HARMONIZATION OF TRAINING STANDARDS

AMCOA CONFERENCE

KIGALI SEPT 23

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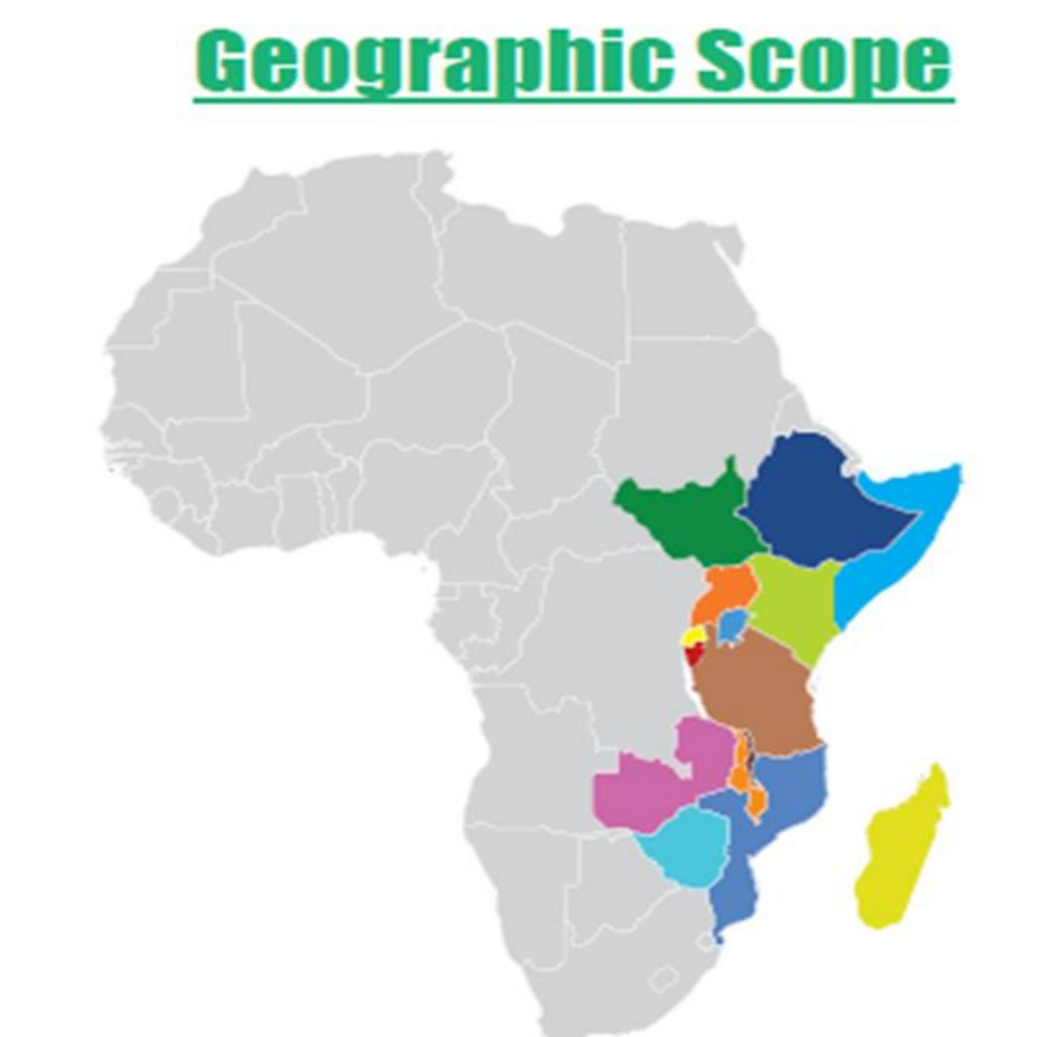
CURRENT COECSA REPRESENTATION



- 12 Countries in ECSA
  (Madagascar not included)

- Zimbabwe, Zambia, Malawi, Mozambique, Rwanda, Burundi, Kenya, Tanzania, Ethiopia, South Sudan, Somalia, Kenya

