

Meeting Report: Training for Fistula Management



Obstetric Fistula Working Group

Niamey, Niger
19-20 April 2005

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Executive Summary

From 19-20 April 2005, UNFPA hosted a meeting of the Obstetric Fistula Working Group on Training for Fistula Management in Niamey, Niger. The working meeting was the first forum to date held to discuss, and arrive at consensus around, universal training standards for fistula treatment providers. While fistula treatment initiatives have been underway worldwide, up until now there has been a lack of consensus around training for fistula management. The international Obstetric Fistula Working Group identified training for fistula management as a critical issue requiring a meeting of experts, discussion and consensus.

The meeting brought together approximately 30 participants including representatives from UNFPA headquarters, country support teams and 11 country offices;¹ as well as partner organizations including WHO, EngenderHealth, AMDD, UNICEF, and AMREF; and medical experts from fistula treatment facilities in Niger, Nigeria, Mali and Tanzania. The meeting was held within the framework of the Campaign to End Fistula, which was launched by UNFPA in 2003 and includes a number of partners at global and national levels.

The objectives of the Training for Fistula Management Meeting included the following:

- To come to agreement on basic standards for training doctors and nurses including minimum qualifications for trainees, number of cases needed to be qualified to provide repair, and basic competencies for each level of trainee.
- To explore existing training guidelines and map out a plan of action for developing technical guidelines for training.
- To review recent findings and recommendations from EngenderHealth's meeting on fistula counselling.
- To map training needs and capacities as determined by needs assessments and training questionnaires.
- To explore the advantages and disadvantages of different training models.

The group was able to come to consensus on many issues and develop recommendations for training. A number of the recommendations are preliminary and meant to guide national and regional planning for training in fistula management, with the understanding that more research is needed in this area.

The meeting provided a critical forum for all Campaign partners to come together and debate for the first time the important issues around training. The recommendations from this working meeting will contribute to fistula management efforts worldwide and may also be published as an annex in WHO's manual *Principles for Preventing and Managing Obstetric Fistula*.

¹ Benin, Burkina Faso, Ghana, Eritrea, Kenya, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone.

Obstetric Fistula

Obstetric fistula is a devastating childbirth injury that occurs when women with prolonged obstructed labour are unable to access prompt and high quality medical care. The constant pressure of the baby's head against the mother's pelvic bone causes a hole to form between the mother's vagina and bladder, or between the vagina and rectum (or both), and the woman is left leaking urine and/or faeces uncontrollably. The baby almost always dies during labour, and the mother is typically left to endure significant economic, social and emotional challenges.

Fistula is a product of poverty, women's poor access to quality maternal health services, and gender discrimination. Because fistula occurs when emergency obstetric care is not available, poor, uneducated women living in remote rural areas are disproportionately affected. Efforts to strengthen health systems, reduce poverty, improve transportation infrastructure, and expand girls' education and women's rights are all critical to reach the goal of eliminating fistula.

The Campaign to End Fistula

The Global Campaign to End Fistula was launched in 2003 in response to emerging evidence on the prevalence of fistula and its impact on women's lives. The Campaign emphasises providing a coordinated, comprehensive response to obstetric fistula, which includes raising awareness at all levels, determining needs, and supporting implementation of national strategies to prevent and treat obstetric fistula and help women reintegrate back into their communities after surgery. Partnership is a cornerstone of the campaign. Governments, UN agencies, health care providers, NGOs and international organizations are working together to ensure women's rights to safe delivery and a life of dignity. Policy and advocacy are also key components of the Campaign. Partners work to reduce the stigma associated with fistula by bringing the problem to the attention of policy-makers and communities. They also help women who have undergone treatment to return to full and productive lives.

Through this global effort, it is hoped that obstetric fistula will eventually be as rare in the developing world as it is in industrialized countries today.

