MINISTRY OF HEALTH

THE REPUBLIC OF UGANDA

NATIONAL TRAINING GUIDELINES AND STANDARDS FOR TREATMENT OF FEMALE GENITAL FISTULA

Produced by: The Department of clinical Services
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ABBREVIATIONS

VVF Vesico-Vaginal Fistula

RVF Recto-Vaginal Fistula

UDHS Uganda Demographic Health Survey

EmONC Emergency Obstetric and new born Care

VHT Village Health Team

HSD Health Sub-District

CBO Community Based Organisation

IEC Information Education and Communication

BCC Behaviour Change Communication

TWG Technical Working Group

MOH Ministry of Health

DHT District Health Team

SRHR Sexual and Reproductive health and Rights

MNH Maternal and Newborn Health

PNFP Private Not For Profit

ANC Antenatal Care
CBT Competency based training
FP Family Planning

HIV Human Immunodeficiency virus
IP Infection Prevention
PNA Performance needs assessment

FOREWORD

The government has instituted measures to accelerate the reduction of maternal morbidity and mortality including the development of the Roadmap to accelerate reduction of maternal and neonatal morbidity and mortality, increasing funding for reproductive health commodities, increasing the number of regional referral hospitals and improving the capacity of existing regional referral hospitals, and earmarking funds for reproductive health. As we endevour to deliver on the outputs of the Roadmap, we still have women succumbing to complications of pregnancy and in particular obstetric fistula.

Obstetric fistula is the single most important complication of pregnancy. A typical victim of this glaring condition is a young girl that is poor, illiterate and from a rural area. In 2006, 2.63% of women of reproductive age reported to have experienced symptoms of obstetric fistula immediately after birth.

By developing these training guidelines for Treatment and Prevention of Female Genital Fistulae Services in Uganda, the government and Ministry of Health is reiterating its commitment towards eliminating this condition through building capacity at all levels. This guide line is intended to guide policy makers, service providers and all stakeholders in building capacity for treatment and prevention of female genital fistulae.

I therefore, call upon all stakeholders from Government, Civil Society, Private sector and Development Partners to utilize these guidelines in planning for capacity building in fistula care and management

Dr Jane Aceng
Director General of Health Services
Ministry of Health

Acknowledgement

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Special tribute goes to the members of the Fistula Technical Working Group that were tirelessly involved in the development of this document:

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It is hoped that these guidelines will be used to guide all stakeholders in implementing the development of capacity for fistula in Uganda.

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INTRODUCTION TO FISTULA TRAINING GUIDELINES AND STANDARDS

There is a crucial need to initiate and sustain fistula programs that increase access and strengthen the capacity of the health care system to provide high quality services for repair and care of women living with female genital fistula. Therefore, it is important to pay particular attention to the quality of training, and to proactively determine how this training fits into the health care system. Furthermore, the quality of training is improved by committing adequate resources to ensure competent trainers, able to train and follow-up their trainees. Women with genital fistulae, their families and the community need to have confidence in the health care system. It is therefore necessary to have pro-active discussions about the quality of training with relevant stakeholders. These fistula training guidelines and standards go towards harmonizing the training approach and to improving the quality of training and hence, service delivery.

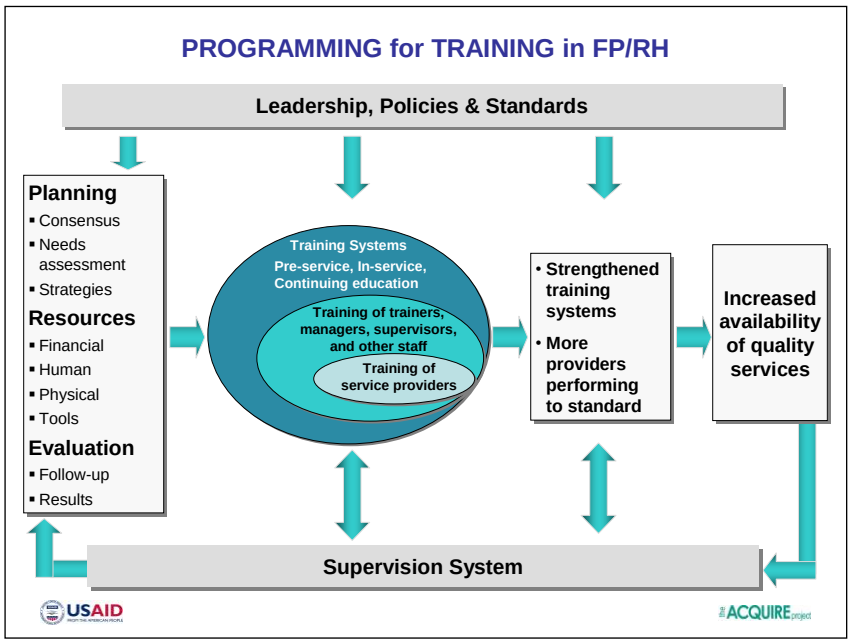
THE CONTEXT FOR FISTULA TRAINING

The strategy for fistula training recognizes and addresses distinct challenges that hinder quality in training. Among them are the following:

