

Community-based education for registrars in family medicine at Walter Sisulu University

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At Walter Sisulu University (WSU), postgraduate registrar training in family medicine commenced in 2008 and is based at Mthatha General Hospital, the District Hospital for King Sabata Dalindyebo Health District. During the first three years of training, the registrars spend 18 months in a district hospital rotating through various units (medicine, surgery, paediatrics and obstetrics), supervised by family physicians. There is an elective period of six months in which they train at other specialist or service units (e.g. hospices) according to the individual's needs. They spent a further 12 months full-time at one of the community health centres (CHC) accredited by the Health Professions Council of South Africa for registrar training in family medicine, under the supervision of a family physician. In this open forum, we have provided the background to this CHC placement and its rationale. We believe that this model will serve the needs of the South African health system.

The medical school at WSU is a pioneer of community-based education (CBE) and problem-based learning (PBL) in South Africa. In line with this educational strategy, the Department of Family Medicine adopted CBE as part of its postgraduate programme. CBE is defined as "a means of achieving educational relevance to community needs, and consequently, of implementing a community-orientated educational programme".¹ CHC training allows the registrars to utilise the community extensively as a learning environment, while students, teachers and community members engage in the learning experience. This service-learning environment also ensures that the community benefits from the academic programme. The registrar is exposed to the most common problems experienced by the population and learns to deliver appropriate healthcare within the available resources. In the CHC, training is carried out with the academic rigour previously reserved for the hospital environment.

While CBE and PBL can be implemented, there is no benefit to society unless there is social accountability.

Social accountability for medical schools is defined as "the obligation to direct their education, research and service activities towards addressing the primary health concerns of the community, region, and/or nation they have a mandate to serve. Priority health concerns are to be identified jointly by governments, healthcare organisations, health professionals and the public".² Social accountability is the most important and difficult challenge in medical education.³ While the goal of medical education is care of the patient, education should be directed towards the health priorities with which the community has been identified. The registrars are encouraged to ensure that services at the community level are of high quality and also that the Master's Degree thesis in family medicine reflects community concerns. The Department of Family Medicine will be guided by community input with regard to its training programme.

Primary healthcare (PHC) is the most cost-effective way to deliver essential health services.⁴ However, the scope of PHC is often misinterpreted. It is not only a set of services, but is also an attempt to improve the health of the community. The approach should encompass the core values of quality, relevance, equity and cost-effectiveness in achieving optimal health outcomes.⁵ The World Health Report 2008, entitled *Primary healthcare now more than ever*, sets the agenda for the renewal of PHC and puts forward four sets of reforms to promote PHC. These reforms pertain to universal coverage, service delivery, public policy and leadership.⁶ PHC is also a vehicle for the successful attainment of Millennium Development Goals (MDG).⁷ South Africa is lagging behind on all of the health-related MDGs.⁸ Therefore, it is essential that family physicians work with other members of the primary healthcare team and the community towards achieving the MDG goals.

CHCs and clinics are the interface between the community and the health and development sectors. They are the most numerous and widespread structures for the delivery of health

services. Therefore, health sector attempts to assist people will either succeed or fail at the CHC level.⁹ Registrars should be involved in the revitalisation of training programmes for CHC and clinic staff. This could take the form of working with people and organisations in the local community, planning, general management, financial management, information management, and liaising with local government, in addition to imparting the usual health skills.

Healthcare task shifting has become an accepted strategy in response to the rapidly expanding demand for healthcare services for human immunodeficiency virus (HIV) and other chronic illnesses, taking cognisance of the current shortage of health workers.¹⁰ Specific tasks are transferred, where appropriate, from highly qualified health workers to those with shorter training and fewer qualifications in order to make optimum use of the available human resources for health. For physicians, the implications of task shifting are perhaps underappreciated with respect to:

- The need for enhanced clinical competence;
- The ability to mentor and communicate effectively with members of healthcare teams with less training; and
- A renewed sense of professionalism that demands accountability of entire healthcare teams for patient outcomes.

The CHC provides an appropriate platform for the registrar to work in a multidisciplinary team (including nurses, doctors, community health workers, social workers, non-governmental and faith-based organisations, and traditional healers) with the common interest of serving the community. For example, Colvin et al have provided evidence that nurse initiation and management of patients on antiretroviral therapy is feasible in South Africa, but requires training and support.¹¹ These can be provided by the registrar training programme at the CHC level.

Like many other developing countries, the South African health system runs many vertical programmes, e.g. HIV, tuberculosis and childhood immunisations. However,

available evidence, which is limited, suggests that integration between horizontal (personal and community-oriented care) and vertical (disease-oriented) care is essential for disease control.¹² Registrars are trained to act as agents for integration at CHCs and to provide comprehensive care.

We are of the opinion that the skills, knowledge and attitudes needed to implement the PHC approach are best learnt at the CHC, as it is linked to the community.

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