



Regional Workforce Development Plan for the ECOWAS Sub-Region

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ACRONYMS AND ABBREVIATIONS

CBT	Competency-based training
ECOWAS	Economic Community of West African States
FC+	Fistula Care <i>Plus</i>
FIGO	International Federation of Gynaecology and Obstetrics
GF	Genital fistula
IF	Iatrogenic fistula
M&E	Monitoring and Evaluation
OF	Obstetric fistula
UNFPA	The United Nations Population Fund
USAID	United States Agency for International Development
WACS	West African College of Surgeons

EXECUTIVE SUMMARY

Genital fistula (GF) is a hole or abnormal opening in the birth canal that results in chronic leakage of urine or feces. Obstetric fistula (OF), the most common form, is due to prolonged or obstructed labor. In recent years, there has been an increase in iatrogenic fistula (IF), caused by complications from interventions during childbirth. GF remains a public health challenge in Africa and some Asian countries due to lack of access to quality maternity care services. National governments and development partners such as EngenderHealth, UNFPA, WHO and USAID have collaborated to provide access to prevention and treatment of obstetric fistula.

“The continued existence of fistula is a visible indicator of the gaps in equitable access to quality care for women’s reproductive health, and addressing these gaps is a necessary condition to achieve universal health care.”

Statement by the Hon. Dr. Osagie Ehanire, Minister of Health, Federal Republic of Nigeria at the virtual Regional Resource Mobilization Meeting organized by the Fistula Care *Plus* project and the West African College of surgeons 2-2-21

In Western and Central Africa, the sister nations of the Economic Community of West African States (ECOWAS) have committed themselves to improve access to quality prevention, treatment and rehabilitation care for women living with fistula. Their goal is to engage relevant stakeholders, including professional organizations and partners, to develop a roadmap for production of a critical mass of manpower that will lead to the elimination of fistula by 2030.

Workforce development requires urgent attention if the goal of elimination of genital fistula is to be achieved. Fistula Care *Plus* (FC+), a USAID-supported global project, managed by EngenderHealth, commissioned the West African College of Surgeons (WACS) to conduct a review of available manpower and other resources dedicated to obstetric fistula in West Africa. The results demonstrated that there are insufficient trained staff and facilities to manage the existing backlog of fistula in the region. The manpower required will include medical doctors, nurses, social health workers, physiotherapists, pharmacists, anesthetists and other supporting staff. It is imperative to invest in the development and mentoring of the next generation of health workers who will take the lead in the region.

This document suggests a template for the development and training of health workers to focus on the management of fistula in ECOWAS member countries. The document highlights essential elements of a workforce development plan that must be designed and implemented at the national level to meet national needs, supported by regional cooperation and collaboration to share strategies, lessons learned and expertise in fistula management.

UNFPA/New York is implementing a global survey on the cost of obstetric fistula, and the new USAID-supported MOMENTUM Safe Surgery in Family Planning and Obstetrics project will continue to coordinate with UNFPA on this survey to assist in the development of costed plans for the management of fistula, including that of the necessary workforce. Costed plans need to be prepared at the national level because the resources required and available in each country vary considerably.

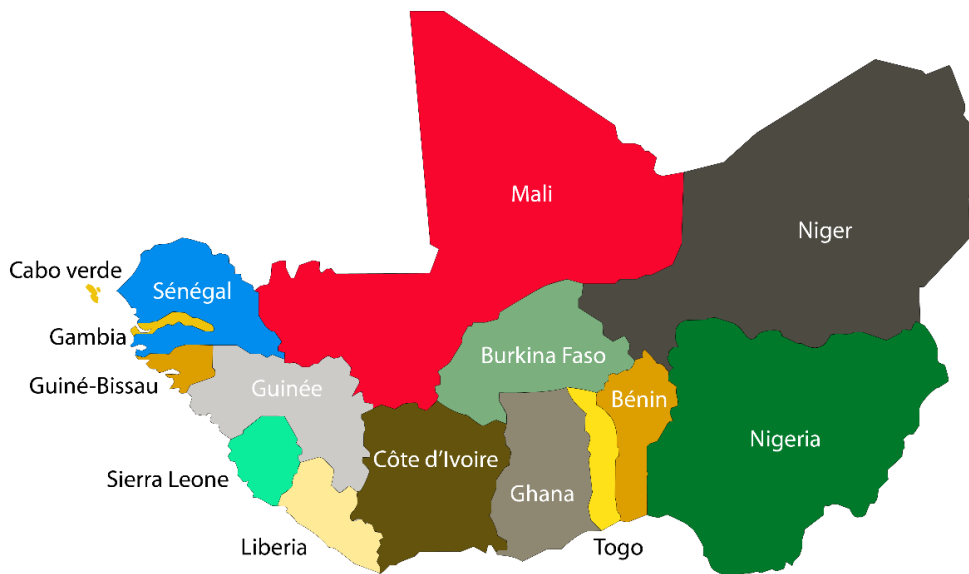
1. INTRODUCTION

Female genital fistula is an abnormal communication between the lower urinary or lower gastrointestinal tract and the genital tract. Genital fistula is largely due to complications of childbirth (obstetrics) and mishap from surgical interventions (iatrogenic). The most common cause of OF is prolonged obstructed labor. Women who experience fistula are often ostracized, stigmatized, separated or divorced, and some are abandoned because of their continuous leakage of urine and or feces.