- Different clinical types of fistulae.
- Divergent degrees of surgical complexity encountered in fistula surgery.
- Lack of standardization in training, curricula.
- Lack of reference materials.
- Inadequate resources for fistula training.
- Dearth of evidence-based clinical and operations research data.

PROGRAMMING FOR TRAINING IN RH

Programming for training will apply a comprehensive view that considers both the systems in which training and services are provided, the MOH structure and level of decentralization; national service delivery and training policies, protocols, and guidelines; social/cultural norms and the greater social/political environment that influences service delivery. The training programme will emphasize the centrally important fundamentals of care – informed choice, medical safety, and continuous quality improvement.



Model adopted from ACQUIRE/Engender Health)

The Programming for Training Model depicts the dynamics of the *inputs* and *activities* that contribute to the desired program *outputs* of strengthened training systems and more providers performing to standard, which in turn contribute to achievement of the larger program *outcome* (goal), **increased availability of quality services**.

THE OVERALL APPROACH TO FISTULA TRAINING

The training approach will be holistic, service-oriented and systems based, and will seek to contribute to sustainable improvements in quality, availability, access, and use of fistula services.

Training is used as part of the learning process interacting with and mutually supporting supervision, management and logistic interventions. This will require program managers, supervisors, and trainers to take an active part in:

- Assisting providers to identify their own training needs
- Creating a supportive environment in which to apply what is learned through training
- Ensuring that providers also have chances to use new knowledge, attitudes and skills that they acquire in training; appropriate equipment, supplies, reference materials, infrastructure, work environment, and policies affecting services
- Monitoring provider performance

KEY PRINCIPLES AND PREMISES IN FISTULA TRAINING

The training approach is characterized by some key principles**:**

- The welfare of the client guides all training;
- A combination of didactic and hands-on training is important, both to bring less experienced surgeons to a baseline level of technical skill (for simple repairs) and to help bring surgeons with more experience to a greater level of technical skill;
- Service providers should be trained in teams that include, Doctor, anesthetist and nurse, counselor, and any other, as logistics allow;
- Providers must consider and conduct counseling as an integral part of clinical care (from pre-operative, intra-operative, through to post-operative periods);
- Training should be competency-based and use adult learning principles: "final" assessment of trainees will inform the level of surgical complexity or fistula class they are competent to repair. Subsequent trainings should then take into consideration the higher the stages of complexity.
- There should be a systematic modular approach/curriculum.
- Trainees should be exposed to different trainers and situations and definite intervals.
- Training should be certified at each level.
- Encourage attaching trainers to specific regions for a specified time to allow for standardization.

Didactic sessions involve open and participatory learning activities. The facilitators meet regularly to review progress of the training and to plan subsequent activities.

The training is also guided by the following premises:

- Experiential learning model
- Linking training to performance
- Evaluating training and performance

Experiential learning involves four steps having an experience, critical reflection, reviewing the experience, conceptualization and interpretation of meaning and learning from it, and then application of the learning and review through action in new situations (Kolb 1984) This model works for knowledge and skills training, one on one training and group training. It builds on the individuals experience and encourages him/her to determine appropriate application to the specific job situation.

Clinical training is designed and conducted according to **Adult learning principles**: it is participatory, relevant and practical. It utilizes behavior modeling, is competency- based and incorporates humanistic learning techniques.

A variety of learning methods are used to make the learning interesting and relevant; to maintain the level of motivation and build on their self esteem and relating their learning to their every day job responsibilities. This can be achieved by creating an environment that is conducive to learning, providing opportunities for discussion and application of what they have learnt and providing positive feedback on their success and support for areas that need improvement. They should feel valued and respected for their experience and perspective. Training should be relevant to what they know and relate to their job expectations. The environment for learning is reinforced using a variety of activities. Learning is applied promptly; during training and immediately after.

