Fistula Care Training Strategy

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Fistula Partners' Meeting

Accra Ghana, April 16, 2008

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FistulaCare

Context: challenges encountered in training

- Many different clinical types of fistula
  - widely divergent degrees of surgical complexity encountered
- Lack of standardization in training
  - curricula and reference materials
  - assessment knowledge, skills, competence
  - duration and training models and in classification of fistula
- Different approaches and skill sets
  - for service provision and for training, even by skilled surgeons
- Varying training site resources
  - personnel, equipment/materials for service provision, for training
- Dearth of evidence based clinical and OR data

Content of training strategy document

- Introduction, context and challenges
- Overall approach to training, key principles and premises
- Training systems, methodology and training models
- Cadres trained; criteria for selecting trainees, trainers, sites
- Skill levels attained and assessment of competence
- Training evaluation and systems for training follow-up
- Supplemental training

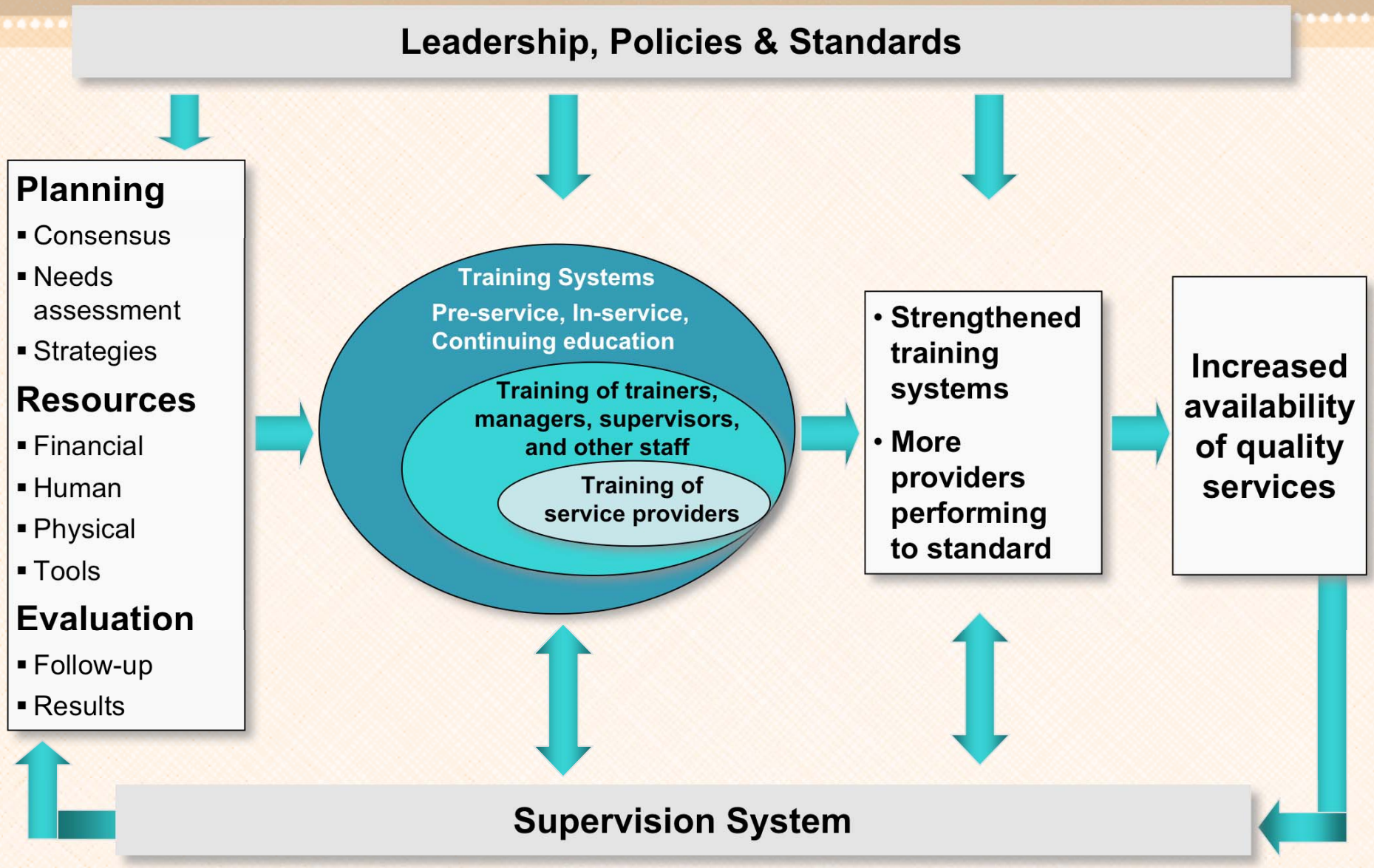
The goal of fistula programs

- To initiate and sustain access and capacity of centers to provide quality services for the care of women living with fistulae
- Therefore crucial to pay close attention to quality of training
- It would be devastating the program if health care that is supposed to help a woman and her family ends up causing them more harm, thus increasing their burden