Global estimates suggest that about two million women currently live with OF and incidence has been put at between 50,000 to 100,000 new cases per year.¹ Africa and Asia have the highest burden of the problem. Despite the burden of OF in Africa, awareness and access to the prevention and treatment for this health challenge is suboptimal. Establishment of national policies is an important first step that any government must take to achieve an impactful program in their country. It is also important that countries with similar health challenges develop partnerships to leverage opportunities and address weaknesses in order to maximize the impact of investment in the control of OF.

ECOWAS is a community of 15 member countries in the West African sub-region that engages in diplomatic partnership in virtually all sectors including economy, education, health, and climate change, amongst others. The 15 ECOWAS members are Benin, Burkina Faso, Cabo Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo. Of these member states, eight are French-speaking, five English-speaking, and two Portuguese-speaking. The two Portuguese-speaking member states are Guinea Bissau and Cabo Verde.

Figure 1: Map of West African sub-region



¹ World Health Organization 2021 <https://www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula>

Population size in ECOWAS countries varies greatly from 2 million in Guinea Bissau to more than 206 million in Nigeria. Obstetric fistula is prevalent in most ECOWAS countries. Data included in a recent mapping exercise conducted by WACS² was drawn from a meta-analysis of household survey data published in 2015.³ In that study, the lifetime prevalence of obstetric fistula among 8 of the ECOWAS member nations ranged from 0.4 in Burkina Faso to 6 in Sierra Leone. The annual average OF estimate in countries in West Africa with the exception of Nigeria is between 300 in Senegal and Mali to 8,300 in Guinea.⁴ Nigeria bears approximately 7.5% of the global burden with a yearly estimate of about 46,800 new cases of obstetric fistula per annum (see Table 1).¹ Other countries in the ECOWAS region that contribute significantly to the burden of OF include Cote d’Ivoire, Benin, Guinea, Sierra Leone and Togo.

Table 1: Burden of lifetime and present vaginal fistula in women of reproductive age (15-49 years) 2006-2013⁵

Country	# of women who have ever had symptoms	# of women with symptoms at time of study	Source/Year of Study
Benin	14,600	9,600	DHS 2011-12
Burkina Faso	1,500	500	DHS 2010
Guinea	13,900	8,300	DHS 2012
Mali	2,300	300	DHS2006
Niger	2,800	900	DHS 2012
Nigeria	115,200	46,800	DHS 2008
Senegal	1,500	300	DHS 2010-2011
Sierra Leone	8,500	4,100	DHS 2013
Togo	3,700	1,500	MICS 2010

² Report of the Mapping Exercise Documenting Fistula Facilities, Skills and Services in the West Africa Sub-region. West African College of Surgeons, 2021

³ Maheu-Giroux M, Fillipi V, Samadoulougou S, et al. Prevalence of vaginal fistula symptoms in 19 sub-Saharan African countries: a meta-analysis of national household survey data. *Lancet Glob Health* 2015; 3: e271–78

⁴ *Ibid*

⁵ Adapted from Mahieu et al. Data are median at 95% credible intervals from DHS and/or MICS

2. RATIONALE FOR A REGIONAL WORKFORCE PLAN ON GENITAL FISTULA MANAGEMENT FOR WEST AFRICA SUB-REGION

In June 2018, the Assembly of Health Ministers of ECOWAS passed a resolution urging member states to focus national investments and resource mobilization for collective action to eradicate fistula in West Africa by 2030. The resolution called for continuous political commitment, the engagement of civil society organisations, professional bodies, development partners and other stakeholders in maintaining and strengthening national integrated health systems and capacities for prevention, identification of cases, surgical and non-surgical management, reintegration and rehabilitation with fistula in the region. The resolution also called for access to quality education for women and girls, and the establishment and enforcement of laws to raise the legal minimum age of marriage.⁶

Availability of adequate manpower to provide the necessary care for obstetric fistula patients in West Africa is lacking. The *Obstetric Fistula Needs Assessments: Findings from Nine Countries published in 2003*⁷ recognized severe limitations of access to treatment, number and skills of surgeons and other key health professionals, bed space, equipment and logistics. This challenge remains central to the problem of poor access to early prevention and treatment as well as rehabilitation programs. At a recent UNFPA meeting it was estimated that 30,000 new cases occur every year in the West and Central Africa Region, and 3,000 benefit (10%) from treatment.⁸ This varies by year and the availability of resources to support treatment. The WACS mapping exercise confirms the continuing scarcity of resources and identifies the following number of centers providing fistula services and fistula surgeons (see Table 2).⁹

