A Guiding Framework for Distributed Health Professions training

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Primafamed Conference Workshop

28 October 2020

12.30-2pm

This research has been supported by the President's Emergency Plan for AIDS relief (PEPFAR) through Centres for Disease Control (CDC) under the terms of GH15-1574

This project is supported by the President's Emergency Plan for AIDS relief (PEPFAR) through Centres for Disease Control (CDC) under the terms of GH001536

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Distributed training?

All learning activities of students in the health professions that take place at health and related facilities other than the central academic hospital

- Also referred to as decentralised or community-based training
- Can be in urban, peri-urban, rural or remote areas
- Take place in clinics, CHCs, district or regional hospitals
- Also outside of public sector in private practices, NGOs, schools, communities, etc
- Student supervision mostly done by local professionals

Evidence for the benefits of distributed training

Distributed training is effective in addressing HRH shortages in underserved and particularly rural areas

- ✓ Workforce effects
- ✓ Educational advantages – for students, supervisors and sites
- ✓ Health services impact

de Villiers et al. BMC Medical Education (2017) 17:196
DOI 10.1186/s12909-017-1050-9

BMC Medical Education

RESEARCH ARTICLE Open Access

Decentralised training for medical students: a scoping review

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Abstract

Background: Increasingly, medical students are trained at sites away from the tertiary academic health centre. A growing body of literature identifies the benefits of decentralised clinical training for students, the health services and the community. A scoping review was done to identify approaches to decentralised training, how these have been implemented and what the outcomes of these approaches have been in an effort to provide a knowledge base towards developing a model for decentralised training for undergraduate medical students in lower and middle-income countries (LMICs).

Methods: Using a comprehensive search strategy, the following databases were searched, namely EBSCO Host, ERIC, HRH Global Resources, Index Medicus, MEDLINE and WHO Repository, generating 3383 references. The review team identified 288 key additional records from other sources. Using prespecified eligibility criteria, the publications were screened through several rounds. Variables for the data-charting process were developed, and the data were entered into a custom-made online Smartsheet database. The data were analysed qualitatively and quantitatively.

Results: One hundred and five articles were included. Terminology most commonly used to describe decentralised training included 'rural', 'community based' and 'longitudinal rural'. The publications largely originated from Australia, the United States of America (USA), Canada and South Africa. Fifty-five percent described decentralised training rotations for periods of more than six months. Thematic analysis of the literature on practice in decentralised medical training identified four themes, each with a number of subthemes. These themes were student learning, the training environment, the role of the community, and leadership and governance.

Conclusions: Evident from our findings are the multiplicity and interconnectedness of factors that characterise approaches to decentralised training. The student experience is nested within a particular context that is framed by the leadership and governance that direct it, and the site and the community in which the training is happening. Each decentralised site is seen to have its own dynamic that may foreground certain elements, responding differently to enabling student learning and influencing the student experience. The insights that have been established through this review have relevance in informing the further expansion of decentralised clinical training, including in LMIC contexts.

Keywords: Decentralised training, Distributed, Rural, Medical student, Undergraduate

African Journal of Primary Health Care & Family Medicine
ISSN: (Online) 2071-2936, (Print) 2071-2928

Decentralised training for medical students: Towards a South African consensus

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Introduction: Health professions training institutions are challenged to produce greater numbers of graduates who are more relevantly trained to provide quality healthcare. Decentralised training offers opportunities to address these quantity, quality and relevance factors. We wanted to draw together existing expertise in decentralised training for the benefit of all health professionals to develop a model for decentralised training for health professions students.

Method: An expert panel workshop was held in October 2015 initiating a process to develop a model for decentralised training in South Africa. Presentations on the status quo in decentralised training at all nine medical schools in South Africa were made and 33 delegates engaged in discussing potential models for decentralised training.

Results: Five factors were found to be crucial for the success of decentralised training, namely the availability of information and communication technology, longitudinal continuous rotations, a focus on primary care, the alignment of medical schools' mission with decentralised training and responsiveness to student needs.

Conclusion: The workshop concluded that training institutions should continue to work together towards formulating decentralised training models and that the involvement of all health professions should be ensured. A tripartite approach between the universities, the Department of Health and the relevant local communities is important in decentralised training. Lastly, curricula should place more emphasis on how students learn rather than how they are taught.