OUTLINE

1. INTRODUCTION
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3. WHO SETS THE STANDARDS AND DRIVES THE PROCESS
4. BUILDING BLOCKS FOR STANDARDIZATION
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    ii. THE COMPETENT DOCTOR WE WANT
    iii. WHO IS THE CUSTODIAN OF THE TRAINING
    iv. WHO CERTIFIES THE COMPLETION OF TRAINING
5. THE QUALIFICATION FRAMEWORK
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INTRODUCTION

1. INTRODUCTION

Standardization is the process of setting the norms for practice; acceptance of the norms by all players and follow-up with assessment for compliance.

Examples:

- **The African Peer review Mechanism created in 2003 by NEPAD (AU Initiative)**
- **Accreditation process for Hospitals whether under International or National framework is the same thing.**

It's a good practice but it must have some incentives and rewards for those who comply because it is a hard task.

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INTRODUCTION

- **The assessment is done in 2 ways:**
- **Self-assessment which is followed by an external assessment.**

Self- assessment is important: Not costly/it allows for quick fix of issues. It is a rehearsal exercise for external assessment.

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INTRODUCTION

The assessment is done in 2 ways:

- **Self-assessment which is followed by an external assessment (Formative).**
- **External assessment(Summative)**

Self- assessment: Not Costly / it allows for a quick fix of issues. It is a rehearsal for external assessment.

But it may not portray the reality:

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2. WHY STANDARDIZE?

- Free movement of health professionals across the countries on the continent presupposes that they are equally competent!
- All communities are entitled to quality care regardless of their socio-economic status.

Quote:

Dr K. LETLAPE, former AMCOA President, Guest speaker to COECSA Congress 2019 in Kigali:

" When a Boeing 737 is flying to Rwanda from whichever country, the CAA does not ask who is the pilot/ Where did he train? How many sky hours of experience…before they allow him/her to land." why? Because they know and trust the Boeing training process they go through regardless of where they train.

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WHO

SET

THE STANDARDS?

MEDICAL COUNCILS SHOULD BE THE CUSTODIANS OF THE STANDARDS

- It depends on the scale and scope of the standardization process.
- Is it in country for national Standards?
- Inter-countries? Regional blocks?

Undergraduate should be separate from Postgraduate: e.g. LCME and ACGME in USA

In our situation: ECSA Professional Regional colleges, as mandated by the Conference of Ministers of ECSA Health Community (9 Colleges today).

IN MOST ESTABLISHED SYSTEMS especially English speaking : Professional colleges exercise delegated power by the Medical Councils for residency training.

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4. BUILDING BLOCKS

i. The DOCTRINE

- COECSA believes in 20+80=100

This will therefore drive the standards we set and the processes we go through.

Building Knowledge+ Building Skills= 100%

- Undergraduate:

80 +20 = 100

- Residency

20+80 = 100

- Super-specialty

100 = 100

BUILDING BLOCKS

ii. THE COMPETENT DOCTOR WE WANT

a. KNOWLEDGE

The Knowledge should be deep enough to become a robust foundation for the future residency program: The Trainees should understand fully the body functions in an integrated way!