Table 2: Number of Fistula Centers and Surgeons in ECOWAS Countries

Country	# of Fistula Centers	# of fistula surgeons
Benin	5	8
Burkina Faso	4	9
Cape Verde	0	0
Cote d'Ivoire	8	44
The Gambia	3	3
Ghana	8	10
Guinea	10	16
Guinea Bissau	3	3

⁶ Resolution on the Elimination of Obstetric Fistula from the ECOWAS Region. 19th Ordinary Session of the Assembly of Health Ministers of ECOWAS. 4-8 June 2018, Banjul, The Gambia.

⁷ Obstetric Fistula Needs Assessment Report: Findings from Nine African Countries. UNFPA, Engenderhealth. 2003

⁸ UNFPA: Strengthened and extended partnership: lever to eliminate obstetric fistula. Virtual Roundtable, 23 March 2021

⁹ Report of the Mapping Exercise Documenting Fistula Facilities, Skills and Services in the West Africa Sub-region. West African College of Surgeons, 2021

Country	# of Fistula Centers	# of fistula surgeons
Liberia	5	5
Mali	9	25
Niger	11	13
Nigeria	21	68
Senegal	11	20
Sierra Leone	1	2

Some of the surgeons identified are not providing routine services and some centers rely on visiting surgeons to provide services. For instance, Cape Verde, relies on cross-border support to provide services. The mapping report identified four FIGO certified trainers for fistula surgery in the region, and nine others were listed as trainers.¹⁰

A well-established fistula treatment center requires a multidisciplinary workforce for efficient and effective service delivery. The principal workforce should include a medical doctor with experience in fistula surgery, nurse/midwife, pharmacist, social worker, anesthetist (including nurse anesthetists), physiotherapist, health educators, ward assistants, laundry/sterilization technicians and support staff to maintain power and water supply.

Training of surgeons in obstetric fistula was *ad hoc* until the International Federation of Obstetrics and Gynaecology (FIGO) and its partners introduced a competency-based training model for medical doctors.¹¹ Similar standardized training methods were developed for the nursing and physiotherapy staff by USAID’s Fistula Care and Fistula Care *Plus* in collaboration with other relevant professional bodies and partners (see chapter 3). To address the intractable backlog of cases of women living with obstetric fistula in the sub-region, a critical mass of trained providers is essential. It is imperative for the West African Region to establish a well-organized, coordinated, and regulated training program with clear objectives, methodology and evaluation strategy. This will help the sub-region to address the imbalance in the required number and type of workforce needed to manage the various cases and aspects of OF in the sub-region.

¹⁰ *Ibid*

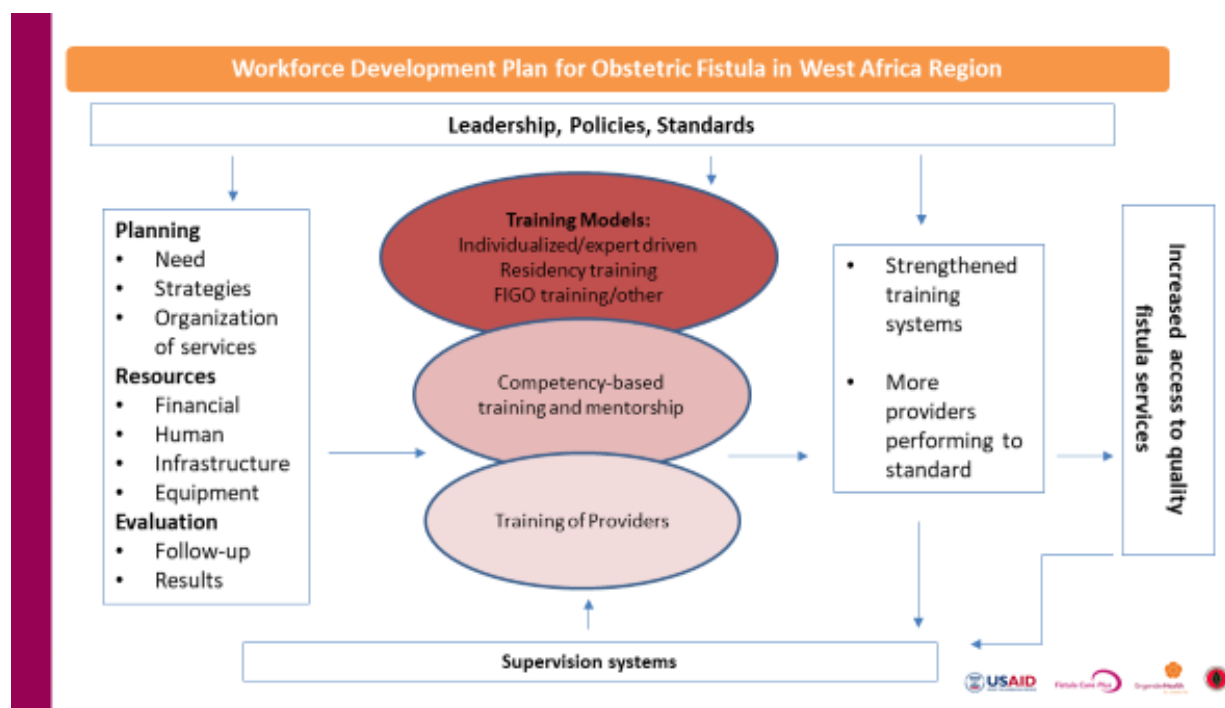
¹¹ Global Competency-based Fistula Surgery Training Manual. FIGO and Partners. 2011