Consensus Statement on Decentralised Training in the Health Professions

Michael Rowe

July 10, 2017

Uncategorized

consensus statement, force, special interest group, succeed

At the closing ceremony of the 2017 SAAHE national conference in Potchefstroom, delegates adopted a conference declaration in the form of the Consensus Statement on Decentralised Training in the Health Professions, which was endorsed by the SAAHE national council.

This statement was the culmination of discussions over the last two years at SAAHE conferences and national workshops, driven by the Stellenbosch University Collaborative Capacity Enhancement with Districts (SUCCEED) project and the Forum for Rural Clinical Education (FORCE), a SAAHE special interest group which is being re-constituted as a special interest group for decentralised education, amongst others. The focus of these discussions has been on the importance and value of decentralised training in terms of transforming teaching and learning and in addressing the human resources for health needs of our country.

Taylor & Francis
Taylor & Francis Group

Medical Teacher

ISSN: 0142-159X (Print) 1466-187X (Online) Journal homepage: https://www.tandfonline.com/loi/imte20

Twelve tips for distributed health professions training

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To cite this article: Susan van Schalkwyk, Ian Couper, Julia Blitz, Athol Kent & Marietjie de Villiers (2020) Twelve tips for distributed health professions training, Medical Teacher, 42:1, 30-35, DOI: 10.1080/0142159X.2018.1542121

To link to this article: https://doi.org/10.1080/0142159X.2018.1542121

Van Schalkwyk *et al. BMC Medical Education* (2020) 20:154
https://doi.org/10.1186/s12909-020-02046-z

BMC Medical Education

RESEARCH ARTICLE Open Access

A framework for distributed health professions training: using participatory action research to build consensus

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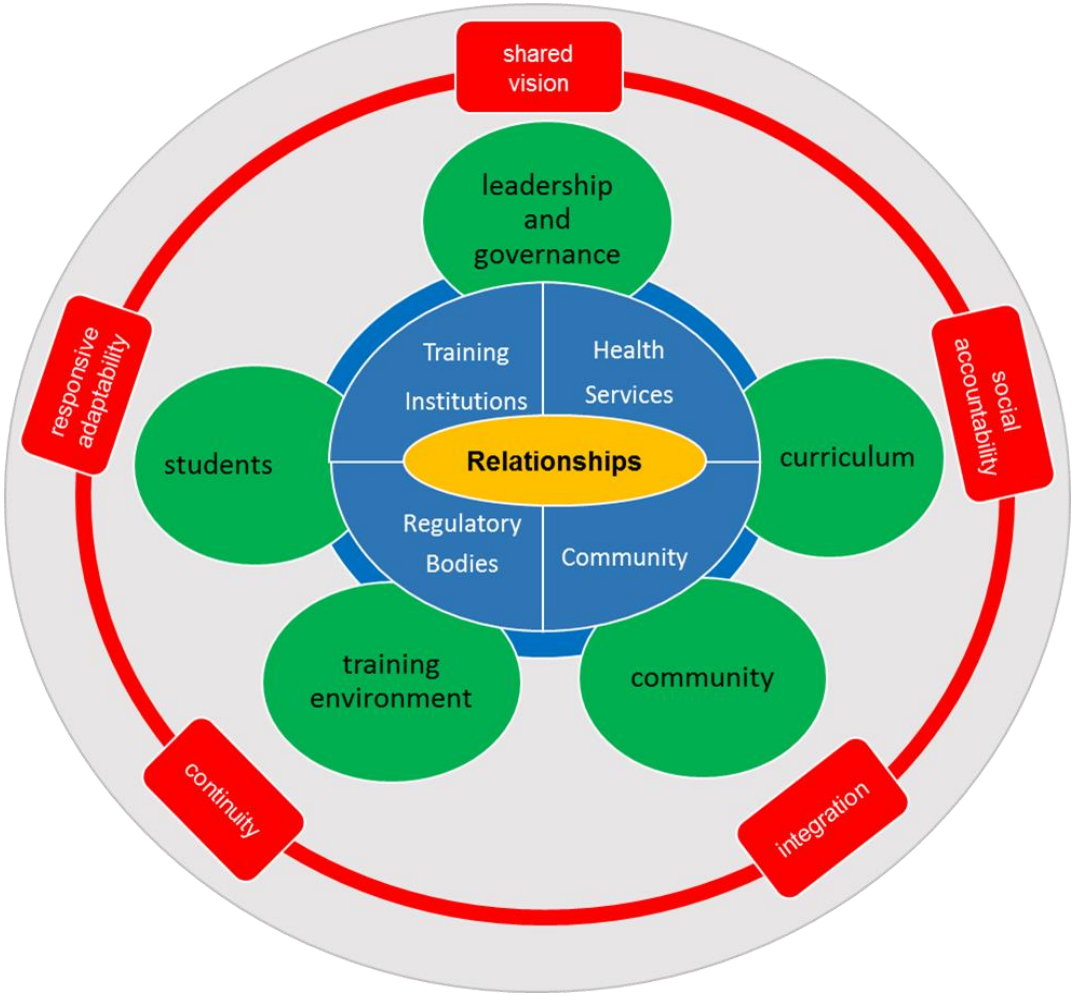
Abstract