For participants to have a clear picture of the performance expected of them and for them to be able to learn more rapidly and effectively, they are COACHED by watching as trainers demonstrate the requisite skills or activities clearly before performing return demonstration.

The goal of the training/precepting is to provide effective and sustainable transfer of knowledge, attitudes and skills. To this end the training draws on the participants' own experiences, utilizes case studies, considers the participants' specific needs and interests, and integrates theoretical/didactic course content with simulation and practicum/clinical practice. The role of the trainer is to guide/facilitate the learning process in a logical order. A key element of this approach, which helps link training to performance, involves giving the participants an opportunity to think about and discuss application of the newly acquired skills to their own work situations.

Competency–based training (CBT) focuses on what the provider can actually do in the workplace as a result of the training. It is concerned with training to standards rather than with the individual's achievement in comparison to others in the class. It emphasizes progress in mastery of specified knowledge, attitude, skills. It is trainee – centered, rather than focused on the unit of time and trainer centered, and uses the following guidelines:

- Ensure adequate resources, materials to support the training system (provision of training materials, manuals, equipment, classroom based training equipment etc)
- Identify training competencies through national and district level learning needs assessments
- Write training objectives to directly address the training competencies
- Follow a system of facilitative supervision to provide feedback, coaching and continued support to facility- based providers
- Assimilate/familiarize all trainers on CBT training principles including skill standardization and competence based assessment tools ; this last aspect is especially challenging in fistula programs

Since the training is competency based, the main focus is on what the trainee can actually do—and will be expected to do—in the workplace as a result of the training. The training also involves instruction in precisely defined skills and knowledge to set standards and assessment of competency through formative and end-of-course observation/assessments.
This approach links training to subsequent desired performance and addresses the learning needs (skills, knowledge, attitudes) of staff at the health care facility. The staff and supervisors are engaged in assessing their own needs and in planning to meet those needs, as well as in planning subsequent ongoing provision of services, including regular monitoring and supervision for improved quality and expanded service delivery. This is where the critical

intersection of training and quality improvement approaches and tools has a part to play. QI approaches and tools enable staff to determine if "training really is the/or part of the answer" to the challenges they face, or whether there are other systemic issues which also need to be addressed in order for skills acquired to be used, updated, and sustained. Without this, it would be wasteful and counterproductive to invest scarce resources in perfunctory training that will not result in improved access and quality of services due to other systemic weaknesses.

LINKING TRAINING TO PERFORMANCE ON-THE-JOB

Transfer of Learning – defined as ensuring the knowledge, attitudes and skills acquired during training/learning are applied on the job – in an interrelated series of tasks. These will be achieved through:

- Institutional commitment e.g. national training policies and service delivery guidelines are in place and providers are oriented to their use
- Effective supervision: facilitative supervision that emphasizes mentoring, joint problem solving and two- way communication between supervisor and supervisee
- Create supportive work environment: provide opportunity to use what was learned, ensure availability of resources to do the job
- Coaching and confidence- building: facilitate on-site coaching for providers, on-site problem solving and constructive feedback to build provider confidence
- Facilitate team work: use team building approaches, COPE, Whole Site Training, Facilitative Supervision
- Training follow-up: facilitate follow- up and support of all training events to ensure trainees are enabled to start services at their work sites as soon as possible
- Whole site training and supervision; team work and sustainability strategies to enhance the application of newly acquired skills

FISTULA TRAINING SYSTEMS, METHODS AND MATERIALS

The training approach focuses on strengthening existing, local training systems, rather than on establishing new parallel systems.

- Humanistic methods will be used. These will include use of anatomic models, audiovisuals and hands on experience, etc. This will allow faster acquisition of skills and attainment of competence with minimal discomfort and no harm to the client. The MOH will identify and supply appropriate materials.
- Although the training is competency based, figures are needed to help in planning, e.g. 10 supervised operative cases and a minimum of two weeks for the initial session of skills competence (to be followed by other sessions), although some take longer, others shorter. Also, given the varying complexity of fistula surgery, only a small proportion of cases may be suitable for the trainee to operate on initially.
- For didactic sessions before and after the hands-on practicum, it is necessary to use an engaging and appropriate variety of methods, materials, and trainers.