The fistula training strategy

- Goes towards informing a uniform approach
  - That is holistic, client – centered, system focused
- The strategy is an outline for more detailed training guidelines/ standards that include more technical content
- Lays emphasis on the fundamentals of care
  - Informed choice, safety and quality improvement
- The training contributes to sustainable improvement
  - in quality, availability, access and use of fistula services

PROGRAMMING for TRAINING in FP/RH



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Linking training to performance gaps

- Training is a very expensive undertaking
- It may be just one of the interventions needed to improve performance
- We should not be trying to train every surgeon from every site
  - poor skills maintenance; lots of trainee attrition
- Proactive buy-in from site for sustainability and ownership
- Institutional/ higher level commitment to supportive work environment
  - ensures early opportunities to implement newly acquired skills
    - General and fistula specific equipment, start up supplies
    - Supportive policies and guidelines for services and clients
    - Facilitative internal and external supervision
      - emphasizing mentoring, coaching, joint problem- solving and two way communication

Fistula clients

Key principles in training strategy

- The welfare of the client guides all training
- Uses adult learning principles and experiential model
- A combination of didactic and hands- on training
- Train in teams to the extent possible
- Consider and conduct counseling as integral part of care
- Training should be competency based
  - final assessment of trainees will inform the level of surgical complexity they are competent to repair

Fistula service Providers:

Criteria for selection of surgical trainee

- Service need/demand and institutional support
- Interest and commitment to providing services
- Intention to remain in this service for a reasonable minimum length of time
  - ideally at site or elsewhere
- Motivation and ability to immediately apply the new skills upon return to their post
- Minimum educational requirements as per MOH policy
- Doctor with minimum 3 years of surgical experience
  - may be specialist (surgeon, Ob/Gyn, urologist) or general physician
  - paramedic only if mandated by specific country policy

Skill level attained by fistula surgeon

- Skills acquisition level
  - to make diagnosis, fistula classification and referral; or as a first step to wards next level of skills
  - the trainee to recognize service systems needed
    - e.g. adjunct staff, equipment, supplies, labs, pre and post op care
  - but trainee will not be competent to perform surgery at his level

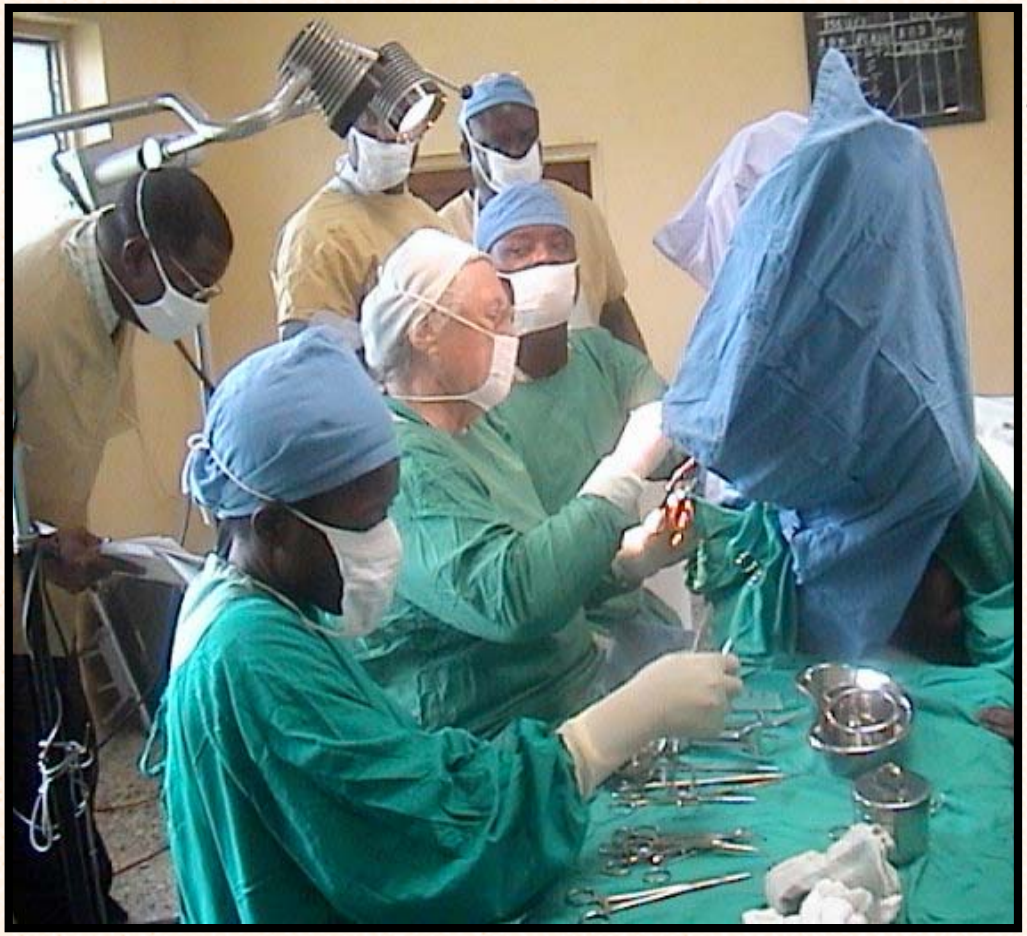
Skill level attained by fistula surgeon (ctd)