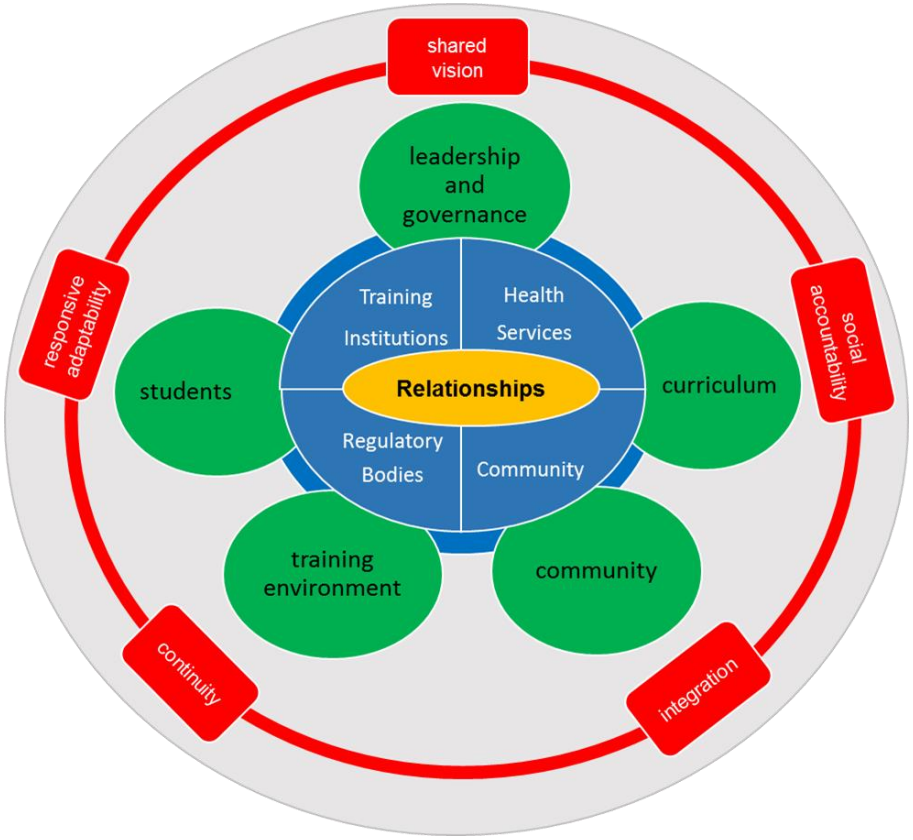
Background: There is a global trend towards providing training for health professions students outside of tertiary academic complexes. In many countries, this shift places pressure on available sites and the resources at their disposal, specifically within the public health sector. Introducing an educational remit into a complex health system is challenging, requiring commitment from a range of stakeholders, including national authorities. To facilitate the effective implementation of distributed training, we developed a guiding framework through an extensive, national