Assessment of training needs:

Assessing training needs should focus on two important aspects of the training domain; performance of providers (knowledge, attitude, skills) and the training capacity of the institution or system to provide trainers. Attitude is more difficult to assess than knowledge and skills, but is also important. The assessment finally should be able to provide direction in the following aspects:

A critical step in planning is to identify the current gap that warrants a training intervention under the three areas:

- Knowledge focuses on the information necessary to deliver the fistula service. What new knowledge should be included in the course?
- Skill is a complete sequence of practical steps that are necessary to perform the fistula service delivery
- Attitude is a tendency to behave in a particular way in association with beliefs people have that will influence the job they perform. Identify what needs to be firmed up and cultivated

Institutional (e.g. MOH) training needs assessments should be geared toward finding the following information through review, interview and observation:

- The organization that oversees training
- Available training strategy/plan to guide training events
- Type of training curricula available for conducting training
- Number or training sites available to conduct training
- Number of qualified trainers for specific training categories
- Number and cadre of providers to be trained per year
- Training equipment and supplies (audiovisuals, equipment, training materials including training manuals
- Infrastructure for training follow-up and support to new providers, as well as support to trainers within the training system

Facility needs assessment: is conducted to identify training site that provides services and with capacity to potentially provide quality training. For the clinical training component, the assessment looks at the adequacy of proposed facility to provide clinical training. It typically includes:

- Availability of fistula services
- Number of staff by category routinely involved in fistula services
- Qualification of service providers
- Types of fistula services offered
- Average number of new and revisiting fistula clients
- Adequacy of IP and other QI practices
- Availability of appropriate equipment and supplies
- Training capacity and capability of the site

FISTULA TRAINING MODELS

The strategy explores the use of different training models (modified from Maggie Bangser and UNFPA Fistula Training workshop, Niamey 2005). The most frequently used, amongst others, are:

- On-site Training:
  - by a master trainer: an expert trainer visits a hospital to do hands-on training
- Workshop Training:
  - intensive trainer-led training for a small group of surgeons at a busy center
- Outreach Training:
  - less experienced surgeon accompanies expert during outreach visits to remote hospitals to gain exposure and training
- Apprenticeship training:
  - more experienced surgeon or 'mentor' meets less experienced 'apprentice' for periodic exchange and hands-on. This may be On- the- Job Training, but needs to be structured and with reference materials
- Training Center:
  - establishment of a regular training program at a major hospital doing fistula repairs
- Medical school and Postgraduate training:
  - mostly for theoretical pre-service "training". But there is potential to arrange some structured hands-on practicum at the medical school or at an affiliated site, especially for residents in OB/GYN and Surgery.

The different models often overlap. They may have varying strengths and challenges depending on local circumstances e.g. implications of being trained away from one's own site for extended periods of time from sites that are commonly personnel- deprived already. The training strategy therefore needs to be flexible and adaptable to specific service and training site capability, as well as trainer and training site resources. Furthermore, even for a specific site and team, it may be necessary to change or to use a hybrid model to cater for update, follow-up and for proficiency-level trainings.

GUIDELINES FOR IDENTIFYING, SELECTING AND ASSESSING HEALTH CARE PROVIDERS

Cadres of Health Care Providers and Community Members to be trained

This training approach is aimed at enabling selection of health care cadres and community members suitable for training in female genital fistula care. The principles governing the selection shall be in line with the GOU policies and the MOH guidelines.
It is required that the trainees attain a minimum level of skill and knowledge as specified in the curriculum.

The certification and accreditation of this training will be the sole responsibility of the MOH.

Guidelines and Standards for Selection of the Different Cadres for Female Genital Fistula Care

CADRE	MINIMUM QUALIFICATION	CERTIFICATION	RESPONSIBILITY
Doctors	Obs/Gyn	Fistula surgeons	Diagnosis

	Urologist General surgeon Medical Officers (min 2 years surgical experience)		Surgery Referral Training Research
Clinical Officers			Screening, diagnosis, referral
Nurse/midwives	Theatre nurse Enrolled nurse/midw Reg. Nurse/mid Compreh. Nurse Diploma/degree	Fistula care nurse/midif	Counseling Diagnosis Nursing care Pre-, post-op care Theatre nurse physiotherapy
Counselors	Nurse/mid Trained med.counselor	FGF-counselor	Pre-, post-op counseling, follow-up and reintegration
Physiotherapist	Physiotherapist Nurse/midwife	FGF-physiotherapist	Pre, post-op physiotherapist
Anaesthetist/ Anaesthetic assistants	Anaesthesiologist Anaesthetic Officer		Anaesthesia
Other staff	Managers Administrators Support staff Comm. liaison Social workers	Will need to be sensitized and incorporated into the fistula care team	
Village Health Teams			Screening, referral Counseling, follow-up, reintegration