3. WORKFORCE DEVELOPMENT PLAN FOR OBSTETRIC FISTULA IN WEST AFRICA REGION

The goal of a workforce development plan (WDP) is to increase access to quality and safe fistula prevention and treatment services for women with fistula in Africa. The WDP provides a template for the design of a country specific training program and curricula for the different cadres of healthcare providers. The content of this document will serve as a guide and reference for policy makers, professional organizations and individuals involved in fistula management to prepare their own plan and curricula within the framework of their educational and healthcare policy. Each country should prioritize specific aspects of the plan and modify it to suit specific country needs.

Operationalizing the WDP will require each ECOWAS member country to take ownership and invest in its implementation. It is our expectation that this edition of the WDP will contribute to the ultimate ambition of eliminating fistula by the year 2030.

Figure 2.



The WDP covers the following components (see Figure 2):

Leadership, policies, and standards:

This addresses the governance structure within the ECOWAS community and within individual member nations required to develop a framework to produce a multi-professional workforce to handle all aspects of fistula management. The leadership of ECOWAS and its various divisions, including the West African Health Organization and other stakeholders, should develop a coalition to produce and promote a robust policy and plan for workforce development, standards of practice, career pathways, and monitoring and

tracking progress within the public sector. It should also articulate an investment plan for the region. (As noted in the Executive Summary, UNFPA is currently developing a global investment strategy. A West and Central Africa study was concluded in 2020 suggesting that reaching 42,000 rural communities, identifying and treating 67,000 women, providing rehabilitation support and transportation to 54,000 women, and supporting outreach and advocacy would cost approximately \$82.6 million. The report has yet to be published.)¹²

Planning, Resource Mobilization and Evaluation:

Planning should cover all aspects of workforce development including, but not limited to, the constitution of a national committee, development of a national policy and strategic plan for OF workforce within the specific health system, development of context specific curricula and training materials, preparation of training venues and trainers, and development of skills acquisition checklists and logbooks. It should also include the development or adaptation of manuals and protocols. National and regional governments in each country should mobilize resources (material and non-material) needed to initiate, implement, and sustain the training program and other related activities. A national monitoring and evaluation program should be part of the design, and data generated from each country should be collated, analyzed, and disseminated to ECOWAS for peer review and sharing of success stories and challenges on the implementation of the training of the workforce.

Training models:

Several training models have already been developed and adopted for skills acquisition in fistula care in Africa. The training models include individualized or expert-specific designs, as part of the curriculum for specialized medical training (residency program in obstetrics and gynecology, urology), and a competency based modular course designed by FIGO and its partners.¹³ It is important that each ECOWAS member country harmonize the training models to achieve maximal benefit for their system. Curricula should be modified to fit the requirements of the health system in each country and offer training certification for the different levels of competency. Institution-driven training models, such as that adopted by WACS for post-fellowship specialty training, promote a sustainable program in the region and ensure institutional memory. In this regard, pathways for lower-level training at Certificate, Diploma and Masters' levels may be considered.

Supervision Systems and Regulation:

This is a critical aspect of workforce development because it will provide opportunity for trainer-trainee interactions and confidence building after the initial training. The trainee should be given the opportunity to learn, cross-check and validate specific skills, as well as to advance their skills. A country-specific committee or agency should regulate training according to the policies, standards and regulations adopted in each country. Regulation should cover training curriculum, training institution certification and recognition of the trainees within the public healthcare system as well as continuous medical education to maintain and scale up the acquired skills. The government, through its Ministry of Health and relevant professional organizations, should collaborate to ensure that an appropriate regulatory mechanism is in place to engender quality of comprehensive care and implementation of best practices on OF in their country.

¹² Restoring Hope, Health & Dignity for All: Investing to End Fistula in West and Central Africa by 2030. UNFPA, December 2020.