The Framework



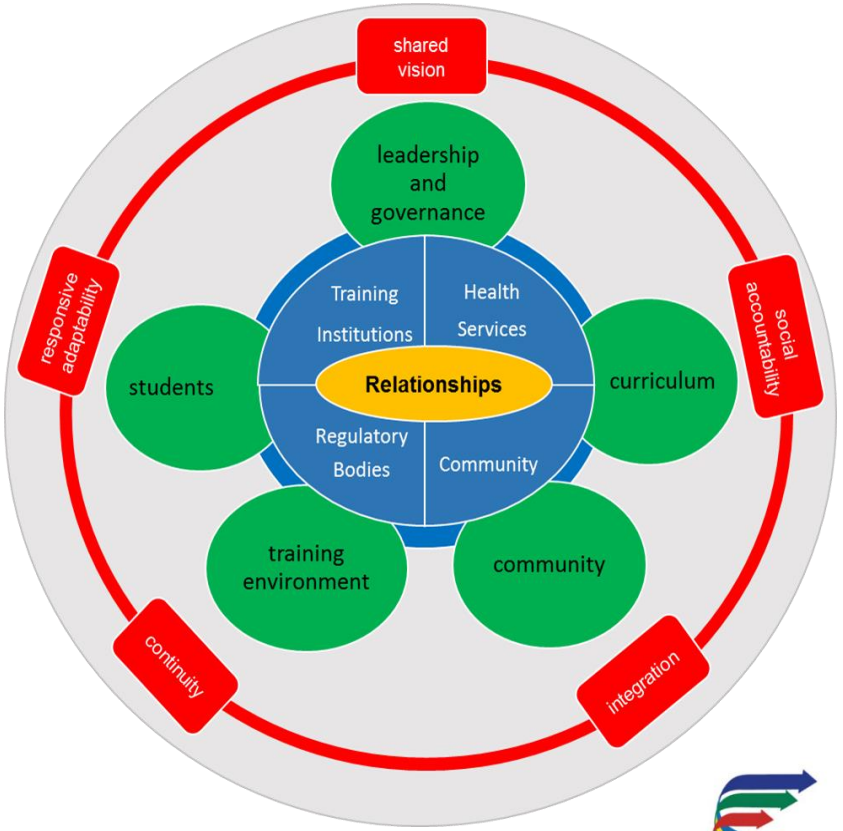
Centrality of Relationships

- Training institutions
- Health services
- Community
- Regulatory bodies



Principles

- Shared vision
- Social accountability
- Integration
- Continuity
- Responsive adaptability