The Campaign's work includes interventions to:

- Prevent fistula from occurring.
- Treat women who are affected.
- Help women who have undergone treatment return to full and productive lives

The Campaign currently covers more than 30 countries in sub-Saharan Africa, South Asia and the Arab States. In each country, the Campaign proceeds in three phases: needs assessment, planning and implementation. The Campaign to End Fistula promotes an integrated approach, which situates fistula programmes within the broader framework of safe motherhood and reproductive health. The strategy reflects the reality that fistula is not a stand-alone issue, and must be a component of maternal and reproductive health policies, programmes and services.

The Obstetric Fistula Working Group

The Obstetric Fistula Working Group is an alliance comprised of international and regional organizations that coordinate fistula elimination efforts worldwide. The Group is tasked with developing a workplan of activities to be carried out at national, regional and international levels including the initiatives of the group as a whole, as well as the individual projects of each member organisation. This collaboration is designed to create an effective alliance and reduce duplication of efforts. Working Group members also provide periodic updates on organizational activities, implement tasks based on recommendations developed at larger international forums, review and endorse joint publications, and establish small project committees to address different fistula-related issues. In addition to participation in the Working Group, member organizations carry out their own activities on fistula prevention and treatment.

Working Group members include: Addis Ababa Fistula Hospital, African Medical and Research Foundation (AMREF), Babbar Ruga Fistula Hospital, Columbia University's Averting Maternal Death and Disability (AMDD) Program, EngenderHealth, Equilibres & Populations, Geneva Foundation for Medical Education and Research (GFMER), International Confederation of Midwives (ICM), International Federation of Gynaecology and Obstetrics (FIGO), United Nations Population Fund (UNFPA), Women's Dignity Project (WDP) and World Health Organization (WHO).

Key recommendations

Consensus on a number of key areas for training in the management of fistula was achieved during the meeting. The below are recommendations based upon the discussions of the Obstetric Fistula Working Group and expert participants at the Niamey meetings, with the recognition that further research, particularly operations research on the different modalities and minimum standards, is needed to validate many of these recommendations and training strategies. As evidence emerges, these recommendations will continue to be reviewed and updated as needed.

Global Workshop Recommendation: Improve the health system capacity in the treatment of obstetric fistula and the management of pregnancy and delivery in order to ensure the effective elimination of obstetric fistula.

- 1- Each country should **develop a national training strategy adapted to its local needs**, under the leadership of the Ministry of Health. National training strategies should take into consideration the following recommendations:
 - Ensure a **minimum of two trainers per country**
 - Consider a **variety of modalities**. Training centres are the preferred model, but on-site training, outreach visits, workshops and various combinations of these modalities, have also been used successfully.²
 - Reflect consensus on **minimum standards** (see page 8).
 - Promote training in **multidisciplinary teams** (urologists, gynaecologists, general surgeons, theatre and post-operative nurses, and optionally anaesthetists).
 - Select trainees based on their **motivation** and ability to **immediately apply** their skills upon return to their posts.
 - Include a supervision strategy with **continuous evaluation of trainee's performance**. The suggested model entails a permanent, dynamic partnership between the trainer and the trained providers and regular collection of data and feedback.
 - Ensure that trained personnel will have the right **conditions** (equipped, functional health facilities; incentives; and other administrative support) to work on their return to the health facilities.
 - Establish links with the University Teaching Hospitals, with the aim of making the training reach **diploma level** to better motivate providers.
 - Ensure that **pre-service curricula** for health personnel (doctors, medical officers, midwives, nurses) include proper management of labour, post-partum care, early recognition, referral and post- treatment care.

- 2- Recognizing that needs vary per country, every country should have **at least one national reference centre** capable of handling simple and complex fistula cases, with at least two

² For further description of the training modalities, see page 15.

trained fistula surgeons to ensure sustainability of services. Depending on prevalence and geographic accessibility, each region of the country should have at least one fistula repair unit capable of repairing simple fistula cases.

