Training for integration

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Summary Training is often suggested as the solution to the inadequacies of the health care system, and there is little doubt that without it, service quality would suffer and new techniques and technologies would be difficult to introduce; clearly it is an important component in any drive to achieve quality of care. However, in this era of cost-effectiveness and cost cutting, which is part of the reason for integration, it is surprising that training is often not well planned and is rarely evaluated in a rational manner. This paper relies on recent discussions within ILEP about training and the use of training materials for leprosy in the present environment – one in which most programmes are being integrated into the general health services. The development of a National Training Plan for Leprosy is proposed, with clear objectives, in order to best utilize the resources available.

Introduction

The noun ‘integration’ and the verb ‘to integrate’ and related terms are used with a variety of meanings in different contexts. In the context of medical services, the word is used to designate a primary health care system in which all manner of diseases are dealt with, in contrast to programmes handling single diseases, so called ‘vertical intervention programmes’. The term ‘Integrated’ is also used in a sociological context to describe a service or institution which is accessible to or made available to, people of different races, cultures, religions and social classes on an equal footing.

All of us know that a system that is ‘integrated’ in the first sense is not necessarily also accessible to all who need it.

Leprosy patients have commonly found themselves excluded from integrated basic health services because of popular misunderstanding of the nature of their disease. These misconceptions have been at least as common and as strong among health professionals as among the public at large.

Many, including the World Bank and WHO, have argued that integrated intervention programmes are more efficient and can be at least as effective as vertical programs, and should therefore be the norm. However, there are problems which must be faced frankly if any general or basic health facility is to provide a service to people with leprosy which is competent to meet their needs for medical care and also willing to allow them access to the services without prejudice or discrimination simply because of their leprosy.

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Additional training is often put forward as the most straightforward method of solving problems in the health care system, and it is certainly important for the maintenance and development of high quality services. However, as integration takes place and cost-effectiveness is emphasized, it is surprising that training is often not well planned and is rarely evaluated in a way that feeds back into improved training opportunities.4

Training can help to provide solutions to many health care delivery problems, but training alone will not eliminate them. Defects in the Health Services that are the result of inadequate budgets, poor supervision or an unreliable system for the provision of essential supplies, for example, will not be corrected by retraining of staff at the periphery of the service. Each of these elements is essential if leprosy work is to be successfully integrated into the general health services.5

Training of service providers will be examined here, but training of consumers (patients and their families), which is also very important, is outside the scope of this paper.

Training three groups of service providers

Service provision for people with leprosy in the context of integration is already carried out in a reproducible pattern in many areas, and mirrors the way other diseases are managed. The general health staff in peripheral clinics see all patients to begin with; minor problems and straightforward cases are managed locally, while the more complex cases are referred to others with more training and experience, usually at a more central location.

Large numbers of general staff therefore need brief, but practical training in dealing with the most common and simple problems, and in recognizing who needs to be referred.4 A very good example of this training being carried out at the start of the process of integration comes from Nepal.5,6

Smaller numbers of more specialized staff need training in greater depth, in order to manage more complicated cases, either at health centre level or at a referral hospital. Some in this second category may be specialist physicians, for example, dermatologists or rehabilitation experts. This group will also include the trainers and facilitators who will actually train the general staff, and their training (the so-called Training of Trainers, or TOT) is a very strategic issue. Most now agree that this group that should be the main focus of attention of the various international training centres, such as ALERT in Ethiopia, recognizing the critical importance of these people for the long-term sustainability of leprosy services in an integrated setting.4,7,8

A third group of staff requiring training are those who previously worked in the vertical leprosy programme and who have valuable experience to contribute. If there are still significant numbers of leprosy patients, these staff members, or some of them, may be able to provide the referral service at health centre level mentioned above. In situations of lower endemicity, these staff members must be retrained to work in the general health services. In addition to retraining, such staff need reassurance in regard to their career and job security. This should be seen as an essential component of any training programme for integration.

A National Training Plan

As the process of integration is planned, the development of a National Training Plan for Leprosy would be one way of ensuring that training for each group of staff is planned
appropriately. The curriculum for each training session would be based on a task analysis, which would indicate all the leprosy related work expected of those particular individuals. For a comprehensive set of tasks see the WHO document *Training in Leprosy.*9 The basic tasks and duties of field workers managing patients with leprosy have not changed much over the years, although many of the technical details have changed considerably.10,11

The Training Plan should include a curriculum and the allocation of adequate resources to support all aspects of the training programme, including trainers and other personnel, facilities, accommodation, transportation and teaching materials, as well as access to patients for practical experience. The curriculum should include a statement of learning objectives, which define the knowledge, skills and attitudes to be demonstrated by the participants at the completion of their training, an overview of the contents of the course, the means of learning to be employed, the learning resources to be available and a detailed timetable for teaching and for assessment.