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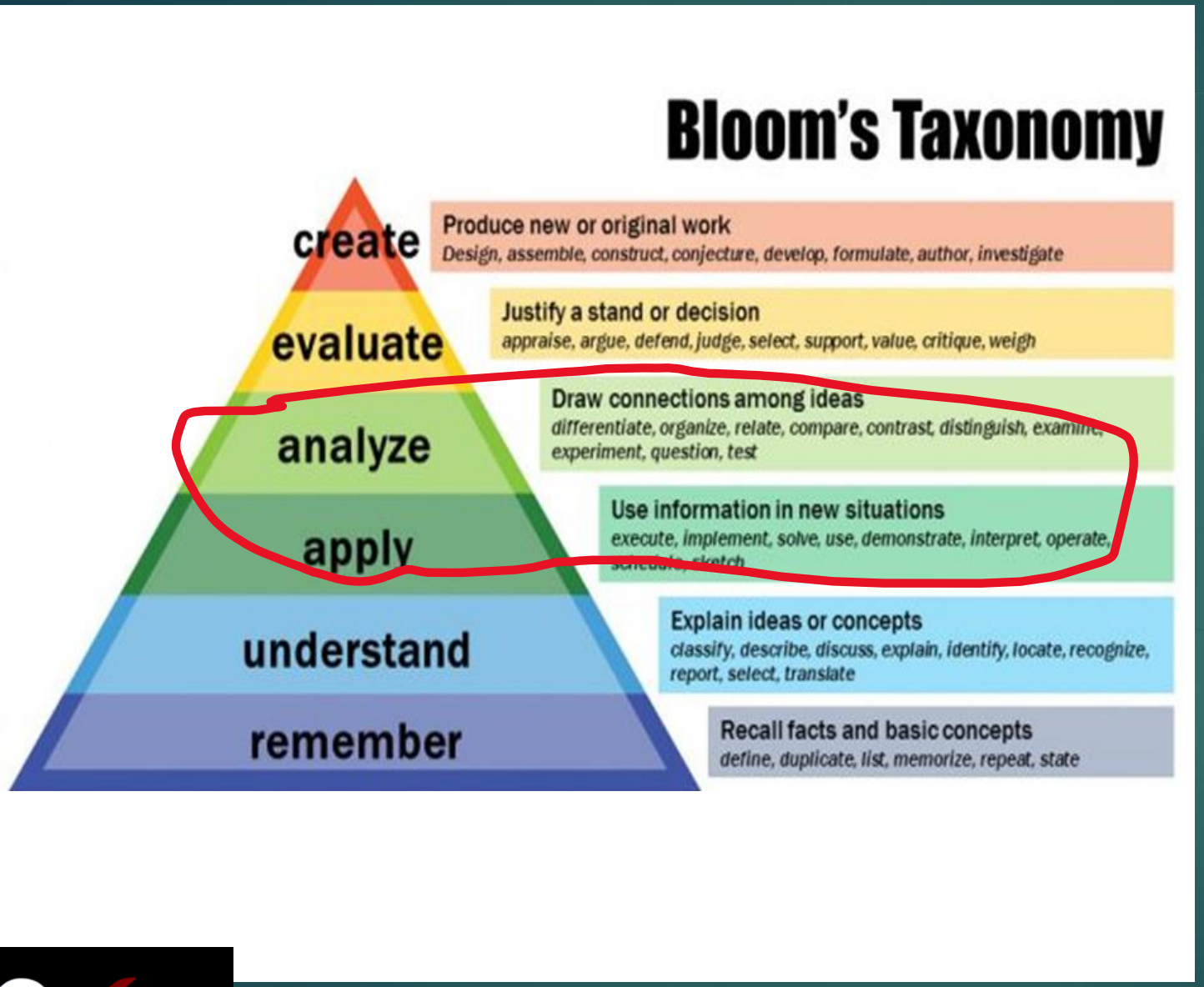

In Medical school, you should spend 80% of your time at learning how to apply and analyze acquired knowledge and the other 20% are dedicated to basic skills

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BUILDING BLOCKS

b. The Skills

- Using the Dreyfus Model of skills acquisition, we should aim to graduate the specialist who is proficient at every skill defined in the curriculum (which should be competency-based!!)

- The right tools should be produced to assess every aspect of the prescribed competencies (WBAs and Milestones)
- The Training Portfolio is the repository of all the learning encounters and should be assessed on regular basis. It is the GPS for the learning journey.

