Community-Based Training in competences for all health professionals including community health workers: how to accredit such programmes?

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1. Introduction.

Any intervention in relation to training health professionals should start from an in-depth analysis of the actual health workforce crisis. The most striking phenomena are the multiple forms of "brain-drain". Most developing countries are confronted with different types of "brain drain": an "internal" brain-drain, shifting health care providers from primary care to secondary care and specialty care, from comprehensive horizontal health care settings towards vertical disease-oriented programs and from rural to urban areas[1]. Moreover, there is an external brain-drain, moving health care providers from countries that face huge difficulties and insecurity to countries where there are more opportunities to function as a health care provider (e.g. from central Africa to Southern Africa), and finally there is the intercontinental brain-drain, bringing nurses and physicians from developing countries towards countries like Canada, United States, United Kingdom, Australia,... The answer to the health workforce crisis is both a question of training sufficient numbers and assuring that the needed quality is present in the health workforce. Nowadays, in Asia, Latin-America, Africa,... an increasing number of medical faculties are established. A lot of those are private initiatives, only accessible for those who can afford to pay high tuition fees or those who can get a bursary that enables them to study. Some of these faculties offer merely theoretical programs, because they are not able to provide clinical bedside training in hospitals at community based settings.

The last three decades have demonstrated a clear need to integrate sufficient amounts of community-based training into the undergraduate curriculum, in order to expose students sufficiently to the reality of primary health care and the needs of local communities. The World Health Report 2008: "Primary health care: Now more than ever!"[2] and the Resolution WHA62.12: "Primary health care: Including health systems strengthening"[3] urge member states to "train and retain adequate numbers of health workers with appropriate skill mix, including primary health care nurses, midwifes, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs".

Nowadays, there are a lot of examples of good practices in undergraduate exposure to community-based education and service: in regions and institutions as varied as B.P. Koirala Institute in Dharan (Nepal), Moi University in Eldoret (Kenya), Walter Sisulu University in South-Africa, Universidade Estadual de Londrina (Brazil), Northern Ontario School of

Medicine (Canada), Ghent University (Belgium)[4], students experience the confrontation with the health needs of the community[5]. By doing so they learn to appreciate, not only the role of professionals, but also the important role of volunteers who give informal contributions to health promotion, disease prevention and care and the importance of participation of the local population in health care delivery[6].

2. Principles and standards to asses the training of health care providers and their competences.

Any assessment of a training programme of health care providers should look carefully to what extent the competences acquired by the students, contribute to the following principles:

a. Relevance of care: care that really answers the needs (and not only the demands) of the local population, taking into account priorities.
b. Equity: care that is responsive to the variation in needs of different social, ethnic,... groups in society, contributing to "social justice";
c. Quality: extent to which the health care provider is able to deal with the "structure, process and outcome"-components of quality of care.
d. Cost-effectiveness: in order to make optimal use of the resources, reconciling individual aspirations of patients with community requirements.
e. Sustainability: looking at the long-term perspective and assessing how measures in health care may influence other sectors (e.g. work, education,...) and to what extent measures in other sectors (environment, transport,...) may affect the health system.
f. Person- and people-centred care: putting the people at the centre of the process.
g. Innovation: competences that enable graduates to continuously reflect on their actual performance and implement continuous innovation.

These principles all refer to the concept of "social accountability" of the training programme and the institution.

At a recent conference (October 10-13, East-London South-Africa), the Global Consensus on Social Accountability of Medical Schools was formulated, inspired by an international reference group of 135 organisations and individuals seen as leaders in medical education, accreditation and social accountability. The Global Consensus on Social Accountability Initiative identified 10 areas that should be reflected in medical education standards, evaluation, accreditation and quality improvement.

Table 1: Social accountability and medical education standards[7].

Area	Description
Area 1.	Anticipation of society's health needs and vision & mission of the medical school
Area 2.	Partnerships with the health system and stakeholders
Area 3.	Evolving roles of doctors and other health professionals
Area 4.	Outcome-based education
Area 5.	Governance of the Medical School
Area 6.	Scope of Standards
Area 7.	Quality improvement in education, research and service delivery
Area 8.	Mandated mechanism for accreditation
Area 9.	Global principles with context specificity
Area 10.	Role of Society

3. The need for Community-Based Training and the strengthening of primary health care.

All over the world the health workforce crisis is most apparent in the ambulatory setting, primary health care and community-based settings. So, community-based training is an essential strategy in the recruitment of health care providers for the primary health care system. Nowadays, it is clear that if we want to achieve the Millennium Development Goals, an emphasis should be put on primary health care and on the integration of person-oriented and community-oriented care[8 9].