A National Plan having the authority of government policy may go some way to countering the reluctance of some staff to accept working with people affected by leprosy. A study in Ethiopia, where stigma remains an important issue, found that many staff could overcome their natural aversion to dealing with leprosy when they considered it their professional duty to do so.12 On the other hand, the effective motivation of staff is an important issue that should influence the design and conduct of all training sessions.

The trainers or facilitators who will do much of this training need to be identified and included in the planning process. They also need to be well motivated and may need further training in teaching methodology to reach their full potential.

**Basic services for managing leprosy**

Tasks to be done at the most peripheral level, will vary according to the leprosy situation, but should include the diagnosis of simple cases (i.e. those with anaesthetic patches) and treatment with MDT; referral of suspects and those who develop any complications of leprosy must also be taught. At the first referral level, it should be possible to make a firm diagnosis in almost all cases of leprosy, which will require greater skill, including the examination of peripheral nerves.13

The levels at which patients are educated for self-care and at which reactions and neuritis can be diagnosed and treated must be determined and the training curricula developed accordingly.

The management of the eye complications of leprosy is important and should be included in the training of any staff involved in general eye care. Great strides are being made in bringing this expertise right out to the periphery in many countries.14–16

Many aspects of rehabilitation are being developed by agencies other than the Ministry of Health and the general health services; this may include other government ministries and NGOs. Staff who assist people affected by leprosy need to be aware of these other services that may be available and what would be appropriate for their patients, so that they can make worthwhile referrals.17 More specialist services, such as preventative and rehabilitative surgery, should be planned at the national level, where the overall need can be assessed.18,19
The organization of training

Training of general health staff is often poorly organized. Staff members may be called to join sessions on a whole range of topics arranged by different agencies. There is a need for co-ordination so that work is disrupted as little as possible. Courses should be short (ideally less than 1 day, for most peripheral staff) and involve minimal wastage of time for travel. Much will depend on the level of clinical skills found in the staff and courses must leave the staff with the skills they need. Follow-up should be frequent to ensure that the training is effective and relevant and in order to motivate the trainee.

For more specialized staff, courses should also be as short as possible and be accompanied by good quality training materials.

There is now a reasonable body of evidence to suggest that interactive and participatory teaching methods increase the level of retention and the chance that future behaviour and performance will benefit from the training. These methods require skill and effort on the part of the facilitator and traditionally, senior health staff have often regarded themselves as too busy to acquire these extra skills, which they may also regard with some suspicion. This is no longer an acceptable excuse and a core of trained and motivated facilitators is essential to make any training programme of this nature effective.

Staff competencies

A general review of the competencies required to care for people with leprosy can be found in Training in Leprosy, mentioned above. These will need to be adapted to suit current local conditions.

One particular competency that is very desirable, and which should be expected in more senior staff, is the ability to make use of self-learning materials and the academic literature in order to keep up to date. Senior staff should be able to review their own performance and acquire new knowledge to fill any gaps they identify. Access may be an issue in some places, but a large amount of high quality material is becoming available on the Internet or on CD-ROM.

Evaluation of the effectiveness of training in the context of integration

All training programmes should be assessed against programme goals defining the skills, knowledge and attitudes that the trainees will have acquired and will be able to demonstrate at the conclusion of the course. The goals of the training programme will be an integral part of the Training Plan and will be derived from the tasks that the different members of staff are required to undertake.

Evaluation of training should not be carried out just at the course level, but should be linked to subsequent performance. Training can be evaluated at various levels, each measuring different things:

- Reaction or response – trainee satisfaction with the programme can be assessed immediately after the course by means of a written questionnaire or checklist. An example may be found in Appendix A.
• **Learning** – knowledge, skills and attitudes learned by the trainees can be assessed at the end of the course or within a few weeks. Assessment of knowledge is relatively easy. A common method is the Multiple Choice Questionnaire (MCQ). MCQs are difficult to prepare well, but can test a great deal of knowledge in a relatively short time. They can be marked quickly and easily. Skills can only be tested by their actual use. The Objective Structured Clinical Examination (OSCE) is a useful substitute for full-scale practical examinations. Instructions for the construction of OSCE examinations are summarized in Appendix 2, but can also be obtained from the Association for the Study of Medical Education (www.asme.org.uk). Questionnaires can be used to detect gross misunderstandings of attitudes, such as may occur through language difficulties, but the real truth about the trainees attitudes can only be learned by observation on the job.