- 3- It is recommended to **avoid a backlog of simple fistula cases** through regular management by trained providers at regional hospitals, while **referring complicated cases** to the specialists at the national reference centre or waiting for the next visit of an experienced specialist. Peripheral centres should function under the supervision of the national centre, with regular monitoring and evaluation of services.
- 4- A **manual with basic guidelines for training** in fistula treatment should be developed by FIGO, in partnership with UNFPA, WHO, the International Federation of Urologists and EngenderHealth, with expert review by the Addis Ababa Fistula Hospital, AMREF and Babbar Ruga Fistula Hospital. The guide should include clinical modules with a standardised classification of types of cases, levels of treatment, different operation techniques, and framework for evaluation of skills, as well as modules on counselling and recommended content (see page 8). Visual training materials should also be considered to supplement the manual.
- 5- WHO with partners should establish a **global database to collect data on fistula treatment** that can be used by the different centres to improve monitoring and evaluation and make data available for research. At national level, systematic data collection should be ensured to improve services for fistula clients and evaluate the quality of obstetric care.
- 6- UNFPA with partners should further **map and analyse regional and global capacities and needs** in training, including the following:
 - Collect and analyse data on training plans, capacities and needs from Campaign countries using the questionnaire revised at the meeting;
 - Evaluate **potential regional training centres**, including their clinical services, for the training of trainers in order to set up regional fistula training centres connected with the various national training and/or repair centres (regional fistula network).
- 7- Guided by community level research, a **comprehensive and integrated communication plan** should be developed in each country (including counselling, mass communication, etc.), taking into consideration the socio-cultural and religious context. Counselling plans should be approached in a cross-cutting and integrated manner, involving different providers and with targeted messages for fistula patients, their spouses, their family and community members.
- 8- A **network of health professionals and programme managers** involved in the Campaign to End Fistula should be established, with the aim of organising a meeting to foster South-South cooperation and exchange of ideas among African experts currently involved in fistula elimination.

Suggested Minimum Standards

Below are suggested minimum standards for the training of health professionals in fistula treatment as a guide for the planning and designing of national training strategies. They are preliminary recommendations based upon the expert opinions of trainers, which will need to be validated through further research. The standards are provided with the understanding that training is a continuous process, and that each specific context may require adaptation of these standards in relation to the national situation and the competencies of trainees and trainers.

Minimal qualification required (simple fistula repair):

For doctors: 3 years surgical practice

For nurses: Any nurse can be trained for any nursing pre-, intra- and post-operative care and anaesthesia if motivated

Minimum duration of training (simple fistula repair):

For specialists (surgeons, urologists, gynaecologists): 2-4 weeks

For doctors with surgical competencies: 4-6 weeks

For a nurse (pre-, intra- and post-operative care): 4 weeks

Minimum number of successfully treated cases required for competence (simple fistula repair):

For specialists: 3

For doctors: 8-10 (Note: doctors with 3 years of surgical experience and assumes a follow-up supervisory strategy is in place)

Requirements to establish a training centre for treatment of obstetric fistula:

- Availability of a trainer: A trainer of trainers needs to be a specialist with a minimum of 500 cases treated successfully, including complex cases. A trainer in treatment of simple obstetric fistula should have a minimum of 300 cases treated successfully, including complex cases. Trainers should demonstrate versatility in pelvic surgery as well as the capacity to motivate and transfer skills to trainees.
- Availability of support personnel
- Availability of building space
- Minimum caseload of the structure is 250 cases per year, recognising that this caseload may not be sufficient in some circumstances

Content for training in the treatment of obstetric fistula:

- Anatomy of the pelvis
- Pathophysiology of obstetric fistula
- Specific counselling for obstetric fistula (pre-, intra-, post-operative and upon discharge)
- Clinical examination of a woman presenting with obstetric fistula
- Classification of obstetric fistula
- Early management of obstetric fistula (treatment with a urinary catheter)
- Pre-operative preparation
- Anaesthesia for obstetric fistula surgery
- Surgical materials
- Operation techniques

- Intra- and post-operative complications
- Post-operative care
- Management of sequelae
- Establishment and management of a fistula treatment service including collection of clinical information (files, protocols), activity reports, and defining a reference system for treatment of complicated cases
- Establishment and management of training structure for the treatment of obstetric fistula



Training for Fistula Management

The meeting was organised to encourage a maximum amount of time for discussion. Each session was facilitated by a group of participants, who provided brief presentations, followed by a structured discussion. There were five sessions held based upon the key objectives of the meeting, including training standards, technical guidelines for training, fistula counselling guidelines, mapping needs and capacities for training, and training models.