¹³ Global Competency-based Fistula Surgery Training Manual. FIGO and Partners. 2011

4. DEVELOPMENT OF CURRICULUM FOR COMPETENCY BASED TRAINING IN GENITAL FISTULA MANAGEMENT FOR WEST AFRICA

The development of curriculum for competency-based training (CBT) in genital fistula should be designed to fit the learning objectives of the target healthcare providers. The curriculum should:

- Cover knowledge and skill acquisition with a mechanism to assess learning during and after training.
- Provide a clear definition of roles and responsibilities between trainers and trainees within the context of provider job descriptions and country specific standards of practice.
- Be designed to foster multidisciplinary teamwork, cohesion and avoid parallel responsibilities among health workers.

There are many available curricula produced by international professional bodies for different healthcare workers on fistula management. These documents are freely available to access and they can be used or adapted (with permission) for the development of in-country curriculum. (see Box 1).

Box 1: List of recommended resources to develop training materials

Global Competency-Based Fistula Surgery Training Manual

Source: https://www.figo.org/sites/default/files/2020-05/FIGO_Global_Competency-Based_Fistula_Surgery_Training_Manual_0.pdf

The Prevention and Management of Obstetric Fistula: A Curriculum for Nurses and Midwives

Source: <https://fistulacare.org/archive/files/3/3.1/Prevention-Management-Nursing-Curriculum-English.pdf>

Counseling the obstetric fistula client

Source: <https://fistulacare.org/archive/files/3/3.1/counseling-curriculum-english.pdf>
<https://fistulacare.org/archive/files/3/3.1/TraumaticFistulaCare.pdf>

Safe Surgery Toolkit

Source: <https://fistulacare.org/surgical-safety-toolkit/>

Implementing Physical Rehabilitation Services into Comprehensive Fistula and Maternity Care: A Training Guide for Health Workers

Source: <https://www.themamas.world/training-guide>

Generally, a CBT based curriculum covers didactic information, practical sessions with hands-on experience and regular feedback between trainers to trainees. In addition, it should address elements of

rehabilitation and reintegration that include empowerment of women. This training approach allows individual trainees to learn at their own pace with the ultimate aim of becoming expert over time.

The curriculum for each cadre of health worker should cover the following:

Learning objectives and deliverables:

The goal and specific objectives for each topic should be described at the beginning. This will assist both the trainer and trainee to know what is expected. A specific time should be allotted to the didactic session.

List of contents (didactic and practical/clinical session):

The curriculum for the training of individual health professionals should be discussed in-country and should cover all topics related to general and specific responsibilities. A list of suggested topics for the individual cadres are presented in the FIGO Training Manual.¹⁴

Training materials:

During planning stage, it is important that a full list of materials required for training is specified for each cadre. The list should include a ventilated venue where COVID-19 protocol can be observed, constant electricity source, projector, computer, dry laboratory materials to demonstrate basic surgical skills such as handling and manipulation of surgical instruments, knot tying, sutures, protective equipment and other necessary materials for didactic and clinical sessions.

Duration of training:

Based on the current reality of each country, a specific timeline for each training should be discussed and agreed. Duration will depend on the prior skills of individual trainees, as well as where they are in the training process for OF. We advocate that the length of training time be reviewed periodically and in individual cases, particularly when the time is not enough to achieve the desired result. See Table 3.

Table 3: Duration of Training (varies within each cadre and competency level)

Cadre of Health Professional	Suggested Duration
Doctors	
Basic surgical skill (FIGO Standard Level)	4-6 weeks
Moderate surgical skill (FIGO Advanced Level)	2-4 weeks
Advanced surgical skill (FIGO Expert Level)	2-3 weeks
Nurses/Midwife	
Perioperative nurse*	2 weeks
Anaesthetic Nurse*	2 weeks
Others	
Physiotherapist**	1 week/on-the-job orientation
Social worker**	1 week/on-the-job orientation
Pharmacist **	1 week/on-the-job orientation

* Qualified professional undergoing fistula-specific skills adaptation

** Qualified professional undergoing fistula-specific orientation

Training requirements:

Clear criteria must be outlined to determine qualifications for national trainers for each cadre of healthcare professionals in OF care. ECOWAS committee, with relevant professionals and other stakeholders, should coordinate and share criteria with member nations to ensure uniformity. For example, FIGO criteria as listed in the FIGO Training manual are already being used to select trainers by WACS and other national governments. Criteria for national trainers’ identification and selection to train

¹⁴ *Ibid*

nurses, conduct fistula specific orientations for physiotherapists and others should be developed at the country level.

Sample of training timetable or timeline:

The curricula identified in Box1 provide sample training timetables. Table 3 also provides suggested durations. Country level OF committees should adopt/adapt a template for specific training of each cadre of health professional.

Supportive supervision:

Training that involves skill acquisition is associated with different learning curves. There should be a mechanism to follow-up trainees at their health centers. The trainers/mentors should be available to answer questions, respond to clarifications and, when necessary, re-train. Countries should develop a follow-up process and schedule for trainers/mentors within specified intervals, which will vary depending on the cadre and, in the case of surgeons, on the level of competency. As a general guide, after successful training, the surgeon returns to base to conduct repairs and a follow up mentoring visit within 3-6 months of self-practice after training is recommended. S/he should also receive on-going remote support and mentoring virtually or via telephone conversation and messaging.