- Competence level
  - Can do diagnosis, classification and actual fistula surgery
- Fistula repairs vary greatly in complexity and difficulty so
  - gradual, progressive increase in skill, surgical efficiency in 3 stages
- Individual country programs may vary in recommendations
  - but all stages of competence will start with an intensive (large caseload and intensive clinical oversight) 2-12 week hands on surgical skills training
  - followed by progressive increase in numbers of fistulae repaired and degree of surgical complexity:
  - Stage I intensive plus additional 100 - 300 simple cases
  - Stage 2: intensive plus additional 100 - 300 simple and moderate complexity cases
  - Stage 3: intensive plus additional 300 - 600 cases, simple, moderate and complicated so as to reach proficiency level

Skill level attained by surgical trainee (ctd)

- Proficiency level
  - able to do most of the complicated cases, safely, efficiently and in correct sequence for key steps and
  - to deal with unexpected complications intra and peri-operative
  - Also beneficial to add a trainers skill set at this stage

Fistula Trainers



What is required to qualify as a Trainer?

- Minimum level 2 competence in fistula surgical skills
- Training skills, respect for training principles and criteria
- Training materials for central training and/or structured OJT
- Currently employed by state or government
  - or has MOH support and recognition
- Works at site providing routine repairs (x1 weekly at least)
- Knowledge of varied approaches of surgical management
  - for different circumstances and complications
- Takes accountability
  - for improvement of their own skill level and development
    - but with administration's support as needed

Criteria for ‘master trainer’

- De facto, not by designation
- Should have proficiency level in fistula surgery
- Highly experienced in service delivery and training
  - advanced training skills
  - can train trainers
  - can develop training courses and materials
- Access to training center material resources
- Large case loads, above 100 yearly so as to maintain skills

Follow-up is crucial and integral to training

- Administrative follow-up and supervision
  - to ensure support, implementation of the training action plan
  - internal supervision is continuous
  - external supervision is twice yearly at least
- Clinical skills follow-up
  - should be proactive and planned and structured
  - conducted by supervisor/trainer during routine service delivery
    - within 6 weeks, then every 6 months
  - encouragement and mentoring fosters early implementation
  - avoids attrition of skills, motivation and confidence
  - continued progression to more challenging cases
  - audit not only successes but also challenges and their resolution

Selection of fistula training sites

Criteria for selection of fistula training site

- Exhibits accepted medical standards and supportive policy
- Fully equipped with general and fistula specific equipment
- Adequate supplies, emergency medications and staff
  - Can handle all complications from fistula surgery or anesthesia
- Suitable infrastructure, work space, amenities and utilities
  - exam/procedure rooms with privacy
  - Theater and wards (ideally dedicated, but may also be shared)
  - Running water, power
  - teaching equipment, supplies, reference materials
  - A space for didactics and practicum
- A trainer, resident or visiting, collateral staff
- Adequate caseload

Training evaluation, 4 levels

- Reaction
  - measures the trainees' perception of the course
  - did they like the course?
- Learning
  - measures the knowledge, attitudes and skills gained
  - was there a positive change?
- Application
  - measures ability and behavior to perform learned skills on the job rather than in the classroom
  - conducted after the training, takes more effort and finances
  - but can be integrated into regular program monitoring, supervision
- Results
  - measures impact of the training program on overall services
  - are more people served in more places with a wider and better quality of interventions and services?
  - even more intense, difficult and expensive to conduct

Supplemental fistula training: may be at skills-building or awareness raising level

- E.g. to posit fistula within Safe Motherhood interventions
  - long term impact, medium or short term
  - e.g. EmONC and HAF (Hospital Acquired fistula)
- Cross-cutting issues
  - such as Quality of Care
    - counseling and informed decision making, COPE for Maternal Health, facilitative supervision
    - Infection Prevention and management of medical waste
  - engaging Men as Partners in prevention and treatment of fistula
- Community outreach, referral systems
- Traumatic fistula and Gender Based Violence
- Poverty, Women's rights and Health Equity

Thank you