A. Training Standards

Facilitators: Dr. Kees Waaldijk/Babbar Ruga Fistula Hospital, Prof. Kalilou Ouattara/Point G Hospital, Yasinta Mkama/Bugando Medical Centre, Dr. Sanda Ganda/ Lamordé National Hospital, Kabir Lawal/Babbar Ruga Fistula Hospital
Rapporteur: Dr. Peter Sikana, UNFPA Sierra Leone

Experiences in fistula training were shared from the countries of Nigeria, Niger, Mali, Kenya and Tanzania. Discussion took place around the different types of personnel that should be included in training efforts and recommended content of training according to the different types of fistula. Dr. Kees Waaldijk, of Babbar Ruga Fistula Hospital in Katsina, Nigeria, began the session by emphasizing that as each country's fistula treatment programs have different arrangements and needs, it may be a challenge to determine universal standards for training. He then went on to discuss his training programme at Babbar Ruga, which includes on-the-job training and workshops. He emphasized that all training should include intensive hands-on practice, and the providers trained at Babbar Ruga include general doctors, surgeons, pre- and post-operative nurses and physiotherapists. Most often a trainee will observe eight or nine repairs and then attempt to do one on his or her own. Training is viewed as teamwork at Babbar Ruga, and must therefore include all members of the fistula medical team, although different levels of providers will have varying training requirements.

Dr. Kalilou Ouattara, from Point G Hospital in Bamako, Mali, emphasized that all levels of providers require both theoretical and practical training. Dr. Sanda Ganda, of Lamordé National Hospital in Niger, described his training programme, which involves all levels of providers. There is a training curriculum with applicable standards that includes both theory and practice. Ms. Yasinta Mkama, a fistula ward nurse from the Bugando Medical Centre, Tanzania, expressed that nurse trainees in fistula management should have work experience in a surgical and gynaecological ward for a minimum of six months. It is also critical for nurses be motivated to work in a fistula ward, and for them to have the desire to train others.

During the course of the discussion, it was agreed that doctors to be trained in fistula repair should preferably have a minimum of three years surgical practice and must be motivated and committed to fistula repair. It was agreed that any nurse, if motivated, can be trained in pre-, intra-, and post-operative nursing care. Training content and duration of training programmes were discussed, and it was agreed that all training programmes should be specifically modified to suit the particular skill level of the trainee. The consensus achieved during these discussions is presented as suggested minimum standards on page eight.

B. Technical Guidelines for Training

Facilitators: Dr. Claude Dumurgier/E&P, Dr. Joseph Ruminjo/EngenderHealth, Dr. Sourou Gbangbade/AMDD, Dr. Abdoulaye Idrissa/Niamey National Hospital

Rapporteur: Dr. Sara Raza Khan, UNFPA Mauritania

During the course of this session, it was universally agreed that multidisciplinary teams, including surgeons (from various specialties), theatre and post-operative nurses, and anaesthetists, are critical for training. Dr. Claude Dumurgier, representing Equilibres et Populations, highlighted that anyone committed to provide fistula treatment care and able to implement their skills should be trained. However, one primary concern raised was that many trained providers have little support to practice their skills, which creates the problem of many trained but few providing repairs. For this reason, it was suggested that centres only train the health professionals who will have the possibility to immediately apply their surgical skills on return to the field. National governments must therefore work to ensure that trained personnel have the right conditions, including equipped, functional health centres and incentives, to provide repairs upon their return to the health facilities. Health facilities will require funding and support from the government as well as international organisations in the establishment of policies, standards, and curricula for fistula repair and training.