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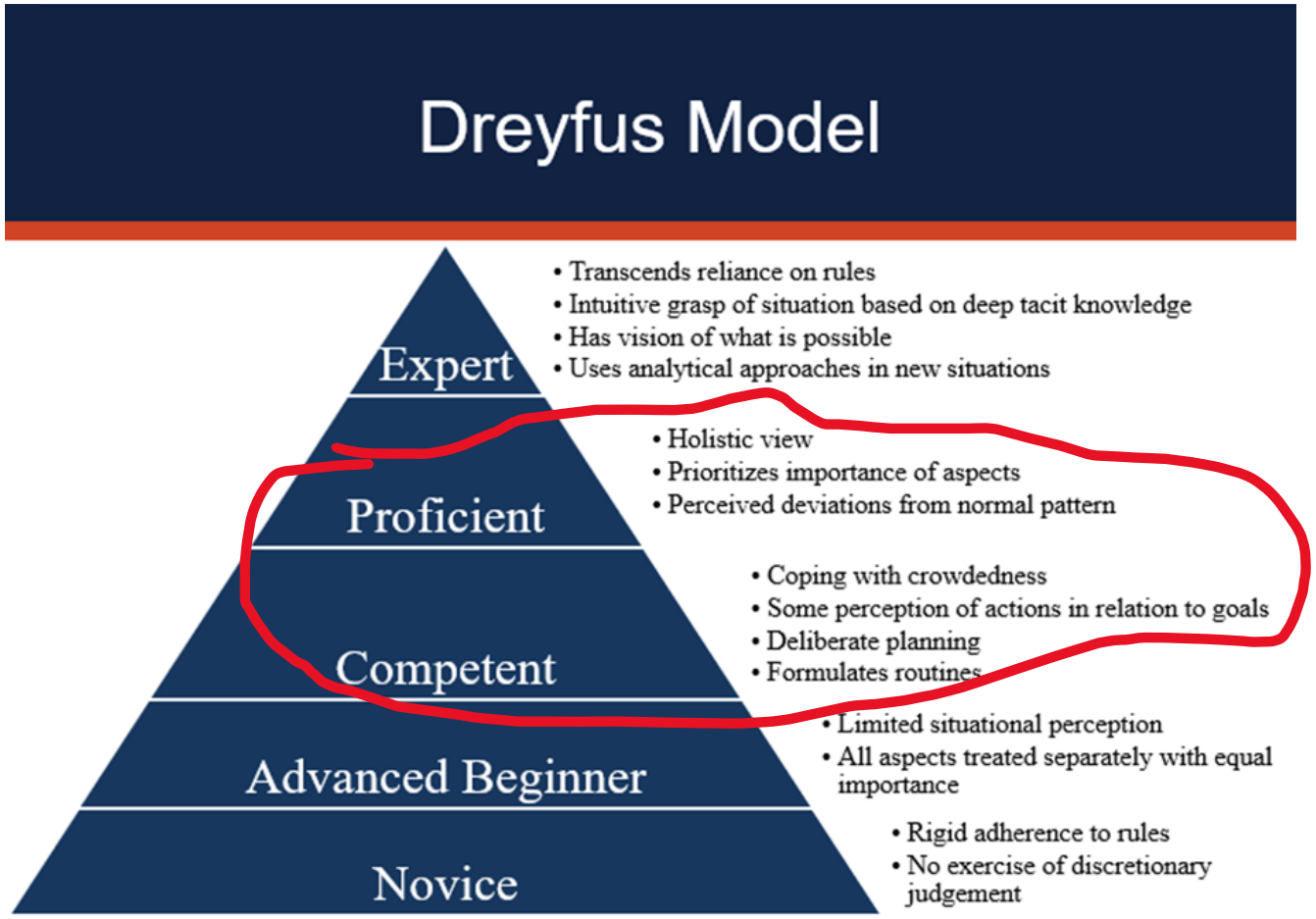

In Residency training, 80% of your time is dedicated to working on your skills to reach at least the competent level and aspire to become proficient

The other 20% is dedicated to Deep levels of knowledge and other activities like Research