Monitoring and evaluation (M&E):

ECOWAS countries can independently or in collaboration design a tool to monitor successes and challenges in the development of a national OF workforce. The M&E plan should include tracking of trainees, performance at their point of service, and access to a range of fistula care including rehabilitation and integration.

Certification process:

The process of certification should be designed to assess proficiency. Evaluation should cover assessment of knowledge, skills, and confidence level to perform procedures. The process of certification should be coordinated at the national level in each country and not left to individual experts to determine. However, the trainer should recommend a trainee upon satisfactory completion of the training course.

Other cross-cutting issues that should be incorporated into the training of healthcare professionals:

Record keeping:

The WDP should incorporate the importance of record keeping. Data safety and data collection (hard copy or electronic) should follow the method and tools approved by the government of the country.

Referral system:

The WDP must address referral within the healthcare system. There should be specific discussions of how fistula patients can be seamlessly referred between the healthcare facilities in the country. The efficiency of referral should be supported by a country/region mapping of fistula care facilities as well as that of fistula surgery competency levels.

Ethical issues on Genital Fistula Management:

All trainees should be introduced to ethical principles with special reference to the particular needs of fistula patients. The training should include informed consent, confidentiality, maleficence and beneficence. Training should address equity and objective selection and listing of cases for surgical repair and other management procedures so that no beneficiary is disenfranchised by the processes.

Governance, Leadership, Teamwork, Shared Vision and Accountability:

Trainees should be introduced to the concepts of leadership, teamwork, shared vision, and accountability. This discussion will explain how these non-material elements can influence the outcome of service delivery for all stakeholders – the clients, care providers and others essential to the care of women with fistula.

5. PROPOSED TRAINING MODEL TEMPLATES FOR HEALTHCARE PROFESSIONALS

Competency-based training and mentorship follows a progression of didactic lectures, practical and hands-on sessions, case studies and follow-up support and tracking (Figure 3).

Figure 3.



Medical Doctor

Training a medical doctor in the management of obstetric fistula is divided into three levels by FIGO. At each level of training, the format should consist of:

- Didactic lecture
- Clinical evaluation
- Diagnosis
- Catheter care and surgery
- Post-operative care
- Rehabilitation
- Supportive supervision

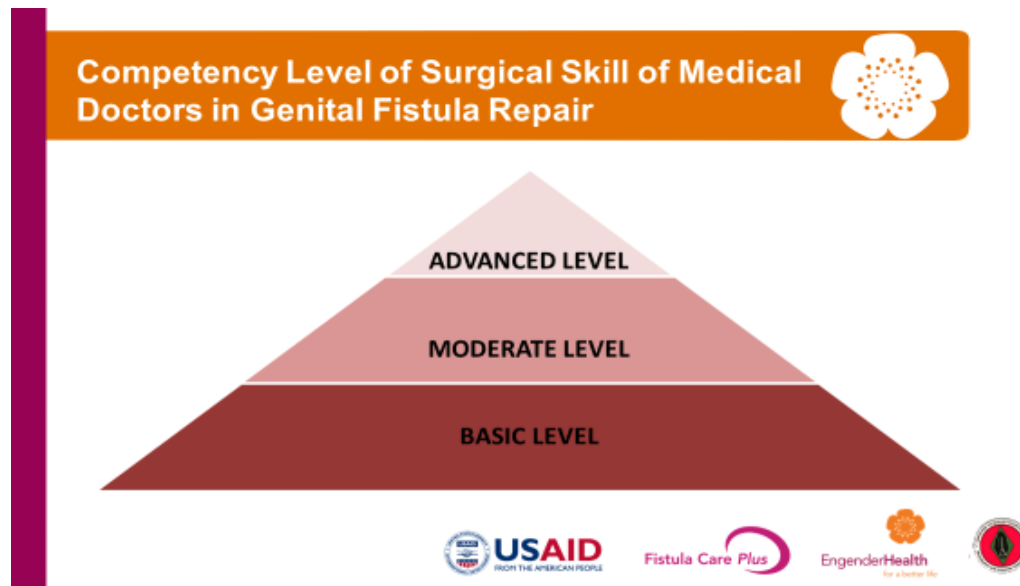
Competency Level of Surgical Skill of Medical Doctors in Genital Fistula Repair:

According to USAID/EngenderHealth¹⁵, the competency of surgical skill for fistula repair is categorized into three levels (which also align with FIGO classification):

- Basic surgical skills acquisition level (FIGO Standard Level)
- Moderate surgical skill, achieving competence in fistula surgery (FIGO Advanced Level)
- Advanced surgical skill, achieving proficiency in fistula surgery (FIGO Expert Level)

¹⁵ Fistula Care Training Strategy Version 1. EngenderHealth 2008

Figure 4:



Prerequisites for Surgical Training:

The following are suggested criteria for selecting eligible medical doctors for specific levels of skill acquisition. Other country specific skills could be added in order to ensure that the right personnel are selected.