In order to avoid a significant backlog of fistula patients, simple cases can regularly be managed by doctors trained in fistula repair in regional referral hospitals, and the complicated cases should be reserved for the specialists at the national reference centre. It was generally agreed that the national fistula centres should regularly follow up and maintain links with the peripheral centres. All centres should work together to reinforce data collection, supervision and referrals. Fistula surgeons from different hospitals in Niger highlighted that collaboration in their country among centres is not adequate and greater efforts need to take place to ensure that centres work together.

To guaranty the continuity of fistula services, it was agreed that every fistula repair site should have at least two doctors trained in fistula repair. Newly trained doctors at the peripheral levels would initially be required to recognize and refer complicated cases to the national reference centre. Undergraduate medical students should assist in the operation theatre and post-operative wards in order to gain interest and knowledge about obstetric fistula before becoming physicians. The group also discussed the difficulties of follow-up with patients after treatment. Mechanisms to ensure follow-up of the patient at one, two and six months after surgery should be considered.

Provision of adequate support facilities for women either awaiting surgery or whose repairs have been unsuccessful has also been mentioned as an important priority. As women often wait long periods of time before receiving treatment, it is important that they have access to the necessary support services and facilities.

It was recommended that the group study the different monetary and non-monetary incentives that can be offered to motivate health professionals. In-depth analyses of training needs and appropriate responses should be carried out in each country. Countries should continue to emphasise the importance of developing a national strategy adapted to its needs, advocating for MOH to take complete responsibility in estimating the needs of the health system and number of patients that require fistula surgery, training the doctors and providing the necessary support.

Additionally, greater participation of the civil society in different aspects of fistula management (counselling, reintegration, cost sharing, social mobilisation, detection of new cases) is equally important. Academic, operational and social research around fistula is critical, with regular data collection taking place between the various fistula repair facilities in a given country. Such systematic data collection can help to improve the services available for fistula clients and allow evaluation of the quality of obstetric care available in various parts of the country. Lastly, the group felt that an important task would be to reflect on the funding mechanisms for hospitals and the human resources required for the management of obstetric fistula. Examples provided by AMREF (100-150 US\$ per patient to the hospital, total cost 200-300 US \$) and Niger experts (300 US\$) were shared and discussed.

C. Fistula Counselling Guidelines

Facilitators: Lauren Pesse/EngenderHealth, Fatimata Moussa/UNFPA Niger

Rapporteur: Dr. Savy Genereux, UNFPA Mauritania

The session began with a presentation on EngenderHealth's recently held Fistula Counselling Experts Meeting, in Kampala, Uganda, 29-30, March 2005. Subsequent to the meeting, EngenderHealth/ACQUIRE conducted focus group discussions with current and former fistula clients to gain additional insight into counselling needs.

During the meeting in Kampala, participants identified an array of myths and misperceptions surrounding the causes and consequences of obstetric fistula and its treatment, which need to be addressed during counselling. The profile of a typical obstetric fistula client was developed, followed by brainstorming the varied needs of women who suffer from this condition. These needs were arranged into the thematic groups of *Counselling* (comprised of Information/Education and Emotional Support), *Social Support, Management* (comprised of Material Support, Clinical Management and Socioeconomic Support) and *Cross-cutting Issues*. Ideas for counselling clients with special needs, such as those who are considerably younger or older than average, those who are HIV-positive, those who are physically or mentally challenged, and those whose fistula is inoperable, were also elucidated. Participants outlined appropriate counselling messages for family members (including husbands), noting when during the spectrum of care family members should be involved. Meeting participants described appropriate behaviours for individuals who counsel women with obstetric fistula, as well as their concerns related to adequately addressing the needs of obstetric fistula clients. Brainstorming on strategies to address these concerns also took place, including sharing of no- or low-cost ways to improve the counselling environment in different types of settings, in order to address key issues such as privacy, confidentiality and staff shortages.

