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Building an Interdisciplinary Clinical Field to Create Demand and Workforce Ahead of Technology Adoption: Evidence from a National Pelvic Floor Surgery Programme

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Abstract

New surgical technologies often reach public health systems before the clinicians who can apply them and before the patient flow that justifies their purchase. This article describes the organizational design of a pelvic floor surgery program prepared in the Republic of Belarus in 2009 and 2010, establishes the order in which its elements were introduced, and derives a transferable model. The study rests on document analysis of the available draft of the national concept, the presentation of the joint project, and three later documents from radiation therapy projects, with each element coded by function and by timing relative to equipment supply. The program merged urology, gynecology, and coloproctology into a single clinical field, placed six centers within existing hospitals, defined a three-stage care pathway with a patient registry, and introduced a mandatory interdisciplinary training cycle with a three-stage skills curriculum. Training of 27 specialists, 3 national events, diagnostic algorithms, updated protocols, public awareness efforts, and assignment of operations to the high-technology care category all preceded any planned procurement. The case supports a model in which the first demand-side and workforce-side elements are built 1 to 4 years before the technology arrives, and the same sequence recurs in subsequent radiation therapy projects. The concept's draft status and the absence of implementation data limit the conclusions.

Keywords: *Pelvic Floor Surgery, Interdisciplinary Clinical Field, Health Workforce, Technology Adoption, Health Program Design, Postgraduate Surgical Training, Belarus.*

INTRODUCTION

A health system that buys a complex surgical technology before it has trained surgeons and organized patients ends up with idle equipment or failed procedures. Greenhalgh and Abimbola (2019) describe adoption as the product of seven interacting domains, from the condition and the technology to the intended adopters, the organization, and the wider system, and they show that projects stall when complexity accumulates across these domains without anyone managing it. Hirst et al. (2019) make a parallel point for surgery: new procedures and devices pass through stages of idea, development, exploration, assessment, and long-term study, yet no agreed international pathway exists for generating evidence along this route. A scoping review of fifty-seven studies that applied the NASSS framework in its first five years found that most applications were retrospective and that the barriers reported most often lay in the organizational and adopter domains (Shin et al., 2025). Both frameworks treat workforce and patient flow as conditions that a technology must meet upon arrival, and the program examined here built those conditions first.

Female pelvic floor disorders suit this question because the patient population is large and the pathway to care is fragmented. A meta-analysis of twenty-two studies estimated the pooled prevalence of pelvic organ prolapse at 30.9% (Hadizadeh-Talasaz et al., 2024), and the Global Burden of Disease series records a rising absolute burden as populations age (B. Wang et al., 2022), and analyses of the 2021 round of the same series extended the estimates across all countries and territories covered by that round and examined their association with the sociodemographic index (R. Wang et al., 2025). Care-seeking lags far behind prevalence: a pooled estimate across forty-one studies found that 28% of women with urinary incontinence had sought help (Liang et al., 2023), and a review of eighty-six studies identified stigma, lack of knowledge, and the expectation of

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dismissal by clinicians as the main barriers (Jouanny et al., 2024). A later meta-analysis drawing on seventy-one studies of urinary incontinence, five of prolapse, and four of fecal incontinence examined visit rates and their determinants across the three conditions (Hou et al., 2025). Urologists treat urinary incontinence, gynecologists treat genital prolapse, and coloproctologists treat defects of the rectovaginal septum, so a woman with a combined defect meets three consultations and three operative traditions.

In the Republic of Belarus at the end of the 2000s, the Ministry of Health and an industrial partner, Johnson & Johnson, formed a joint working group to address this fragmentation. The group drafted a project plan in 2009 and, in 2010, a concept of a state program titled Development of Pelvic Floor Surgery in the Republic of Belarus for 2011 to 2015. The organizational model, the staged plan, and the training curriculum described in this article rest on direct participation in that working group and on first-hand drafting of the project plan, while the clinical content of the diagnostic algorithms and treatment protocols came from the chief specialists of the Ministry and from the departments of the Belarusian Medical Academy of Postgraduate Education.

The analysis covers the period from 2006 to 2015, and the radiation therapy documents extend the comparison to 2021. The material is documentary throughout, and the design decisions of those years are read from the texts in which they were recorded. The reading is retrospective by construction, since the article appears in 2026, and the discussion sets the decisions of the period against the state of the question at the time of publication, when implementation research has accumulated a decade of evidence on why technologies fail to embed and when the burden of pelvic floor disorders has continued to grow.