• **Behaviour and performance** – changes in the trainees’ behaviour in a way that improves job performance must be assessed in the workplace, 6 months to a year after the course. It is very important to determine the impact that training has had on job performance. However, it is important to recognize that performance is strongly influenced by working conditions. Trainees who return to work in programmes where other staff are unwilling to work with leprosy patients or where supervisors themselves fail to practice quality clinical care and record keeping, for example, will find it very difficult to implement the skills and attitudes they have been taught. On the job performance must be assessed by observation of crucial behaviours. Even experienced observers will find that a written list of aspects of behaviour to be observed is a useful aid. A helpful example of such a checklist in use 6–12 months after the training course, is given in the report from Nepal already mentioned.  

• **Results** – final results that the training programme produces, as these relate to key outcomes and behaviours can only be assessed later. The results of the training may be seen in various programme and epidemiological indicators, such as treatment completion rates and disability rates at diagnosis and at release from treatment, but such changes will take time to become apparent – perhaps two or more years after the course. Other indicators checked through routine supervision may show change over time, as the training has an effect. For example, a review of clinical records for completeness and accuracy, a well-functioning referral system and satisfaction expressed by patients at interview.

**Conclusion**

This paper arises from discussions held within ILEP, in particular, the Action Group on Teaching and Learning Materials (TALMielp) and the Temporary Expert Group on Training, from which a more formal report is also expected. The main conclusions can be summarized as a need for:

• A National Training Plan for Leprosy, which relates to the planning process for integration and contains clear training objectives;
• An analysis of training needs at various levels, including a task analysis;
• The development of a core group of skilled facilitators;
• The use of effective teaching methods;
• The identification and use of high quality teaching materials;
• An evaluation strategy concentrating on the longer-term results of training.
Acknowledgements

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References

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Appendix 1. Evaluation of a training session

Session title: ______________ Facilitator: ____________

Please mark each scale to indicate your opinion of the session:
<In these scales, each category should be set just above the vertical marks on the scale>

The length of the session was:

Far too short   Too short   About right   Too long   Far too long
|________|________|________|________|________|

The content of the session was:

Very oversimplified   Too simple   About right   Hard to follow   Impossible to understand
|________|________|________|________|________|

Which teaching methods were used in the session?
Please mark each item either Y=Yes or N=No

Lecture _______ Group discussion _______ Small group work _______
Slides _______ Overheads _______ Multi-media _______
Drama _______ Exercises _______ Case studies _______

How would you rate the value of the handout for you?

Useless   Unhelpful   Neutral   Helpful   Very helpful
|________|________|________|________|________|

How useful would the session be for a colleague doing a similar job to you?

Useless   Unhelpful   Neutral   Helpful   Very helpful
|________|________|________|________|________|

Please indicate one thing you learned during this session that was really new for you: it could be a fact that you learned, or a skill (how to do something), or you heard something that changed your attitude about something:

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Do you have any suggestions about how this session could have been better?

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Appendix 2. The Objective Structured Clinical Examination (OSCE)\textsuperscript{26}

*Principle:* The clinical competencies to be tested are broken down into components, each of which is assessed in turn, at one of the ‘stations’ in the examination. The student spends about 5 min at each of the 20 or so stations set up for the examination. Each station may test either a skill, in which the student has to carry out a particular procedure (while being observed by an examiner with a checklist), or knowledge, in which the student has to answer some questions or interpret some data. The students will each start at a different station and rotate to the next one in sequence — a bell can be sounded every 5 min to signal the time to move on.

*Variations:* A wide range of items can be included in an OSCE and the competence of the student assessed against a standard. These may include:

- history taking from a patient
- physical examination of a patient
- inspection of a patient or a photograph
- interpretation of a patient’s chart or laboratory results
- patient education
- interpersonal skills (e.g. informing the patient of the diagnosis)
- use of a piece of equipment (e.g. surgical, clinical, therapeutic, etc.)
- examination of specimens
- practical procedures

The required activity must be limited in time, so that, with the time needed to answer questions, it can be completed in the 5-min period. The examiners can decide on the contents of each station, the complexity of the items, the standards to be set and the way in which each item is scored.