Basic surgical skill requirements

- Medical doctor or junior resident in surgical specialty (OBGYN/Urology/General surgery).
- Interested in surgical specialty.
- Willing to develop a career on Genital Fistula Management.
- Has some knowledge of basic surgical principles: asepsis technique, surgical knotting, handling of surgical instruments.

Moderate surgical training requirements

- Medical doctor or senior resident in surgical specialty (OBGYN/Urology/General surgery).
- Has basic surgical skill on genital fistula surgery.
- Must have been working on fistula management (surgery) for more than two years with more than 70% closure rate on basic level fistula surgery.
- Must have facility for abdominal and ureteric repair and reconstruction apart from vaginal repair.

Advanced surgical training requirements

- A medical doctor with surgical experience of more than 5 years
- A consultant OBGYN/Urologist/General surgeon
- The medical doctor must have been trained in moderate surgical skill for genital fistula repair.
- The medical doctor must have 70% and above closure rate in moderate cases of genital fistula.
- The medical doctor should have unhindered access to general urological experts and the availability of a plastic surgeon will be an asset.

- A fully established recovery room and preferably an intensive care unit should be available.

Other Categories of Health workers

Nurses/Midwives

In most of the healthcare facilities where fistula repairs are performed, nurses are either assigned to work in the wards/clinic or theater. It is important that these roles are assigned before they are introduced to the training. Nurses conduct the initial evaluation of fistula patients in the outpatient clinic. They are responsible for the care of patients on admission, and before, during and after surgical repair.

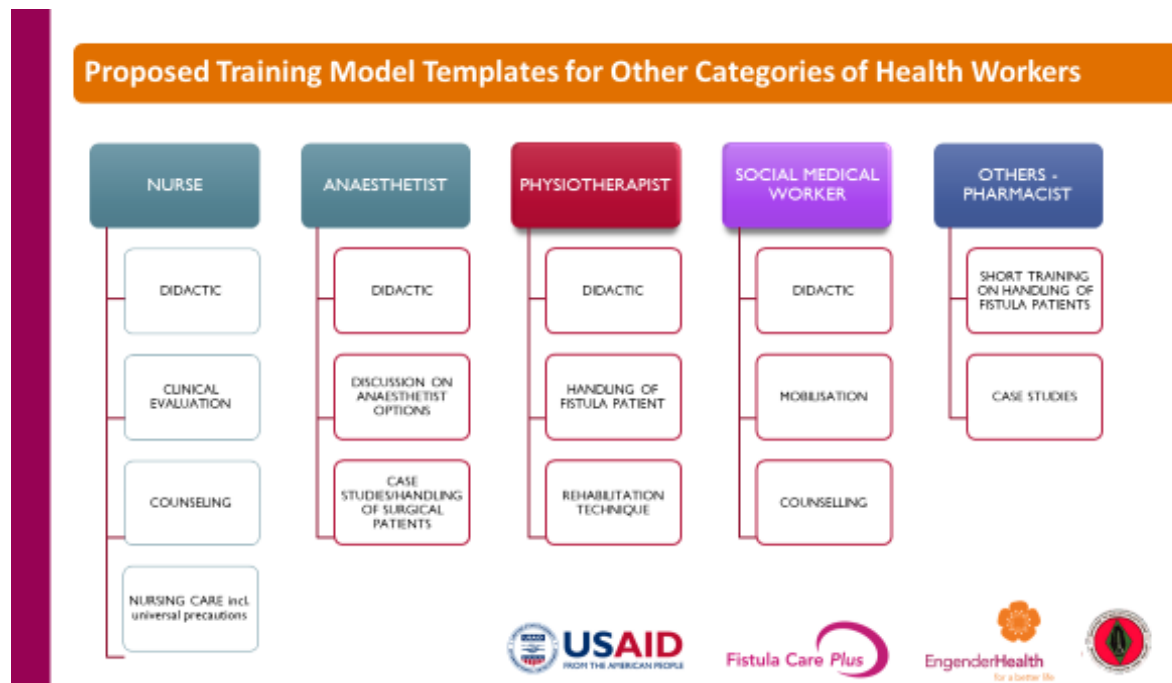
Their training should include:

- Didactic sessions
- Clinical evaluation
- Interpersonal communication skills
- Counselling before and after fistula repair
- Nursing care process – catheter, perineal care, bowel preparation and family planning

Physiotherapy, Pharmacy, Anaesthesia and Social Health worker

Since the number of staff that will be needed for these services – physiotherapy, pharmacy, anaesthesia and social health worker – are relatively small (usually less than five), it may be cost effective to incorporate their training with the training that is organised for medical doctors or nurses. The summary of key sections of training that should be considered for this category of health workers are as shown in Figure 5.

