where the first person went outside and told one person a very detailed story about a profound birth she had attended. One by one they relayed the message to the next person until the last one shared with the group the story. This was an exercise in illustrating how it is important to listen to details and pay attention to what others are saying when they are telling you something that is meaningful to them.

**WHAT WENT WELL**

The telephone game really highlighted how hard we must all work to focus on other people’s points of view. It was a fantastic exercise that everyone enjoyed. The story told was about a woman who came in labor, had not known she was having twins, the midwife delivered the first one, realized there was another baby, had to urgently find a doctor, determined the baby was breech, tried to turn the baby using heroic measures, when that failed tried to move her to the OR for surgery, when that failed, she delivered the preterm baby breech. The final person stood up and said, “A woman came in labor. The midwife was scared because she did not know the woman’s due date and could not find a doctor. In the end the baby and the mother were fine.” Everyone was silent for about 5 seconds and then burst into laughter at how altered the story had become.

We can say with 100% certainty that every participant can correctly define the difference between privacy and confidentiality. These definitions seem to have been integrated into the materials and activities with enough repetition that everyone felt confident to volunteer and group examples we gave them of each into categories accurately on the chalkboard.

**WHAT NEEDS IMPROVEMENT**

We had tried to go around the room and have each person read a line from the PowerPoint with a list of items to illustrate what humanized care is (such as treating women well regardless of age, ethnicity, marital status, and health status such as HIV+). We learned to consider the varying literacy levels in the groups.

**HOW WE ARE FINE-TUNING THE MODULE**

We will make all read-alouds by a volunteer or read alternately by the two trainers or a voiceover.
OVERVIEW

In this module, training participants learned what informed consent means and how to assure that all patients are aware of their rights as childbearing women. They also explored Evidence-Based Practice (EBP) and why it is a critical part of Respectful Maternity Care. Specific topics included how to manage a patient that goes against medical advice and appropriate means of communicating patient information to colleagues. Finally, it reminded participants that even when disagreements about care with fellow staff or patients arise speaking respectfully and quietly will maintain the appropriate atmosphere and environment for respectful maternity care to take place. Specifically, they learned to:

- perform informed consent
- state basic obstetric Evidence-Based Practices
- discuss what maintaining a woman’s dignity means
- develop methods for caring for women who may not agree to certain procedures or management that staff recommends
- practice appropriate methods of communicating with other staff about patient care issues.

METHODOLOGY

- We collaboratively helped the group define what informed consent means and why it is important, why looking at scientific evidence and not just reverting to practices “because that is how they have always been done” is critical, and what it means to maintain someone’s dignity.
- The simulation done was about dealing with an angry family and a patient who do not agree to have a procedure done that the health worker recommends. They split into small groups and each person played each part. Then we met as a large group to discuss how it went.

- We had participants volunteer to give informed consent for the following procedures: episiotomy, amniotomy (breaking the water), and inserting an IV. The group gave feedback to the volunteer.

**WHAT WENT WELL**

As with all the other modules, the group really enjoyed the role-playing and activities where they all get to take a turn as the most active speaker.

When we started the simulation, a lot of the acting revolved around how to convince an unwilling woman to do what you wanted her to do. By the end it was about how to shift your plan of care to adjust to the patient’s desires. It was very powerful to watch the participants make this shift just with feedback from their group members.

Not one single participant had even heard the words ‘informed consent’ when we began, much less had understood that it is a basic human right to have a say in what things are done to your body and when. By the end, they were such strong advocates for this and even had some heated discussions about specific ethical cases where a woman might choose against medical advice and have it harm her baby. Watching that discourse was amazing.

**WHAT NEEDS IMPROVEMENT**

The section with learning all the definitions seemed boring to them and too much like the rote learning they were used to.

**HOW WE ARE FINE-TUNING THE MODULE**

We will create a more interactive activity for defining concepts, not having the definition segment all grouped into one section; and we will be choosing the best timing for the academic-heavy modules so everyone can take in and retain as much as possible.
OVERVIEW

In this module, training participants learned why labor support of all women in labor is necessary, how to provide it, and non-pharmacologic methods of managing pain. They also explored how to communicate with and engage family members to take on the role of support person, and how and why freedom of movement and the choice of what position a woman would like to give birth in are important. By the end of this module they:

- were able to define what labor support is and why it is important
- had learned methods for providing pain relief to laboring women that are non-pharmacologic
- practiced communicating with patients’ families and how to engage them in providing support to laboring women
- gained an understanding of the importance of laboring and delivering in the positions that the woman chooses
- discussed methods for providing the technical skill required during labor and delivery in positions they may not be familiar with.