The ideas discussed during the Kampala meeting will be used to inform programming and will be disseminated to individuals, agencies and facilities working on obstetric fistula. These findings will also guide development of a counselling training curriculum tailored to the specific counselling and informational needs of obstetric fistula clients.

Group discussion following the EngenderHealth presentation highlighted the necessity of conducting preliminary community studies to evaluate the need for information among patients, providers and the community. Based on these survey findings, communications plans should be developed that include different communications channels; for instance, counselling, mass

communication, etc. Counselling should take into account socio-cultural and religious factors. It was agreed that counselling should take place, before delivery as part of antenatal care, during examination to ensure a better reaction to fistula treatment, and at the time of treatment (pre- and post-operatively) regarding the surgery, post-operative care, resumption of sexual activity after treatment, sequelae, and planning of the next pregnancy. The providers involved in counselling would include the medical team, social workers, support groups and community health agents. The targets of counselling efforts would include the fistula treatment clients, their partners, family members, community, traditional and religious leaders and elected officials.

Some aspects to be included in the counselling content are the following:

For the client:

- How the fistula occurred
- How the treatment will take place
- The importance of prenatal care
- The importance of delivering in a health unit
- Personal hygiene and nutrition
- Family planning
- Post-operative care

For partners and family

- Psychological support
- Socio-economic support
- Post-operative care
- The importance of delivering in a health unit

For the community

- Information about fistula to demystify the condition
- Emphasis should be placed on the causal factors of fistula
- Explanation of how the fistula is treated and that the client is now healed and should re-enter social life with support.

D. Mapping Needs and Capacities for Training

Facilitators: Kate Ramsey/UNFPA HQ, Katie Tell/UNFPA HQ, Dr. Precy Cabrera/UNFPA Kenya, Gifty Addico/UNFPA Ghana
Rapporteur: Dr. Olga Sankara/UNFPA Burkina Faso

The results of a brief survey to map capacities and needs for training were presented by Kate Ramsey and Katie Tell of UNFPA. The survey consisted of a questionnaire, which was distributed to countries via UNFPA country offices and through the Obstetric Fistula Working Group. The questionnaire explored both the institutional and human resource capacities and needs for training. While questionnaires for 13 countries were received, the lack of universal

definitions for many terms made comparisons across countries difficult.³ Despite its limitations, the survey revealed some important issues. For instance, the majority of countries had some national providers that could perform simple fistula repairs (range of 0 to 30), but few to none skilled in complicated repairs. Overall, very few countries documented nurses trained in fistula management or social workers trained in counselling. Fistula surgeons were reported as having received training through a number of modalities including fistula treatment centres, workshops, on-the-job training, self-training through practice and post-graduate studies. A number of gaps and challenges were identified, including the following:

- In more than half of countries, no official training is currently underway.
- Fistula training is concentrated in one medical speciality in some countries, making it difficult for other surgeons to become involved.
- Some expatriate experts, supported by external organisations to provide treatment services, do not transfer their skills to national doctors.
- The critical shortage of health workers also affects availability of trainees.
- Current training only includes theoretical aspects in some countries.
- Existing training centres do not have sufficient space to meet the current demand.

To gain a clearer image of the current training needs, a small group was formed to refine the questionnaire and define the terminology. It will then be distributed to each Campaign country and the data will be analysed to guide regional and global strategies for training. Additionally, to meet regional needs, the group concluded that at least two more regional training centres, in addition to Addis Ababa Fistula Hospital and Babbar Ruga Fistula Hospital, will need to be established. UNFPA was encouraged to proceed with the planned evaluation of potential regional training centres for the training of trainers.