Figure 5.



6. REQUIREMENTS FOR ORGANIZATION OF FISTULA SERVICES IN WEST AFRICA

This section describes the requirement for setting up a facility for fistula management. This could be established within an existing health facility or as a stand-alone facility.

Clear rationale for setting a fistula center:

There should be a clear rationale to establish a healthcare facility for fistula care including the type of services that should be offered. Similarly, the type of service; stand-alone fistula care center or an integrated services facility should be justified. A stand-alone fistula center, though more expensive to establish, may be justified by a high caseload and complexities of cases. In addition, countries without sufficient health professionals may justify partnership with visiting professionals, especially surgeons.

Engagement of key stakeholders:

Each country should establish a clear policy and strategy for fistula management. The stakeholders should include professional associations, development partners and other organizations that are involved in fistula care as well as recognized in-country experienced fistula care professionals.

Accessibility and affordability:

There should be a clear strategy for how patients can access a fistula treatment center in each locality. Recognizing that women with fistula are usually poor and vulnerable, governments are encouraged to finance the treatment of fistula patients or incorporate their treatment into health insurance.

Infrastructure & Instruments:

The facility must have a blood bank or blood supply. It should have infrastructure for specialized services, including other surgical specialties such as urology, plastic surgery, urodynamics, radiological support (for intravenous urogram and ultrasound). A comprehensive list of equipment for diagnosis, management on the ward and surgical instruments should be listed and assembled.¹⁶

Safe Surgery Toolkit¹⁷, and Water Sanitation and Hygiene (WASH)¹⁸:

Facilities offering fistula surgery must be operating within accepted medical standards and be fully equipped and staffed to address all potential complications relating to anesthesia or fistula surgery. The Safe Surgery Toolkit, developed by FC+, was designed to provide an adaptable system of quality assurance tools to ensure patient safety. It was adapted for fistula, incontinence and prolapse surgery to standardize the quality and safety of surgical management.

WASH is critical to effective fistula service. WASH availability in low- and middle-income countries is often sub-optimal and this has dire consequences for health care service provision, including fistula

¹⁶ Direct Relief, in collaboration with FIGO, has developed a standardized set of equipment and medicines required for fistula surgery. <https://www.directrelief.org/2016/05/figo-direct-relief-join-expand-improve-obstetric-fistula-repair-surgery/>

¹⁷ The Safe Surgery Toolkit can be accessed at: <https://fistulacare.org/resources/fistula-services/surgical-safety-toolkit/>

¹⁸ WASH can be accessed at: <https://www.who.int/health-topics/water-sanitation-and-hygiene-wash>

services. Fistula repair centers must ensure the availability of adequate WASH services through adaptation of appropriate and relevant technology to ensure sustainability.

Workforce:

We have previously described the key positions required to support fistula services at a treatment center, including medical doctors, nurses, physiotherapy, social worker, pharmacy, ward assistants and security guards. Governments will need to assess at least the following components to decide the scale of the workforce required to ensure access to quality fistula treatment:

- What is the known backlog of fistula cases in the country based on hospital records?
- Is there an estimate of fistula incidence from a DHS or other study that can provide data for planning?
- Can women reach a facility in a timely manner? What transportation is available to them?
- How many beds at a facility can be made available for women with fistula for a minimum 10 day stay?
- Is there sufficient nursing staff to provide 24/7 care for women with fistula during their stay?
- Is surgical capacity available and to what level – basic, moderate, advanced? How many surgeons are currently available and where are they stationed? How many medical doctors are available or interested to be trained in fistula surgery and where are they stationed? What resources are available to support training?
- Can the facility perform safe and appropriate fistula surgery? Are the necessary operating theaters, equipment, material and drugs available to support safe surgery on an ongoing basis?
- If outreach services are to be provided, what conditions need to be in place before such outreach can take place safely?
- What resources are available to support the necessary infrastructure, equipment, material, and drugs?
- Can surgery be provided without catastrophic expenditure on the part of the patient?

Funding:

There should be a clear budgetary provision for obstetric fistula by the national government. Government should also endeavor to coordinate resources from development partners to avoid parallel programs.

Sustainability:

A sustainability plan on how fistula care will be managed without interruption should be formulated in each country. This will include financing, career development for the workforce and maintenance of infrastructure. Another important aspect of sustainability is engagement of critical stakeholders on their role and commitment to sustain the fistula control program.

7. CONCLUSION

The intent of this document is to provide a template for a workforce development plan to ECOWAS member countries to facilitate standardized quality services for women with fistula, with the ultimate goal of eliminating fistula in the region by 2030.

“We are now faced with the fact that tomorrow is today. We are confronted with the **fierce urgency of now**..... This is no time for apathy or complacency. This is a time for vigorous and positive action.”

Martin Luther King, August 28, 1963.