Criteria for fistula trainee selection and assessment

The selection of trainees is a crucial part of the training process and preparation. It is imprudent to invest scant resources in training a provider multiple times if the training is not going to translate into increased and better quality services to the community. Although the ultimate specific decision for which provider is selected for training is usually made by site administration, it is critical that all stakeholders' buy-in into a standard trainee selection criteria. Judicious selection contributes greatly to the success or failure of the strategy. Selection criteria include:

- Interest in providing fistula services
- Self-motivation and ability to immediately apply new skills after training
- Minimum educational requirements as per MOH policy
- Basic surgical skills (minimum 2 years experience advised for a medical officer)
- Basic counseling skills

- Basic nursing skills
- Service demand/need
- Institutional support
- Intention to remain in this service for at least two years

SELECT PROPOSED CURRICULUM CONTENT

Surgeons

- Epidemiology of Female Genital Fistula
    - Magnitude of the problem
    - Distribution of the problem
    - Public health aspects including prevention
    - Re-integration
- Diagnosis
    - Signs and Symptoms
    - Investigations
    - Classification
    - Prognosis
- Management
    - Pre-operative Care
    - Intra-operative Care
    - Management of simple urinary fistula
    - Management of recto-vaginal fistula, perineal tears(3^{rd} and 4^{th} degree)
    - Management of complex/complicated Fistula
    - Adjunctive surgery
    - Counseling
    - Physiotherapy
    - Management of post-repair incontinence
    - Complications of fistula repairs
    - Nursing Care
    - Non-Surgical Management
- Documentation
    - Record Keeping
    - Collection, storage, and use of information
    - Data retrieval
- Assessment methods (eg.
    - pre and post-test, knowledge and skills
    - OSATS
- Referral and social reintegration
- Tools (see appendix)
    - Learning Tools
    - Protocols
    - Data collection tools
    - Guidelines Counseling
- Physiotherapy for fistula clients
- Complications of fistula repairs
- Referral and social reintegration
- Management of post-repair incontinence
- Anesthesia for fistula clients

SKILL LEVEL ATTAINED AFTER FISTULA TRAINING

Skill Level Attained by General Site Staff

- Orientation to fistula service provision
    - Whole Site Training for support staff, site managers/administrators
    - Study tour for selected site managers/administrators- to a model site for orientation in administration, logistics, advocacy, costing, record keeping overview and community linkages

Skill level Attained by Nurse/Midwife

- Operative theater and scrub nursing skills
- Pre /post fistula repair skills
- Skills for individual and family/couple counseling,
- Skills for rehabilitation
- Skills in community collaboration

Skill Level Attained by Physiotherapist, Anesthetist

- Competence and, eventually, proficiency in fistula counseling, pre and post operative care, scrub nursing, physiotherapy and anesthesia. (The extent of prior experience is here not as crucial as it is for surgical experience)
- Trainer for these skills would, in addition, need training skills.

Skill Level Attained by Fistula Surgeon

There are several skill levels that can be achieved stepwise from the training, and they may be partly influenced by the methodology and approaches used.

- Skills acquisition level
    - Knowledge and skills to make diagnosis, fistula classification and referral; or as a first step towards next level of skills.
- Competence level
    - **Standard**: intensive plus additional (50 - 100 simple cases.
    - **Advanced**: intensive plus additional 100 - 200 cases simple and moderate complexity cases
    - **Expert**: intensive plus additional more than 400 cases, simple, moderate and high complexity cases so as to reach proficiency level. Ideally, every skilled fistula repair surgeon should want to be a trainer someday, and it would be advantageous to add a Trainer of Trainers' and training skills standardization set at this stage.
- **Proficiency level:** The surgeon is able to do high complexity fistula cases, safely, efficiently and in correct sequence for key steps, and to deal with unexpected complications during surgery. Conceptually, proficiency can be achieved at each of the above levels.

NB: The trainer will have to declare the level of skill competence not the trainee

Update fistula training may be needed occasionally. It is especially useful for those already with basic skills who have not been providing fistula services regularly, and therefore need a refresher course.

GUIDELINES SYSTEM FOR REFERRAL OF COMPLICATED CASES

The training implements a protocol for determining which cases can be done by trainees, as follows:

- Establish fistula referral units to facilitate upward referral or downward transfers. Deferrals should also be considered.
- Harmonizing their diagnosis with the classification and perceived complexity of the fistula- and how to refer complicated case to more experienced surgeons.
- This would include protocol for upward and downward referral (transfers), referral mechanisms and supportive logistical systems, minimum preparations needed before referral, outgoing referral and base records needed.
- The trainees must recognize and accept their current skill level - avoiding false confidence - so that they do not try to operate on cases of complexity beyond their competence.
- The trainees will be aware of equipment, staff and support systems needed for post-op care, etc. depending on the fistula class and what the trainer/ policy allows them to do.