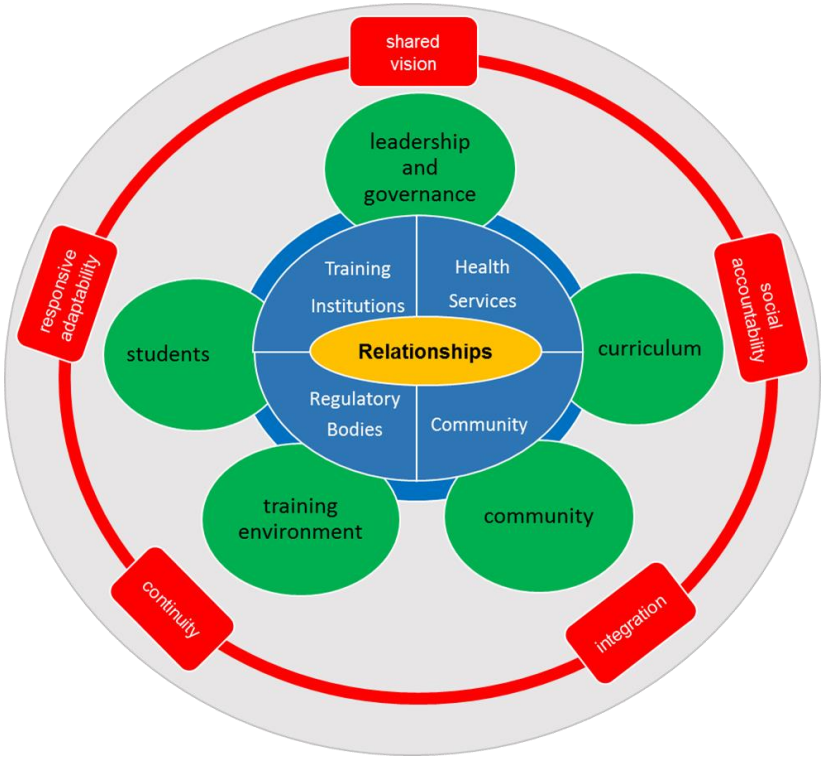


Principles

- Shared vision – all role players across all levels share the vision for decentralised training as a catalyst for good quality, relevant health professions training addressing the health care and human resources needs of the country;
- Social accountability – orientating the training of students towards the health needs of the community in order to foster the development of socially accountable health care workers who are motivated to work in underserved areas once qualified;
- Responsive adaptability – continuous renewal and adaptation of curricula and training methods, ensuring they are flexible but achieve educational equivalence in different settings so as to be responsive to community and health system needs;
- Continuity – immersed, longitudinal, decentralised training in and with communities, fostering continuity of learning and relationships with health services, managers, health care teams, trainers, staff, training institution(s), students, patients/clients and the community;
- Integration – fostering an integrated approach to learning, a curriculum that merges clinical and public health approaches, promotes interprofessional learning and collaborative practice across disciplines and various levels of care.

Components

- Leadership and governance
- Students
- Curriculum
- Training environment
- Community



Components

- Leadership and governance relates to the decision-making processes and roles and responsibilities of stakeholders influencing effective decentralised training.
- The curriculum is the scaffolding that informs the learning outcomes, content, mode of delivery, and assessment of students, and evaluation of the curriculum itself.
- The community is defined as the population that utilises the local health facility.
- Training environment includes (a) people who work at the decentralised training site, and in the community, contributing to the training of the students; and (b) the training site which is the context and physical environment within which the decentralised training takes place.
- The students are learners enrolled in undergraduate studies in any of the health professions at a training institution.

Example of enabling factors

Component: Students

Definition: The students are learners enrolled in undergraduate studies in any of the health professions at a training institution.

Enabling Factors:

- ✓ Students:
  - ✓ receive orientation before they begin a rotation
  - ✓ have academic and social support available when and where they need it
  - ✓ provide feedback after they complete a rotation
  - ✓ have adequate arrangements for safety and security
- ✓ Student-staff ratios are mutually agreed upon during site selection
- ✓ At least two students are assigned to a site to ensure peer engagement
- ✓ Reasonable logistical arrangements are made by the training institution

41 Enabling factors

Leadership and governance influences effective DHPT, through the decision-making processes and roles and responsibilities of stakeholders.

1 All role players, including the health services, community, and training institutions, engage in mutually beneficial and equitable partnerships.
2 The roles and responsibilities of training institutions, health services, and communities, are clear to everyone involved.
3 All levels of management are committed to effective collaboration to support students' learning.
4 Senior management of all role players demonstrate collaborative and visionary leadership toward a shared purpose.
5 Champions take responsibility for distributed training.
6 Funding for training initiatives is made available through a transparent funding model.
7 Formal and informal communication channels exist across all levels and among multiple role players.
8 Monitoring, evaluation, and research on distributed training initiatives are encouraged by leadership.
9 The training institution:
- implements institutional policies that support distributed training.
- supports and capacitates primary supervisors and other site staff involved with students (see also factor 31).
- builds and maintains relationships with the site.
- selects students most likely to practice in rural and remote areas.
- becomes familiar with each site's strengths and challenges.

The curriculum provides the scaffolding that informs the learning outcomes, content, mode of delivery, and assessment of students, and evaluation of the curriculum itself.

10 Management of the training institution takes leadership in prioritising and implementing distributed training programmes.
11 Consistency amongst learning outcomes across training institutions is required for students to learn together at the same site.
12 Learning outcomes for distributed training include a focus on:
- Social determinants of health.
- Common, undifferentiated problems in primary health care.
- An integrated spectrum of health and illness.
- Cultural awareness.

13 The curriculum for distributed training uses:
- Various teaching and learning approaches (e.g., student-centered, interprofessional, competency-based, self-directed, debriefing and reflection).
- A patient-centered approach to care.
- Opportunities for developing a range of competencies.
- Flexibility to adapt to the realities of the individual site.
- On-site, integrated and continuous student assessment.

14 Distributed training rotations should be of sufficient length to allow for immersion and integration for students, and continuity for the site.
15 Provision is made for regular and structured feedback from and to students.
16 Applicability of learning outcomes is assured by continuous monitoring, review, and modification of the curriculum.

The community is defined as the population that utilises the local health facility where students are trained, and is the reference point for the curriculum.