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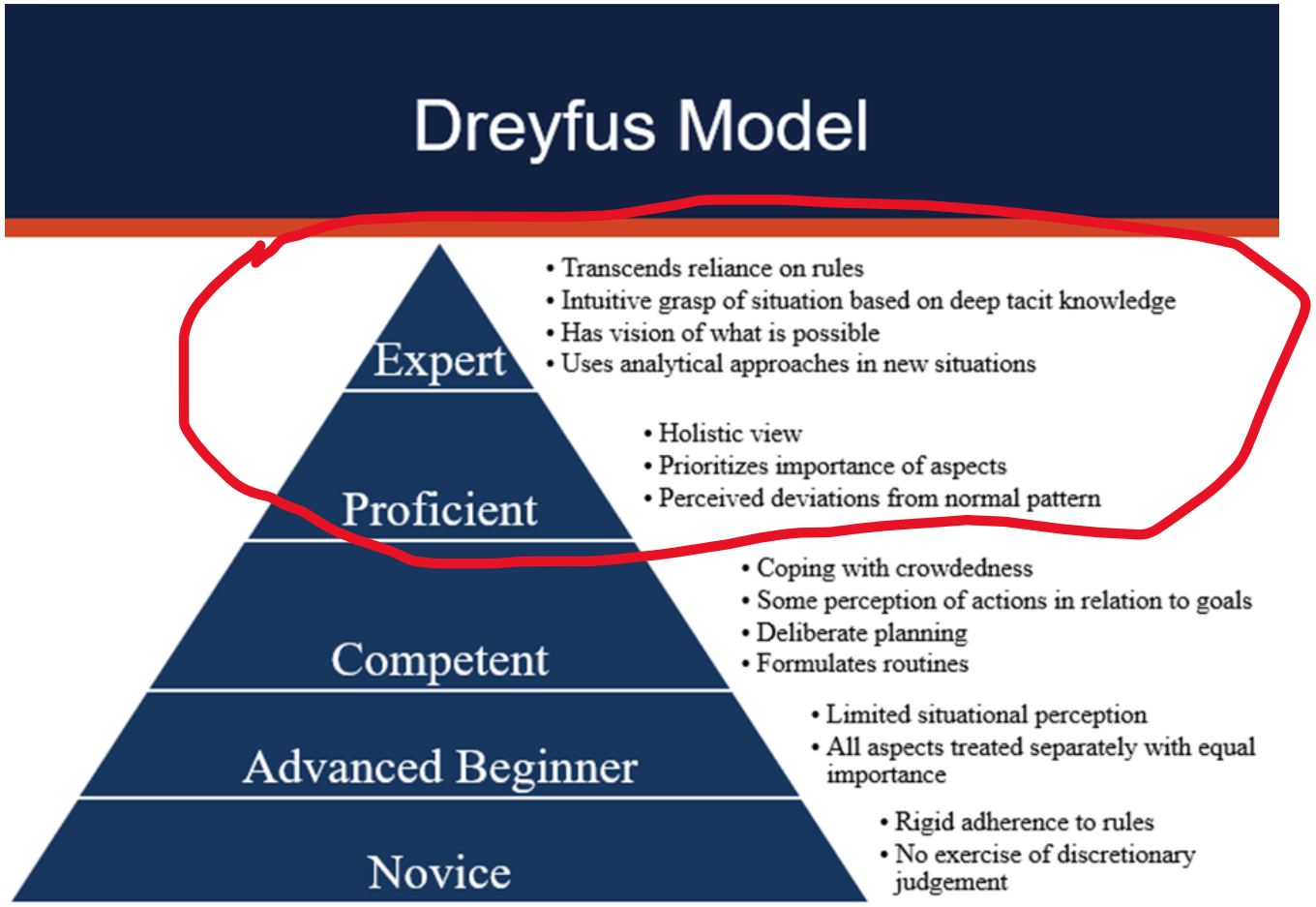

In Super-specialty Training, Your time is dedicated 100% on Skills. It is an apprenticeship that should lead to proficient and sometimes expert

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IMPLEMENTATION

1. Same curriculum: Competence based
2. Curriculum implementation tools
3. Same accreditation process for training Centres
4. Training the trainers program
5. Same exams.