The article pursues three aims: to describe the organizational elements of the program in the available draft, to establish the order in which those elements appeared relative to the planned supply of equipment, and to derive a model that can be transferred to a different technology and tested against documents from later radiation therapy projects. The analysis is organizational throughout, makes no claim about the efficacy or safety of any device, and names no commercial product.

METHODS

The study follows a descriptive single-case design based on document analysis. Five documents form the corpus. The first is the draft concept of the state program Development of Pelvic Floor Surgery in the Republic of Belarus for 2011 to 2015, dated 2010, with nine chapters covering the rationale, centers, stages of care, material base, financing, management, and expected results. The second is the presentation of the joint project of the Ministry of Health and the industrial partner, dated Minsk 2009, which reports completed and planned stages of work and the design of the training center. The third is a memorandum between the Ministry of Health of the Republic of Tatarstan and a manufacturer of radiation therapy equipment, available in an undated, unsigned copy. The fourth is the order of the Ministry of Health of the Republic of Dagestan on a conference on neuro-oncology held on November 24, 2021. The fifth is an analytical document on a public-private partnership model for radiation therapy in Russia.

The two Belarusian documents exist in Russian and English versions, and all terms and figures were checked against the Russian originals. Documents are cited by issuing body, number, and date, and signature blocks are not reproduced. Because the copy of the concept bears no signature, every statement about its content refers to the available draft.

Each organizational element in the corpus was coded on two axes. The first axis is function: elements that create demand raise detection and channel patients toward a center, elements that create workforce train clinicians, and elements that fix practice give the new field a place in protocols, registries, tariff categories, and program status. The second axis is timing relative to the first planned supply of equipment and consumables to the centers. The NASSS-CAT tools (Greenhalgh et al., 2020) provided the checklist of complexity domains used to distinguish organizational elements from clinical ones, and coding of the Russian texts was cross-checked against the presentation slides that report completed work by stage.

The method has four constraints: one edition of each document, the draft status of the concept, no service data after 2011, and unreferenced clinical figures within the documents, which are replaced with references to external literature.

RESULTS

The Initial State

The rationale chapter of the concept and the opening slides of the presentation describe the situation before the project. Three specialties treated three symptom groups in isolation: urologists handled stress incontinence, gynecologists handled cystocele and uterine prolapse, and coloproctologists handled rectocele. Combined defects, which the presentation marks as the typical case, fell between them. The documents record that no dedicated service existed, that none of the techniques in use had been standardized, and that patients presented late because neither they nor primary care physicians recognized the conditions as treatable. Referral abroad for reconstructive surgery appears in the concept as a cost that the program was meant to remove.

The Staged Logic

The presentation frames the work as six steps: assessment of the situation, construction of an ideal model, systematization of data, formation of a working group, staged implementation, and analysis of results. The short horizon covered 2009, the

medium horizon covered 2010 to 2012, and the long horizon covered 2013 to 2015. Fig. 1 maps the program's elements against this timeline and separates those that build demand and workforce from those that deliver technology.

The left column of Fig. 1 fills from 2006 onward. The industrial partner funded training for 27 Belarusian specialists at three university clinics in Russia between 2006 and 2009, and three national events with invited professors were held in 2007, 2008, and 2009. By 2009, the chief specialists of the Ministry and the partner had organized statistical registration of patients, drafted diagnostic algorithms, updated treatment protocols, and prepared the curriculum of an interdisciplinary postgraduate cycle. The right column stays empty until the medium horizon, where the plan places equipment and consumables for the centers. This sequence constitutes the main empirical finding: the first demand-side and workforce-side elements were in place one to four years before any procurement was planned, and the mandatory cycle for primary care physicians ran in parallel with the centers' equipment.