17 Community stakeholders are identified and engaged.
18 Strong partnerships are forged and maintained with community stakeholders at the training site.
19 The community is involved in and supports the shared vision for the training initiative that meets their needs.
20 Students and staff are aware of and oriented to community needs.
21 Learning opportunities are available wherever health services are provided in the community, including home-based care.
22 Students learn through being immersed in the community.
23 Role players engage in collective celebration of accomplishments.

The training environment includes (a) people who work at the distributed training site, and in the community, contributing to the training of the students; and (b) the training site as the context and physical environment within which the distributed training takes place.

(a) people

24 There is a dedicated person at the training site who coordinates the training and communicates with the training institution.
25 Staff from various professions work with students at the site to facilitate their learning. They are provided opportunities to learn how to teach, developing an understanding of the importance of role modelling, resilience and professionalism.
26 Before students arrive, staff at the site receive the information they need about learning outcomes and relevant guidelines to support students' learning.
27 Site staff who train students receive recognition from the training institution.
28 Site staff provide feedback about student performance.
29 Subject specialists support distributed training through regular outreach visits.
30 At least one health professional is motivated and available to act as primary supervisor for students.
31 The primary supervisor:
- develops, implements, and evaluates the training at the site.
- is involved in formative and summative assessment of students.
- receives the necessary support and training technologies.
- develops her/his own capacity in teaching and learning, which is made available by the training institution.

(b) Place

32 The training site is selected collaboratively by stakeholders, including service providers, training institution, site management, and relevant others.
33 Site selection is based on patient profile, learning outcomes, quality of care, and other factors that will provide relevant learning opportunities.
34 Medical equipment, appropriate to the level of care of the facility and to the required learning outcomes, is available.
35 Sufficient space for training activities is made available.
36 Materials to enhance learning are made available on-site, preferably through internet connectivity and information technology equipment.
37 Depending on location of the site, accommodation and transport for students are made available. Include community outreach and the use of community resources where appropriate.

The students are learners enrolled for any programme in health professions at a training institution.

38 Students:
- receive orientation before they begin a rotation.
- have academic and social support available when and where they need it.
- provide feedback after they complete a rotation.
- have adequate arrangements for safety and security.

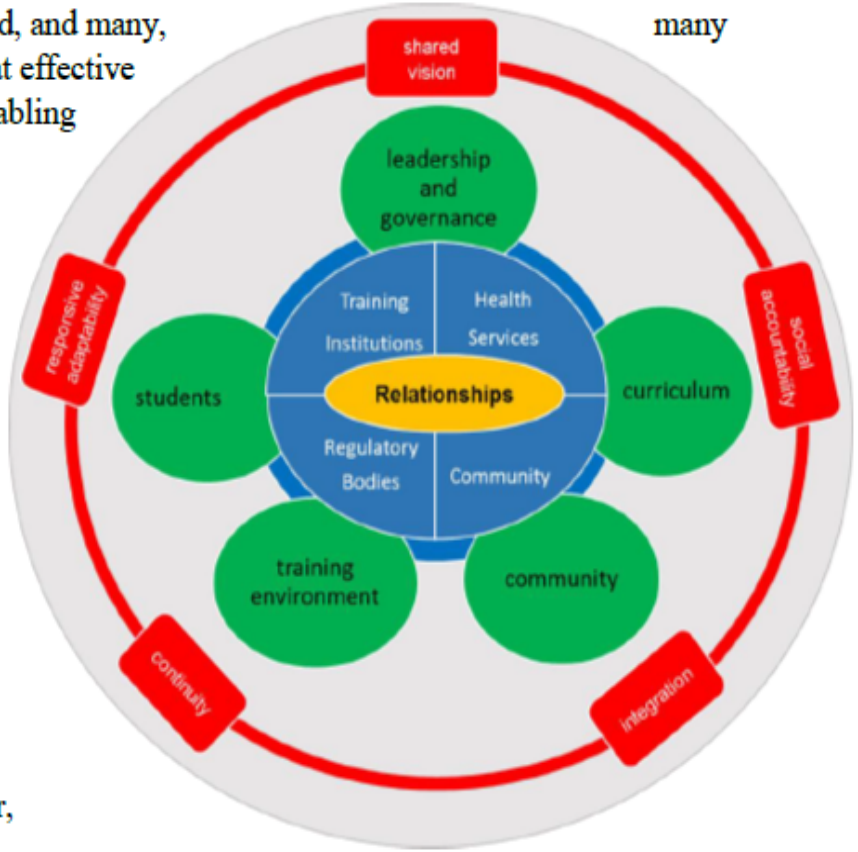
39 Student-staff ratios are mutually agreed upon during site selection.
40 At least two students are assigned to a site to ensure peer engagement.
41 Reasonable logistical arrangements are made by the training institution.