The questionnaire highlighted the lack of data collection. While many fistula treatment facilities do record data, the data between facilities are often not comparable and rarely compiled. It was agreed that there is a need to include standardised items on obstetric fistula in national data collection, which will contribute to a better understanding of the condition as well as facilitate monitoring of national fistula strategies. Several participants also raised concerns about recording recurring cases of fistula and noted a need to consider this issue in data collection design. Inclusion of questions on obstetric fistula in regular national surveys, such as the Demographic and Health Surveys and the Multiple Indicator Cluster Surveys, were also discussed as a means to ensure routine collection of data at a national level. To further promote data collection and research, development of a regional or global database by WHO that could include inputs from the countries was encouraged. The database could be utilised by researchers to explore fistula-related issues from clinical techniques to the characteristics of fistula patients.

The group strongly recommended that a strategy for training be included in national strategies for fistula elimination. The training strategy should take into consideration training needs as well as ensure adequate support, incentives and an enabling environment for providers to continue providing care after training. In addition, the group discussed specifics to guide

³ Bangladesh, Benin, Burkina Faso, Democratic Republic of Congo, Eritrea, Kenya, Mauritania, Niger, Senegal, Sierra Leone, Sudan, Tanzania, Uganda

countries in formulating these strategies. Participants concurred that each country should have a minimum of two national trainers to meet demand and ensure adequate follow-up support for trainees. The group deliberated training a critical mass versus a small cadre of motivated providers. Considering the nature of the issue and the shortage of health care workers, participants advocated for training for a select number of motivated providers, including physicians (not limited to specific specialisations), theatre and post-operative nurses, social workers, and where possible anaesthetists and physiotherapists. Expert fistula trainers noted that it is best when possible to train providers as a team. To estimate the number of physicians needed, each fistula treatment facility, if possible, should have two surgeons specialised in fistula repair to ensure sustainability. The participating surgeons estimated that in fistula treatment centres that are units in a larger facility (the majority of countries), a surgeon who has time dedicated to fistula treatment could feasibly repair up to 200 cases per year.

While much of the discussion focused on training specific to surgical treatment and care of fistula, the need for training concerning prevention and diagnosis of fistula was also recognised. This training could be addressed through pre-service curricula with the aim of developing competence among a maximum of providers, including but not limited to doctors, medical officers, midwives, and nurses. In this way, skills such as proper management of labour, post-partum care, diagnosis and early recognition of fistula, referral, and post-fistula treatment care can be integrated into regular health care services.

E. Models for Training

Facilitators: Dr. Tom Raassen/AMREF; Dr. Kees Waaldijk/Babbar Ruga Fistula Hospital, Katsina, Nigeria; Dr. Lucien Djangnikpo/Central Maternity Hospital of Zinder, Niger, Dr. Idi Nafiou/University of Niamey, Niger
Rapporteur: Dr. Myriam Cissoko, UNFPA/Mali

Participants during this session explored several types of training modalities that are currently in use. Dr. Tom Raassen of AMREF and Dr. Kees Waaldijk presented their experiences with the various models. Dr. Raassen discussed the following models, many of which he employs in combination in his training work in Kenya, Tanzania and Uganda:

Training centres: A trainee spends time at a centre with a high caseload where there are specialised fistula surgeons. The trainee typically spends one to two months at the centre both observing surgery and conducting between eight and ten simple repairs. Frequently, a team, including both surgeons and nurses, are trained together. Trainees may also return for further training. The training centre model is considered the most ideal; however, some drawbacks are the amount of time health professionals must spend away from their facilities and the difficulties in ensuring a sufficient caseload for adequate exposure.

Workshops: During a workshop, a group of six to eight trainee surgeons are brought together for two weeks of observation of 50 to 60 surgical repairs and a series of lectures. Two trainers conduct the training at a selected facility. Outreach, for instance via radio, may be required to ensure an adequate caseload. Workshops are beneficial for networking and to expose trainees to a variety of cases or to highlight specialised techniques for more experienced trainees.

Disadvantages to this method include the strain on the hosting facility, which must have both the institutional and human resource capacity for the increased caseload, and the low number of hands-on opportunities for trainees.

On-site: Trainees receive training of one to two weeks on-site from a visiting specialist. This training is heavily focused on practical hands-on learning. Regular training visits for a period of several years are needed to adequately build the skills of the trainee. The hospital must schedule sufficient operations and ensure access to an operating theatre and ward space. The model offers intensive team training within local conditions and without pulling staff away for long periods of time. The major difficulty is the strain on the hosting facility.