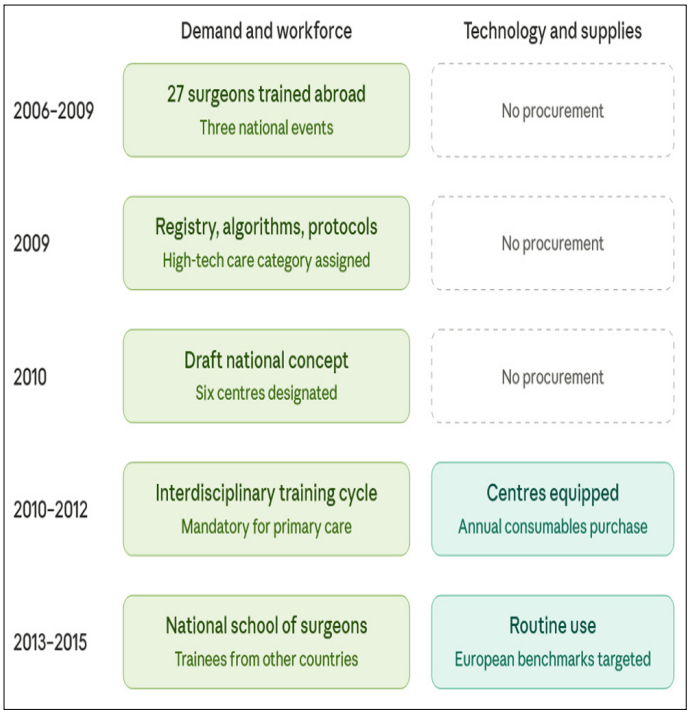

Fig. 1. Timeline of the program from 2006 to 2015: demand and workforce elements and the timing of technology supply

A New Interdisciplinary Field

The concept proposes a separate direction of care, named uroproctogynecology, that combines gynecology, urology, and proctology under the heading of pelvic floor surgery. The concept argues that the pooled experience of the three specialties allows combined defects to be treated at a new level, and in organizational terms the merger produced four shared instruments: one set of diagnostic criteria and protocols, one patient registry, one postgraduate cycle taught by four departments of the postgraduate academy, with topographic anatomy beside the three clinical ones, and a scheme of cross-hospitalization that allowed joint operations. The field was thus defined by a shared patient population and curriculum, while each specialty retained its own department, beds, and staff.

Centers Inside Existing Hospitals

The concept places the Republican Specialized Center for Pelvic Floor Surgery on the basis of the urology and proctology departments of the Minsk Regional Clinical Hospital, with a branch in the gynecology department of the Third City Clinical Hospital in Minsk, and both hospitals host departments of the postgraduate academy. Five regional centers follow the same pattern in Grodno, Mogilev, Gomel, Brest, and Vitebsk: each is based on a regional or emergency hospital with existing urology, surgery, or gynecology departments, and any missing department sends that patient group to the republican center or a neighboring hospital. No new building appears in the concept, which provides for the allocation of beds within existing departments and for annual purchase of consumables by the institutions themselves under national procurement law.

The Care Pathway and the Registry

Chapter five of the concept describes a three-stage pathway, and Fig. 2 shows the route a patient follows through primary care, the center, the hospital, and back to primary care.

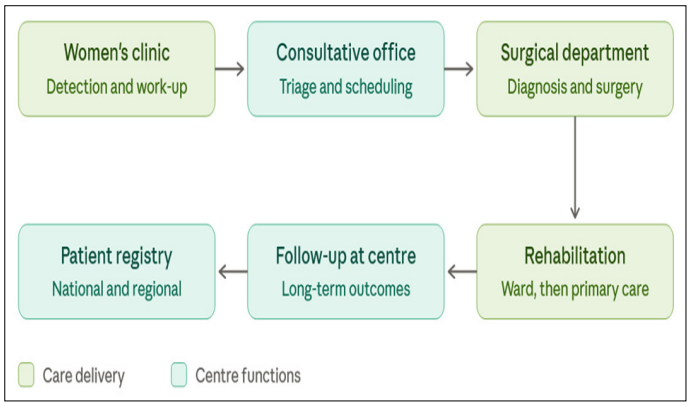

Fig. 2. Care pathway for patients with urinary incontinence and genital prolapse in the draft concept

At the outpatient stage, the women's consultation clinic or the urology office of a polyclinic detects the condition, examines the patient by protocol, and prepares her for surgery, while the consultative office of the center receives referrals, checks the examination, sets the date of admission, and enters the patient in the registry. At the hospital stage, the surgical department completes diagnostic tests, selects the technique, and performs the operation. At the rehabilitation stage, primary care detects complications and determines the period of incapacity, and the consultative office reviews operated patients and analyzes long-term results. The registry closes the loop in two forms: a republican register kept by the republican center and regional registers kept by each regional center.

Training

The concept and presentation describe an interdisciplinary cycle titled Pelvic Floor Surgery at the postgraduate academy, with two layers of trainees. The draft made attendance mandatory for all primary care physicians in women's consultation clinics and polyclinic urology offices, and this layer creates detection and therefore demand, while all center staff complete the full operative track, which creates the workforce. The cycle was designed with an equal share of theory and practice; groups were limited to 12 participants; and the teaching rooms were to receive live video from operating rooms. Fig. 3 shows the three-stage structure of the curriculum.