IMPLEMENTATION TOOL

Applying the Framework for Effective Decentralised Health Professions Training

Simple Rules Rubric

Every system will have a unique implementation of the Framework for Effective Decentralised Health Professions Training. The most effective implementation for your institution will depend on the maturity of your program, the number of institutions involved, the geographical distribution, the number of students and disciplines represented, and many, many other factors. While many variations are to be expected, evidence shows that effective programmes share patterns of performance, which are represented in the enabling factors of the Framework for Effective Decentralised Health Professions Training.



Complexity of the training context and the number of players make it difficult to plan for, apply, and evaluate all the individual enabling factors at the same time. A short list of simple rules encompass the factors, and they simplify the process while continuing to set conditions for patterns of effective teaching and learning. Those Simple Rules are:

I. Build and maintain relationships
II. Move toward a shared vision
III. Fulfill roles and responsibilities
IV. Balance needs and provide support
V. Engage with learning
VI. Evaluate and provide feedback

The Simple Rules Rubric organizes the enabling factors to help you plan for, implement, and evaluate changes in your program over time.

Implementation tool - example

III. **Fulfill roles and responsibilities** Each role player has specific responsibilities and effective decentralised training for the health professions requires them to fulfill their commitments.	Not at all	Somewhat	To a great extent	Not applicable	Next Steps
a. The roles and responsibilities are clear for the training institution, health service, and community.					
b. Training institution selects students most likely to practice in decentralised areas (relevant for training institution leaders).					
c. Management of the training institution takes leadership in prioritising and implementing programmes.					
d. Different training institutions using the same training site have consistent learning outcomes (relevant for training institution management).					
e. Subject specialists support decentralised training through regular outreach visits.					
f. At least one health professional is motivated and available to act as primary supervisor for students.					
g. The primary supervisor: • develops, implements, and evaluates the training at the site. • develops her/his own capacity in teaching and learning, which is made available by the training institution.					

Discussion: Enabling factors

I. Leadership and Governance

Leadership and governance relates to the decision-making processes and roles and responsibilities of stakeholders influencing effective decentralised training, including the following factors:

1. All role players, including the health services, community, and training institutions, engage in mutually beneficial and equitable partnerships.
2. The roles and responsibilities of training institutions, health services, and communities, are clear to everyone involved.
3. All levels of management are committed to effective collaboration to support students' learning.
4. Senior management of all role players demonstrate collaborative and visionary leadership toward a shared purpose.
5. Champions take responsibility for decentralised training.
6. Funding for training initiatives is made available through a transparent funding model.
7. Formal and informal communication channels exist across all levels and among multiple role players.
8. Monitoring, evaluation, and research on decentralised training initiatives are encouraged by leadership.
9. The training institution:
    a. implements institutional policies that support decentralised training.
    b. supports and capacitates primary supervisors and other site staff involved with students (see also factor 31).
    c. builds and maintains relationships with the site.
    d. selects students most likely to practice in rural and remote areas.
    e. becomes familiar with each site's strengths and challenges.

Discussion: Enabling factors

II. Curriculum

The curriculum is the scaffolding that informs the learning outcomes, content, mode of delivery, and assessment of students, and evaluation of the curriculum itself. Curriculum factors for effective decentralised training include:

1. Management of the training institution takes leadership in prioritising and implementing decentralised training programmes.
2. Consistency amongst learning outcomes across training institutions is required for students to learn together at the same training site.
3. Learning outcomes for decentralised training include a focus on:
    a. Social determinants of health.
    b. Common, undifferentiated problems in primary health care.
    c. An integrated spectrum of health and illness.
    d. Cultural awareness.
4. The curriculum for decentralised training uses:
    a. Various teaching and learning approaches (e.g., student-centered, interprofessional, competency-based, self-directed, debriefing and reflection).
    b. A patient-centered approach to care.
    c. Opportunities for developing a range of competencies.
    d. Flexibility to adapt to the realities of the individual site.
    e. On-site, integrated and continuous student assessment.
5. Decentralised training rotations should be of sufficient length to allow for immersion and integration for students, and continuity for the site.
6. Provision is made for regular and structured feedback from and to students.
7. Applicability of learning outcomes is assured by continuous monitoring, review, and modification of the curriculum.