In addition, it is necessary to understand that a complicated case may not be recognized as such until too late in the pre-operative or even intra operative phase. And serious complications could also arise in the post operative phase, requiring a need for referral or consultation with a senior, either physically or remotely. For some intra operative complications, there is also the option of not trying to complete the operation at that particular time, and deferring it to a future session when the danger has passed.

Table 1: Task Distribution of Fistula Repair and referral/transfer by Level of the health care delivery system in Uganda

Level	New tasks
VHT	Case detection, awareness, community mobilisation and
HC II and III	Prevention, case detection, follow up and referral
HC IV	Prevention, case detection, follow up and referral
General Hospitals	Simple fistula repairs, Monitoring
District Health Office	Building appropriate facility, administrative and multi-sectoral capacity to adequately address obstetric fistula
Regional Referral Hospital	Complex fistula repairs, Out-reach, training and technical Supervision
National Referral	Repair of very complex fistula, Training and technical

Hospital	Supervision
Ministry of Health	Set rights and gender based policy framework, set standards OF clinical care and training programs, developing centres of excellence, input with supplies, equipment and training, develop related services

HOW DO WE MEASURE THE COMPETENCE OF THE TRAINEE: use the Global competence based fistula surgery training manual

Formal standards/requirements for qualifying as a competent provider as established by the MOH will be followed. Using these standards, trainee competency will be assessed by trainers through observation at various stages during and after the training period. Knowledge and clinical skills will be assessed to evaluate whether trainees perform to standard. This will be done using various approved methods e.g. A national body of fistula surgeons will be developed to conduct continuous assessments.
,Along with clinical skills check lists for the various cadres are used for formative and end-point evaluation to determine whether trainees perform to standard. Critical steps are identified in the clinical check lists and providers must perform all of these steps correctly, completely and consistently to be deemed competent. Because formal standards/scores required for qualifying as a competent provider are established in each country program, there may be some variation among field programs, with requirements for qualifying as competent being about 85% on "must know content" knowledge assessments and in clinical practice, in addition to performing all critical steps competently. Periodic appraisal should also be done on all trainees. Traiees should have fistula log bookd in which to record all the surgeries done since training, as well as outcomes and challenges. The log book would be revised by clinical supervisors and trainers during follow up.

Trainer/participant ratio and duration of training

Each trainer should Ideally, not train more than two surgeon trainees hands-on per session. The Other cadres who are not surgeons (non surgical trainees) will be trained as a group, per cadre, as provided by the facility, as long as the facility is not crowded.

- For specialists (surgeons, urologists, gynecologists) minimum 2-4 weeks
- For general practioners with surgical competence minimum of 4-8 weeks
- For nurses (pre intra and post-operative care) minimum of 2-4 weeks

Additional training shall be offered as and when there are opportunities/demand

GUIDELINES FOR FOLLOW UP AFTER TRAINING

Follow-up is a crucial and integral part of training and should be done for all trainees.
Two broad types of follow-up are as follows:

- Administrative Follow-up and Supervision
    - To ensure continued support, encouragement and mentoring in the work environment, and also the implementation of the training action plan
    - Oversight by on-site supervisor is continuous; external supervisory visits may be quaterly or at least twice a year.
    - Additional follow-up could be conducted by email/phone.
- Clinical Skills Follow-up
    - The encouragement and coaching/mentoring fosters early implementation of new skills, retention and continual improvement in skills and confidence for progressively more challenging cases. This follow-up should be done in a planned, pro-active, structured manner. The baseline for reference is the end of the competency- based training assessment by the trainer – and also subsequent follow-up visits- regarding the repair skills and level of functioning achieved by the trainee. During follow-up, it is important to audit not only the successes, but also the challenges and clinical or sytem failures, the reasons for the failures and to design possible strategies to tackle them.

Team follow-up will be regular and based on the schedule outlined below. The entire surgical team should be followed-up.

- 6-12 weeks post training for the first follow-up
- Every 3-6 months for the first year.
- Once per year after the first year.