Outreach visits: One trainer travels with a trainee surgeon with some experience to another hospital to provide fistula repairs - typically to a remote hospital where services are not often available. Again, the hospital will need to be prepared, both with sufficient caseload and space for the patients. With this modality, outreach services are provided to a remote area and the trainee surgeon receives intensive training and hands-on experience. Drawbacks include the difficulties of pulling staff from their regular posts and the strain on the hosting facility.

Dr. Kees Waaldijk also described his experience in training, which include all of the above. In northern Nigeria, he typically uses a combination of the training centre and on-site training modalities. Trainees begin with two months at the training centre, and continuous supervision and training are provided through regular visits to the trainees' facilities.

Based on these presentations, advantages and disadvantages of the models were discussed. While it was generally agreed that training centres are the preferred model, the group concurred that all models and combinations of models should be considered when designing national training centres. Regardless, a strategy for supervision of trainees was deemed essential to ensure adequate follow-up and to promote a system of continuous learning. Based on previous experiences, supervision should include a permanent and dynamic partnership between the trainer and the trainees, including regular collection of data and feedback, as well as follow-up visits by the trainer. More research was encouraged to improve the evidence base on the different types of training models.

Mechanisms for motivating providers involved in fistula repair were raised again as an important component. Despite the fact that trainees should have pre-existing commitment, incentives are essential to ensure that their motivation is maintained. While it was felt that a number of mechanisms need to be explored, raising the training to diploma level was particularly discussed as a means to encourage providers. It was acknowledged that this will require structuring and standardisation of training, which could be undertaken by a small working group. Networking was also considered important to stimulate interest among providers as well as to gain consensus on critical issues. Participants proposed the formation of a network, including both expert clinicians and programme managers involved in fistula elimination. The aim of the network would be to encourage South-South cooperation in the fight against fistula and more specifically to organise a meeting of expert health professionals to exchange ideas regarding clinical techniques, experiences and results.

Annex: Meeting Agenda

Tuesday, 19 April

Opening Ceremony

Chair: Marlene Francois-Lays, UNFPA Representative, Niger

9:00 – 9:05	Welcome remarks	Marlene Francois-Lays UNFPA Representative, Niger
9:05 – 9:20	Opening Statement	Mme. Ousmane Zeinabou Moulay Minister of Women’s Promotion and Child Protection

Working Session

Chair: Dr. Florence Ebanyat, RH Adviser, UNFPA CST Harare

9:30 – 9:35	Meeting Goals and Objectives	Kate Ramsey UNFPA, New York
9:35 – 9:45	Introductions	
9:45 – 9:50	Announcements	Ibrahima Issiaka
9:50 – 11:30	Session Topic: Training Standards	
10:30 – 10:45	Tea Break	
11:30 – 13:30	Session Topic: Technical Guidelines for Training Session	
13:30 – 14:30	Lunch	
14:30 – 16:30	Session Topic: Fistula Counselling Guidelines	
15:30 – 15:45	Tea Break	
16:30 – 17:00	Closing discussion	
19:30	Group Dinner	

Wednesday, 20 April

Chair: Dr. Luc de Bernis, WHO

8:00 – 11:00	Visit to Niamey National Hospital and Lamordé National Hospital	
11:15 – 11:30	Review of previous day	Dr. Florence Ebanyat UNFPA CST Harare
11:30 – 13:30	Session Topic: Mapping Exercise for Training	
13:30 – 14:30	Lunch	
14:30 – 16:30	Session Topic: Training Models	
15:30 – 15:45	Tea Break	
16:30 – 17:00	Working Session: Facilitators and rapporteurs meet to develop recommendations	
17:00 – 18:00	Presentation and discussion of recommendations	Dr. Isabelle Moreira, UNFPA Senegal

Annex: List of Participants

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