Discussion: Enabling factors

III. Community

The community is defined as the population that utilises the local health facility. Community engagement factors for effective decentralised training include:

1. Community stakeholders are identified and engaged.
2. Strong partnerships are forged and maintained with community stakeholders at the training site.
3. The community is involved in and supports the shared vision for the training initiative that meets their needs.
4. Students and staff are aware of and oriented to community needs.
5. Learning opportunities are available wherever health services are provided in the community, including home-based care.
6. Students learn through being immersed in the community.
7. Role players engage in collective celebration of accomplishments.

Discussion: Enabling factors

IVa. Training Environment (people)

People who work at the decentralised training site, and in the community, contribute to the training of the students. The following factors relate to people at the training site:

1. There is a dedicated person at the training site who coordinates the training and communicates with the training institution.
2. Staff from various professions work with students at the site to facilitate their learning. They are provided opportunities to learn how to teach, developing an understanding of the importance of role modelling, resilience and professionalism.
3. Before students arrive, staff at the site receive the information they need about learning outcomes and relevant guidelines to support students' learning.
4. Site staff who train students receive recognition from the training institution.
5. Site staff provide feedback about student performance.
6. Subject specialists support decentralised training through regular outreach visits.
7. At least one health professional is motivated and available to act as primary supervisor for students.
8. The primary supervisor:
    a. develops, implements, and evaluates the training at the site.
    b. is involved in formative and summative assessment of students.
    c. receives the necessary support and training technologies.
    d. develops her/his own capacity in teaching and learning, which is made available by the training institution.

Discussion: Enabling factors

IVb. Training Environment (structure)

The training site is the context and physical environment within which the decentralised training takes place, including the following factors

1. The training site is selected collaboratively by stakeholders, including service providers, training institution, site management, and relevant others.
2. Site selection is based on patient profile, learning outcomes, quality of care, and other factors that will provide relevant learning opportunities.
3. Medical equipment, appropriate to the level of care of the facility and to the required learning outcomes, is available.
4. Sufficient space for training activities is made available.
5. Materials to enhance learning are made available on-site, preferably through internet connectivity and information technology equipment.
6. Depending on location of the site, accommodation and transport for students are made available. Include community outreach and the use of community resources where appropriate.

Discussion: Enabling factors

V. Students

The students are learners enrolled in undergraduate studies in any of the health professions at a training institution. The following factors are essential for students at a decentralised training site:

1. Students:
    a. receive orientation before they begin a rotation.
    b. have academic and social support available when and where they need it.
    c. provide feedback after they complete a rotation.
    d. have adequate arrangements for safety and security.
2. Student-staff ratios are mutually agreed upon during site selection.
3. At least two students are assigned to a site to ensure peer engagement.
4. Reasonable logistical arrangements are made by the training institution.

12 Tips

- Tip 1: Choose the “right” sites
- Tip 2: Build mutually beneficial relationships
- Tip 3: Move toward a shared vision
- Tip 4: Be clear about your intentions

van Schalkwyk S, Couper I, Blitz J, Kent A, de Villiers M. Twelve tips for distributed health professions training. Med Teach. 2020; 42(1):30-35.

12 Tips

- Tip 5: Establish clear channels of communication
- Tip 6: Clarify roles and responsibilities
- Tip 7: Orientate and support your supervisors
- Tip 8: Choose the “right” students and help them stay

van Schalkwyk S, Couper I, Blitz J, Kent A, de Villiers M. Twelve tips for distributed health professions training. Med Teach. 2020; 42(1):30-35.

12 Tips

- Tip 9: Jointly develop learning opportunities
- Tip 10: Use the site to innovate
- Tip 11: Identify and support champions at both the institution and the sites
- Tip 12: Adopt a critically reflective practice

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