The members of The Network: Towards Unity for Health (www.the-networktufh.org) have clearly demonstrated how important it is to have all stakeholders on board in order to create synergies between education and health care: cooperation of academics, communities, managers, providers,... is needed in order to make a difference. Moreover, community-based training[10], illustrates the important role of volunteers and community health workers in the health system.

The Primafamed-network (www.primafamed.ugent.be) has demonstrated in more than 15 countries in Sub-Saharan Africa, how important it is to create a specific post-graduate training for primary health care physicians, that work as family physicians in multidisciplinary primary health care teams. Nowadays, a clear profile for the African family physicians" has been defined and training programmes are developed accordingly[11 12]. The Primafamed-network uses the strategy of South-South cooperation in order to enhance capacity-building.

4. Strategy for implementation of standards in order to assess and accredit programs for Community-Based Training and competences for all health professionals including community health workers.

Although it is important to define international standards, a process of implementation of standards to assess community-based training requires a bottom-up strategy. Ten steps can be defined:

1) Involve all stakeholders in the process of operationalising the standards: not only health care providers and academics, but also representatives of the population, health managers, representatives of other sectors in relation to welfare,... should be involved.
2) Include a timeframe to create a sufficient amount of "ownership" through a participatory process, so that training institutions "internalise" the standards as being relevant for their educational processes.
3) Communicate clearly about the standards and the way they are operationalised.
4) Define the legislative framework wherein the process of assessment and accreditation will take place. Indicate clearly what will be the consequences for the institutions (e.g. in terms of financial and other resources).
5) Establish and recognise independent accreditation bodies that will be in charge of the accreditation-procedures.
6) Assess whether accreditation bodies should be national or supranational. Sometimes, a supranational approach is worthwhile, as it may strengthen independency, provided local governments accept the authority of those international bodies.

7) Take advantage of existing structures. An example: the Interuniversity Council for Eastern Africa could be an appropriate environment wherein one or more accreditation bodies may function.
8) Start with the try-out on voluntary basis, so that institutions see the advantage of participation in an accreditation process.
9) Make the procedure as transparent as possible with emphasis on the self-study report, the SWOT-analysis by the institution, the proposals for improvement by the institution and the report of the study visit by the experts. Foresee an appeal-procedure for the institution.
10) Communicate the conclusions clearly and make sure that the consequences are put into practice.

5. What makes a strategy towards Community-Based Training into a success?

The assessment of community-based training programmes is very often complex, as it is a multi-centre endeavour by the faculty. Therefore, site visits are of utmost importance. Moreover, as it is impossible to visit all training sites, the assessment of the "Quality Assurance System" that the faculty puts forward in order to guarantee the quality of the training at the different training sites could be worthwhile.
An important indicator is the "output", e.g. the number of graduates that opt for a career in primary health care. When looking at the output, we should be very careful about absolute figures, as, very often, the result will be determined by the context. So, contextualisation of data is of utmost importance when assessing community-based teaching.

It will be important to assess strategies that are actually used in order to increase the workforce in rural and remote areas. In a lot of countries, a "compulsory" community service obliges the graduates to work 1 or 2 years after graduation, in rural or remote areas. The impact of this experience should carefully be assessed, as sometimes the working conditions in those areas are so poor, that providers never want to return to these areas.

Finally, a Health Systems Approach will be needed in order to understand the contribution the programme makes e.g. in addressing the health workforce crisis. International measures are needed to limit the brain-drain. An example could be that countries that integrate health care providers coming from developing countries in their health system are obliged to refund the actual cost of the training of that health care provider in the receiving country to the country of origin.

6. The assessment and accreditation of Community-Based Training and competences.

The assessment and accreditation of Community-Based Training and competences for all health professionals including community health workers, is an important challenge. Apart from the need for a clear conceptual framework (and there is a lot of expertise and good practices), the overarching concept of "social accountability" of training programs has to be taken into account. Moreover, a clear strategic approach is needed, in order to avoid a disruptive impact of accreditation procedures. Finally, these accreditation procedures have to be linked to the health workforce crisis. Therefore, there is a need for more research on the determinants of the health workforce crisis and how this crisis can be addressed. In the framework of the EU-FP7-project: "Human Resources for African Primary Care", Ghent

University, together with Oxford University, the Medical University of Vienna, University of Botswana, University of Witwatersrand, Ahfad University for Women (Sudan), Université de Bamako in Mali and Mbarara University of Science and Technology in Uganda will start a four-years research project that may contribute to the analysis of community-based training and competences for all health professionals in order to address to the health workforce crisis.

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