NUMBERS OF FISTULA SERVICE PROVIDERS NEEDED AT SITE

The training strategy results in not only a certain number of local surgeons competent to do simple repairs, but also a subset of them to do complicated repairs. Furthermore, some of them also get training skills and also training of trainer skills. The numbers needed will vary with skill level, type of site and magnitude of the fistula problem locally, but the minimum numbers suggested are the following:

Cadre	**Number trained per site**
Surgeon	2
Ward Nurse	6
Theatre Nurse	6
Anaesthetist	2
Counsellor	2
Physiotherapist	2

GUIDELINES FOR IDENTIFYING, SELECTING AND ASSESSING TRAINERS

Fistula trainers are clinical providers who must have extensive experience and be able to perform competently the technique they are teaching. Additionally, they must be able to communicate effectively so as to impart knowledge in instructional sessions and to transfer technical skills in practical sessions. They must be approved by the Association of Fistula Surgeons in collaboration with the MOH.

Criteria for qualification as a fistula trainer at each level and accredited by Ministry of Health*:*

A. Trainer /Preceptor

- Should be trained to a stage 2 competency level at a minimum.
- Should be trained as a trainer.
- Should adhere to the training principles and criteria.
- have knowledge of different approaches of surgical management to deal with different circumstances and complications encountered at fistula surgery.
- Take accountability for their own skill levels.
- Trainers should also have demonstrated ability as instructors, with specific competencies in communications, training, and human relations; medicine and surgery; and the service delivery system.

B. Fistula Advanced Trainers

Criteria to Qualify as an Advanced Trainer (who would train other staff to be fistula surgeons and trainers)

- One should have advanced TOT skills, can train trainers and is able to develop training courses and materials.
    - Should be stage 3 competency at a minimum, and can do most medium complexity and at least some high complexity fistula repairs

C. Fistula Master Trainers

Criteria to Qualify as a Master Trainer (who would train other staff to be trainers)

- To qualify as a "master trainer," one should be a highly experienced trainer with advanced training skills, who can train trainers and can also develop training courses and materials, and can design and evaluate training curricula.
    - Should have achieved **proficiency level** in fistula surgery (as described above), and can do all simple and moderate complexity fistula as well as most high complexity fistula.

GUIDELINES FOR DETERMINING THE QUALITY OF THE TRAINERS AND OF THE TRAINING

In addition to the criteria for trainer identification and selection, trainers shall be assessed during and after each training course. This will be done using recognized methods (e.g. verbal interviews and semi-structured training evaluation forms).

This assessment will offer a platform for positive feedback and constructive critique which is objective, specific, and can be acted on.

TRAINING EVALUATION: use the Global competence based fistula surgery training manual

GUIDELINES FOR FISTULA TRAINING SITE SELECTION CRITERIA FOR SELECTION OF FISTULA TRAINING SITE

The key determinants in selecting a fistula training site are case load and quality of care.

Additional requirements that are specific to clinical training will include:

- Facilities fully equipped and staffed to handle all immediate complications related to anesthesia or fistula surgery
- Standard infection prevention practices
- Counseling and informed choice
- Records management
- Laboratory able to perform basic hematology, blood grouping, etc.
- Adequate infrastructure and amenities/utilities, (ex. adequate examination rooms (with privacy), teaching space, procedure rooms, and /or surgical and recovery areas/ wards preferably dedicated to fistula, but may also be shared, laboratory, power, running water, etc.)
- Appropriate general and fistula specific equipment and supplies for wards and theater
- A supportive policy, guidelines, supervision
- Readily available teaching aids, (ex. audiovisual equipment, computer-ware, printed materials and other training and library/reference materials);
- Have a Trainer/ Trainer of trainers with documented experience in fistula repair proficiency and training skills; the trainer may be visiting/sessional or residential
- Community networks for support of women and families affected by fistula

SUPPLEMENTAL FISTULA TRAINING

It is important to link fistula training to other aspects of health care. Listed below are some of the important aspects.

- Emergency Obstetric Care
- Neonatal Care
- Family Planning
- Health Care Referral Systems
- Infection Prevention, HIV, engaging men As partners in prevention and treatment of fistula
- Affirmative Action (Gender Based Violence, Poverty, Women's Rights, Health Equity and Governance)

COMMUNITY COLLABORATION IN FISTULA TRAINING

Community representative functioning as a liason between fistula training sites and community for:

- Client Identification
- Provide information regarding fistula repair services
- Provide fistula prevention messages
- Client follow-up and reintegration
- Inter-sectoral linkages (SRH and social services)
- SOPs for programming clinical training and for evaluating various aspects of clinical training (i.e., trainees, trainers, sites, training course, and the community's needs.)