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ASSESSMENT TOOLS

(The only way to prove that the competencies have been acquired at the right level. They drive the learning process)

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BUILDING BLOCKS

iii. WHO SHOULD RUN THE TRAINING

1. Undergraduate:

There is a consensus:

Medical school under a University.

(80% Knowledge) : The primary responsibility belongs to the Dean

2. Residency training:

Accredited Hospitals (80% skills):

(The Role of Universities should be limited)

3. Super-specialty fellowship training

The primary responsibility is the Specialty department of the hospital.

(100% Super Skills in a narrow field)

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BUILDING BLOCKS

iv. CERTIFICATION

1. Universities sets exams and awards the medical degree for undergraduates: (**Naming?!**)
2. Specialist qualification at the completion is awarded by:
   - Professional Colleges in most Countries (They set the Curricula+ assessment tools, accreditation of training Centres and exams): WACP/WACS; ECSA(CHS), ZACOMS,……
   - Universities: In some countries (**M Med,** …)
3. Super-specialty: Certification by the Accredited training Hospital.

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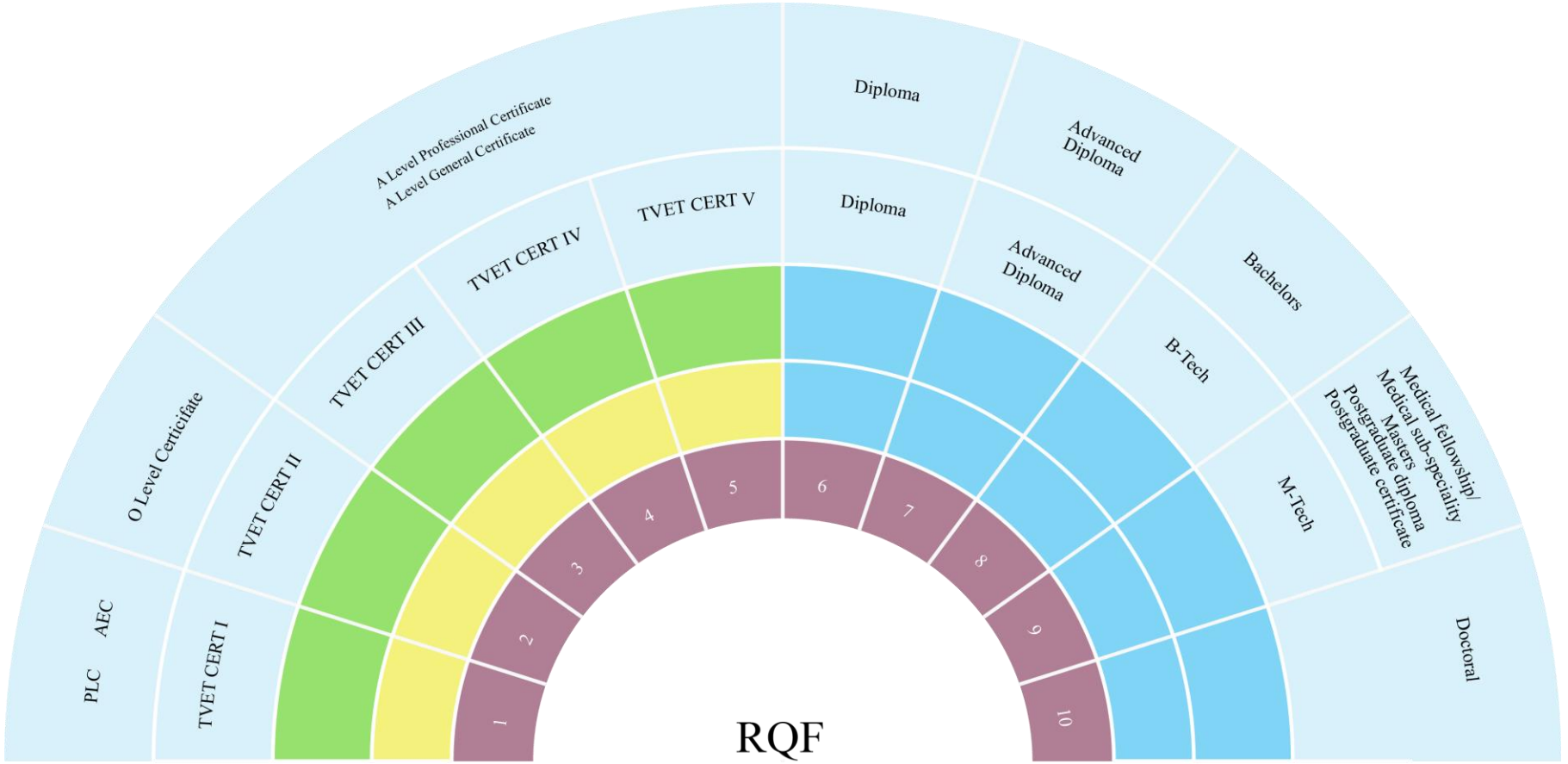
5. NATIONAL QUALIFICATION FRAMEWORK