METHODOLOGY

- We discussed the benefits of changing positions in labor, labor support as a comfort measure but also to improve medical outcomes.

- The simulation involved using labor support methods that the group came up with such as:

  - Remind the woman in labor to relax and focus
Remind her to breathe slowly and calmly
Make suggestions for beneficial position changes if she needs them
Remind her to stay mobile as this accelerates labor, provides gravity to aid with descent of the baby, and is usually more comfortable for the woman
Remind her to urinate about every hour
Remind her to drink and eat for energy.

– Each participant had to demonstrate a position other than flat on her back that a woman might give birth or labor in.

– We viewed a short film called “Birth in the Squatting Position” from 1979 in Brazil.

– We came up with solutions as a group for problems they faced in integrating family members to help give care.

WHAT WENT WELL

The participants all had excellent ideas for labor support and seemed to truly enjoy that aspect of the job and in fact expressed wishing they had more time to spend caring for women rather than dealing with operational issues on the ward. It sparked amazing discussions about why each of them chose the profession of providing maternity care.

Demonstrating giving birth in various and at times unusual positions was very entertaining for them, especially watching the men ‘give birth’.

Watching them literally light up when they saw with their own eyes videos of women giving birth upright after several long and heated conversations about how this could never work in a hospital was so awesome! It was like watching an entire room of people become inspired and amazed at once. They all asked for a copy of the video afterwards to share with their friends and colleagues who were not at the workshop. One participant said, “That just changed my entire view of birth!”

WHAT NEEDS IMPROVEMENT

This module needs much more time. It as the one they enjoyed the most.

HOW WE ARE FINE-TUNING THE MODULE

We will allot more time for this module.
Module 5

OVERVIEW

In this module, training participants learned about breastfeeding, bonding, and why guarding the immediate postpartum period and creating a safe environment is part of providing Respectful Maternity Care. They also learned about evidenced-based practices for the immediate post-delivery period including delayed cord clamping, skin-to-skin contact, and non-separation bonding. By the end of this module they were able to:

- state the benefits of breastfeeding
- educate women on the 6 most important ways to promote successful breastfeeding
- explain why promoting mother/baby bonding, skin-to-skin contact, and non-separation of the mother/baby dyad are important
- understand the benefits of delayed cord clamping and its appropriate use.

METHODOLOGY

- We had a group discussion about the benefits to mother and baby of breastfeeding, how to promote the guidelines set forth by the WHO, and how to troubleshoot issues with babies who cannot be breastfed due to maternal morbidity, physiologic problems or maternal mortality.

- A slide show on delayed cord clamping was shown based on WHO guidelines.

- A large group discussion on cultural beliefs on mother/baby bonding took place.
WHAT WENT WELL

The participants actually had a high degree of knowledge on the content of this module, we were very impressed. They were already following WHO guidelines, in fact to some degree better than most developed nations currently do.

A very interesting discussion about the beliefs of various ethnic groups within South Sudan occurred in regards to the care of the new mother and newborn. The participants seemed intrigued to understand basic things about each other’s ethnic groups that they had not known. In particular, beliefs about witchcraft and traditional medicine became a central theme.

Another discussion was what to do with babies whose mothers have died and the family is too poor to care for the baby. One midwife told the story of an abandoned baby whose mother had died and the family left without the baby. She shared how she was caring for the baby in the nursery for 3 months already and buying formula with her own money. Several in the group actually offered to help her. This was touching and amazing.

WHAT NEEDS IMPROVEMENT

This module could be abbreviated, at least within South Sudan. Much of this has already been successfully integrated as normal practice within the public facility infrastructure and certainly within the training programs.

HOW WE ARE FINE-TUNING THE MODULE

We will shorten the length of this module and make it more interactive since the content is already known by our target groups but might benefit from troubleshooting type activities.
OVERVIEW

In this module, training participants learned why a **healthy and respectful work environment** is important for **reducing stress and burnout** and allowing everyone to work at their **fullest potential**, for promoting respectful maternity care for patients, and why it improves outcomes. They learned effective communication methods for talking to colleagues appropriately and effectively so that safe care is provided and job satisfaction is high. By the end of the module they had:

- defined what a healthy work environment means
- learned methods for interpersonal communication with their colleagues
- practiced communicating with each other in order to simulate the workplace
- gained an understanding of how job satisfaction and stress reduction are related to patient care and outcomes.