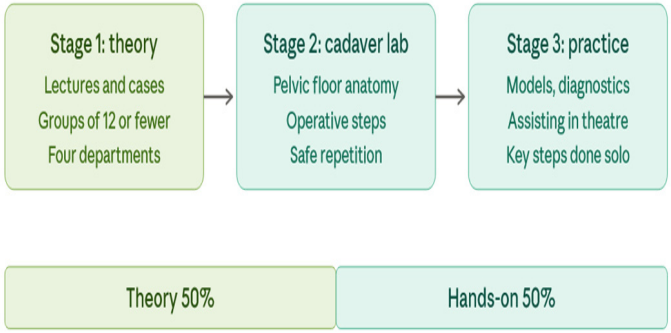

Fig. 3. Three-stage curriculum of the training cycle, Pelvic Floor Surgery at the postgraduate academy

The first stage combines lectures with video case reviews. The second stage takes place on cadaveric material and covers pelvic floor anatomy and the main steps of the operations. The third stage moves to clinical cases, working with diagnostic equipment, rehearsing operations on models with non-sterile samples, and assisting in real operations, so that by the end of the cycle, a trainee can perform the main steps unaided. The long-term plan sets the goal of establishing a national school of pelvic surgeons capable of training physicians from other countries.

Public Awareness

The concept lists the education of the population as one of the functions of every center. The presentation records television programs on urinary incontinence in 2008 and on genital prolapse in 2009 on a national channel, and the launch of two websites, one for physicians and one for patients. The medium-term plan adds lectures and booklets in women's consultation clinics, patient schools, and press articles, all of which address the late presentation described in the rationale.

Normative Fixation

Several elements gave the new practice a place in the regulatory and financing system. The presentation reports that treatment protocols had been updated and approved by 2009, that criteria for diagnosis and for incapacity after surgery had been developed, and that reconstructive operations on the pelvic floor with synthetic implants had been assigned to the category of high-technology care with a complexity coefficient of 2.5. The concept itself was drafted as a state program financed within the current republican and local budgets under the control of the Ministry of Health. Table 1 summarizes the elements by function, by stage, and by responsible body.

Table 1. Elements of the program by function, stage, and responsible body

Element	Function	Stage	Responsible body
Training of twenty-seven specialists in Russian university clinics	Workforce	2006 to 2009	Industrial partner, host clinics
Three national scientific events with invited professors	Workforce, demand	2007 to 2009	Ministry, postgraduate academy, partner
Statistical registration of patients	Norm	2009	Ministry, partner
Diagnostic algorithms and updated treatment protocols	Norm	2009	Chief specialists of the Ministry
Assignment to the high-technology category, coefficient 2.5	Norm	2009	Ministry of Health
Draft concept of the state program	Norm	2010	Working group, Ministry
Republican center and five regional centers	Workforce, demand	2010 to 2012	Ministry, host hospitals
Mandatory attendance of primary care physicians at the cycle	Demand	2010 to 2012	Postgraduate academy
Operative track of the cycle for center staff	Workforce	2010 to 2012	Postgraduate academy, partner
Equipment and consumables for the centers	Technology	2010 to 2012	Host hospitals
Public awareness: television, websites, patient schools	Demand	2008 to 2012	Partner, centers

DISCUSSION

The model

Table 1 reads as a model of three functions arranged in time. Demand creation includes training of primary care physicians, public awareness, and the pathway that carries a detected patient to a center. Workforce creation includes the postgraduate cycle, training abroad, and the centers as clinical bases, and normative fixation includes the protocols, the registry, the tariff category, and the program status. The technology enters at the medium horizon into a system that already has a core of trained surgeons, approved protocols,

a tariff that pays for the operation, and a registry that records the result, while the mandatory cycle for primary care physicians and the equipment of the centers proceed within the same horizon. In the terms of Greenhalgh and Abimbola (2019), the program reduced complexity in the adopter and organizational domains before the technology domain became active, and in the terms of Hirst et al. (2019), it built the registry of the long-term study stage before the exploration stage began.

Transferability

The same sequence appears in three later documents from radiation therapy projects, the latest dated 2021, and Table 2 sets the Belarusian elements against their counterparts.

The Tatarstan memorandum identifies the training of healthcare workers as a key factor in development and extends it to all staff levels. The analytical document on the partnership model places lead educational centers before the installation of systems in federal centers. The Dagestan order of November 2021 shows a region without a radiotherapy center, bringing four specialties into a single discussion by ministerial instruction, which repeats the functions of the national events of 2007 to 2009 and the attendance rule for primary care physicians. None of the national programs in these documents were approved based on the available corpus, so the counterparts in Table 2 are design intentions. The sections of the analytical document on the staged plan and the training strategy rest on first-hand work in the same role as in the Belarusian project, and their reappearance across two technologies and two countries marks the sequence as a transferable design and a documented working practice.