CLINICAL TRAINING SOPs

MOH formal training SOPs and updated Training Resource Packages should be in place (or, if not already in place, will need to be developed). These documents contain the guidelines and standards for programming and evaluation of training. The monitoring for training events includes number, type and the cadres trained

MOH SOPs for evaluating clinical training should include the indicator of performing to standard (PTS), which is the proportion of persons in clinical trainings that performed to established guidelines and standards by the end of the training, by training type and cadre.

MOH will be responsible for certification and accreditation.

RECORD KEEPING

Record keeping is an essential component of the female genital fistula service delivery. This is because the records assits in follow-up of care, decision making, service improvement, planning for resources, audit, care evaluation, research and midoc-legal purposes.

Female genital fistula records should be incorporated in the HMIS.

NON-SURGICAL TREATMENT AND INNOVATIONS

The use of catheterization for treatment and prevention of small fistula and prevention should be strengthened. There is a need to develop protocols for catheter management in the prevention of fistula and in the primary treatment of select fistula cases.

Innovations into new, surgical and non-surgical interventions are recommended and should be encouraged. This is because these methods maybe cost effective and can be used at different levels of care. However, guidelines or protocols should be developed regarding any new form of treatment once there is a clear evidence base, prior to inclusion in training.

REFERENCE MATERIALS

- MOH guidelines and materials (need to be listed)

- Sexual and Reproductive Health Policy Guidelines
- WHO: Guiding Principles for Clinical Management and Programme Development, eds Lewis G and de Bernis L, 2006.
- Waaldijk K Step by Step Surgery of Vesico-Vaginal Fistula, 1994
- Hancock B: First Steps in Vesico-Vaginal Fistula Repair, 2005
- Add additional reference materials from Joseph's power point presentation
- Need for additional local studies, ex. UDHS, studies conducted by researchers in the country

REFERENCES

1. AVSC International; AVSC Medical Division Coordination Manual, 1996
2. AVSC International; Training Desk Reference; Guidelines and Resources, Working Draft, 1997
3. UNFPA, Niamey Fistula Training meeting, May 2004
4. Bangser, M. Fistula Training Models, Women's Dignity Project, 2004
5. IntraHealth (PRIME II Project) and JHPIEGO, Transfer of Learning: a Guide to Strengthening Performance of Health Care Providers, 2002
6. EngenderHealth, Counseling the Obstetric Fistula Client: a training curriculum, working draft, 2006
7. WHO, Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development; Integrated Management of Pregnancy and Childbirth (IMPAC), 2006
8. ACQUIRE/EngenderHealth: Programming for Training in RH, Resource Package, working draft, 2008
9. Kirkpatrick, DL. Evaluating Training Programs. Berret Koehler Publisher, Inc. San Francisco, CA, 1994

APPENDIX 1 :HARMONIZED OR FC/EH STANDARD FISTULA EQUIPMENT AND SUPPLIES LIST

APPENDIX 2: DEFINITIONS

Performance needs assessment (PNA): a method of identifying performance gaps at national or district level. It is based on analysis of desired performance and actual performance amongst providers or systems.

Training for skills and knowledge may be just one of the interventions needed for performance improvement along with clear job expectations (job description), motivation and incentives for performing to standard, clear and immediate performance feedback, supportive work environment and job satisfaction,

Training needs assessment: a process that assists in identifying the training capacity (physical infrastructure, human resource, policy and guidelines) of a national training system, and institutional service delivery facility so as to plan implement and evaluate a training program

APPENDIX 3: TRAINING QUARTERLY REPORT FORM

APPENDIX 4: Qualifications

- Qualifications in communications, training, human relations
    - Ability to communicate calmly and effectively with clients and trainees before, during and after the procedure
    - Ability to impart both theoretical and practical knowledge to trainees.
    - Experience as a trainer
    - Ability to facilitate a group dynamics
    - Familiarity with teaching aids that will be used in a training, such as competency- based checklists, films, slides and anatomic models
    - Positive attitude about working with both clients and trainees

- Medicine and surgery
    - Commitment to high quality services
    - Proficiency and on-going extensive experience performing fistula surgery
    - Understanding and ability to manage possible side effects and complications from surgery and medications
    - Knowledge of accepted standard regimens for analgesia and anesthesia
    - Knowledge of relevant infection prevention practices

- The Service Delivery system
    - Knowledge of counseling, informed choice and client –provider interaction
    - Medical screening and pre-operative assessment
    - Post-operative care and follow- up of clients
    - Establishment, management and supervision of logistics, service delivery and surgical theater
    - Client record keeping system
    - Referral system
    - Maintenance of training records