METHODOLOGY

- We had a group discussion about how stress and burnout are antecedents to treating others (patients and fellow workers) poorly.

- We reinforced the ‘**quick 4’** at reducing stress:
  
  1. Make sure to **take a break after particularly stressful events**. You need to do this to keep yourself fresh. Try a five-minute walk. Small breaks throughout the day will keep your performance at its best.
2. **Being prepared** ahead of time will give you the upper hand in any situation and prevent unnecessary stress. Show up for your shift a little early in order to have time to “settle in” and prepare for the work you are about to do. Sit for 5 minutes and think about how you hope the day will go and just breathe!

3. **Take care of yourself.** Eat healthy, make sure you are getting exercise and enough sleep.

4. **Balance work and family.** Spend quality time with your family without thinking about work or taking any work home with you (such as checking e-mails or doing paperwork or projects or work phone calls). If you need to stay late at work to finish things, choose that over doing it on your family/personal time.

– We then did an activity called ‘continuum’ where one side of the room was 100% agree and the other side 100% disagree, and the participants had to stand anywhere in the room along the imaginary continuum to show answers for the following and then discuss their feelings:

  - I love everything about my job
  - I feel like people listen to my ideas at work
  - I think the work I do is important
  - I am friends with my coworkers
  - I think I have strong clinical skills
  - I am good with people
  - There are new clinical skills I would like to learn

– We talked about ways to improve work morale even when conditions are very hard. Goals and benchmarks were set revolving around the ideas the participants came up with.

**WHAT WENT WELL**

The participants were surprised and somewhat relieved to learn that they all, regardless of professional role, had similar feelings about their work environment.

It seems many barriers were broken in terms of the pecking order that exists within the hospital system based on educational level—very amazing to observe them become friends!

Setting their own terms for accountability made them more meaningful and likely to be followed. The ideas they came up with such as staff appreciation days, monthly working group meetings with people from each professional cadre all together, and quarterly recognition awards for excellent work seemed concrete and very positive.

**WHAT NEEDS IMPROVEMENT**

This module should probably be expanded, done earlier in the training to work on group bonding and shared vision creation in order to promote more open discussions in the other modules.

**HOW WE ARE FINE-TUNING THE MODULE**

We will have this module earlier in the workshop, create actual working groups and give the participants time to begin planning events such as staff appreciation day or award recognition voting criteria, etc. if the workshops have people from the same training program or facility.
OTHER GENERAL LESSONS LEARNED AND CONSIDERATIONS FOR FINE TUNING

- Many participants expressed the desire to have a clinical component to the training program added where Master Trainers observe them with actual patients and then give feedback.

- Master Trainers need to be able to adapt quickly and be creative. One example is how the staff participants and Master Trainers decided to switch the training from English to Juba Arabic once it was determined that 3 participants had limited English speaking skills. The pre and post-test was translated on the spot as well.

- Laminated cards with the PowerPoint materials could be made in case electricity is not consistent.

- Adding time at the end of the training to discuss suggestions, ideas, and opinions about the workshop would be helpful.

- More time needs to be devoted to discussing Evidence-Based Practice in regards to episiotomy and giving birth upright. Both groups wanted to discuss this at length.

- Awarding participants formal certificates of completion was considered the highlight for many participants. Many had never had any classroom learning and certainly had never been given a certificate. Several of the participants kissed the papers and held them up proudly while everyone cheered for each other when they received them and had their photo taken with the trainers. This should be formally added to the workshop manual so it is always included.

Next Steps

- Have Master Trainers facilitate RMC Workshops for the other 2 classes of midwifery students at JCONAM and for the remaining staff from JTH and PHCCs in Central Equatoria.

- Obtain funding to bring RMC Workshops to staff from other states in South Sudan using the Master Trainers themselves as well as having them train 3-4 new Master Trainers in each state.

- Expand the RMC Model to generalize the concepts of compassion and respect among health workers from all medical specialties.

- Establish Juba Teaching Hospital as a Center of Excellence for the nation by building a fully functional, equipped and staffed facility with RMC concepts as the foundation of service delivery and model of South Sudanese healthcare.

- Replicate the model created in South Sudan in other RMF operating regions such as Pakistan, India, Uganda, Kenya, and Haiti.

- Apply these concepts to other sectors outside of healthcare so there is a global paradigm shift towards community resilience, compassion for others regardless of circumstances, and prioritizing humanity within the context of everything done within the development world.