Table 2. Elements of the pelvic floor program and their counterparts in later radiation therapy projects

Element in the pelvic floor program	Counterpart in radiation therapy projects	Source document
Interdisciplinary cycle taught by four departments	Training programs for all staff levels, including engineers and medical physicists	Tatarstan memorandum, available copy
Republican center as a clinical base	Reference center for demonstrations inside a working hospital	Tatarstan memorandum, available copy
Training of center staff before equipment supply	First stage of the draft national program creates lead educational centers, second stage installs systems	Analytical document on the partnership model
Industrial partner funds training of specialists	Manufacturer responsible for training physicians and medical physicists	Analytical document on the partnership model
Patient registry and care pathway	Hospital organizes the flow of oncology patients, ministry reimburses each treated case	Analytical document on the partnership model
Mandatory training for primary care physicians	Ministerial order obliging four specialties to attend a regional conference	Dagestan order, November 2021
National events with invited professors	Regional conference in a region without its own center	Dagestan order, November 2021

Relation to the Literature

Later evidence supports the interdisciplinary team as the organizing unit: a tertiary unit in Cambridge found that joint pelvic floor meetings changed the management plan in 20% of cases and the responsible team in 16% (Pandeva et al., 2019). A systematic review that searched the literature through September 2024 reached the same conclusion for the full range of pelvic floor disorders and called for standardized protocols for such teams (Tsai et al., 2026). The registry element anticipated a development that would become mandatory elsewhere a decade later, when the Australasian Pelvic Floor Procedure Registry began tracking outcomes of pelvic floor procedures (Jayasinghe et al., 2023). A systematic review of cadaveric simulation reported short-term skill gains and no evidence of transfer to live surgery (James et al., 2019), and a review of urogynecologic surgical education found that most studies stop short of a six-month follow-up (Patel et al., 2023). The Belarusian curriculum addressed this gap through its third stage, in which trainees assist in real operations.

The role of the Industrial Partner

The partner appears in the documents as a funder of training abroad and of national events, as a member of the working group, as a co-organizer of public awareness work, and as a supplier of non-sterile samples for training. The concept assigns procurement to the hospitals and names no supplier.

Limitations

Four limitations apply. The analysis rests on a single edition of each document, and the concept is a draft whose approval and execution cannot be verified in the corpus. No data on operations, training throughput, or outcomes after 2011 were available, so all quantitative statements describe plans and preparatory steps. The account draws on first-hand participation, which provides insight into intent and carries the risk of a favorable reading. The regulatory environment for synthetic implants in pelvic surgery changed in several jurisdictions after 2010, and Rotem et al. (2024) document the resulting divergence between countries, although the

pathway, the registry, the training, and the staged sequence do not depend on any particular device.

CONCLUSION

The Belarusian program for pelvic floor surgery, in its available draft version, introduces a complex surgical technology by beginning with clinicians and patients and ending with equipment. Three decisions define the design. The first merged three specialties into a single clinical field with a common curriculum, protocols, and registry, which gave combined defects a single point of care. The second phase placed six centers within existing hospitals and built the care pathway from existing departments. The third timed the elements: training abroad, national events, registration, protocols, the tariff category, and public awareness came first, and the centers, the mandatory cycle, and the equipment followed together in the medium horizon into a system that already had a trained core.

The same order reappears in later radiation therapy projects in Tatarstan, in a draft national program for Russia, and in Dagestan, where training and educational centers precede the installation of systems. The evidence remains documentary, and future work should test the model against implementation records and examine how commercial and public interests shaped the sequence. For a health system that plans to acquire a costly technology, the case suggests an order of work: name the field, train the operators and the referrers, write the norms, and buy the equipment last. The case belongs to the years 2006 to 2015 and is read here in 2026, when a decade of implementation research has confirmed that adoption fails most often in the organizational and adopter domains that the program addressed first. Later evidence has given the design of that period a vocabulary and has left its logic intact.

Conflict of interest

During the period covered by the reference case, the author held a position at a manufacturer of the product class under review and was responsible for developing a product launch strategy for emerging markets. This explains access to the design documentation underlying the analysis and also introduces potential bias in the estimates. Three measures have been taken to mitigate this bias. Numerical statements about market conditions and clinical outcomes are based on independent published sources, while indicators retrieved from internal design documentation, specifically, the ratio of implant types, the ratio of theory to practice in the training cycle, and the maximum training group size, are marked in the text as estimates and program parameters and are not presented as established facts. Trademarks have been replaced with generic terms. Planned and contractual project indicators are separated from established facts and are not presented as results. The author did not receive any funding related to the preparation of this article.

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