Key:

Qualification levels

Awards at the appropriate levels

Basic education

Lower level TVET

General & TVET Higher education

RQF Ecosystem of the Education Sub-Frameworks

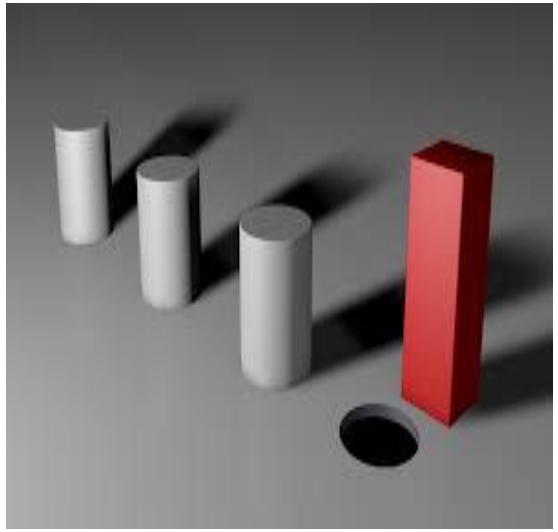
REQF Levels	Qualification Types			Nr. of Credits	
10	PhD			360	
9	Masters / Postgraduates/Medical Fellowship		M. Tech	180	180
8	Bachelors		B. Tech	480	480
7	Advanced Diploma		Advanced Diploma	360	360
6	Diploma		Diploma	240	240
5	Advanced General Certificate of Secondary Education	Advanced Professional Certificate of Secondary Education	TVET Certificate V	*3510	156
4			TVET Certificate IV		156
3			TVET Certificate III		156
2	Ordinary Level Certificate of Education		TVET Certificate II	*3510	156
1	Primary School Leaving Certificate		TVET Certificate I	*1560	40
	Adult Education Certificate			*972	

*: Notional Hours

Structure

The RQF Qualifications Map

A Square peg in a round hole



COECSA CURRICULUM & IT'S TOOLS

- **In total: 10 Learning Domains divided into 139 learning outcomes or competencies. There are 25 assessment forms for objective assessment and 51 Milestones.**
- For Each learning Outcome (competency), the assessment tools are defined
- These filled forms are then used for the Milestone assessment for each competency
- **The progression through the training program is not based on time spent in training or Exams passed. It is through Milestones achieved.**
- **THIS DOES NOT FIT INTO THE RQF**

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6. CONCLUSIONS

1. Standardization of Medical training through the harmonization of its building blocks at national/ regional and continental level is the way to go if we are committed to quality care for all
2. Regional professional colleges should be supported by the regulatory bodies in order ultimately get to one Continental qualification.
3. The traditional University based education has led to Qualifications Frameworks which are academic in nature and don't fit the professional medical qualifications.
4. It is urgent for the Medical practice regulatory bodies to drive the production and adoption of Health workers Professional Qualifications Framework.

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THANK YOU